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1 DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

RMPS REVIEW COMMITTEE MEETING

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Conference Room G-H
Parklawn Building
Rockville, Maryland

Thursday, 21 September 1972

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PROCEEDINGS

DR. SCHMIDT: Good morning. I missed my chance a minute ago, there was a little lull in conversation and obviously it was time to begin. But someone said something and I missed that opportunity.

I am used to a lot of feedback from my Executive Committee and its groups that I work with, but it usually is not as noisy as the feedback this morning. The room is turned around and there are some new audio equipment in here. We may have a little more music than usual. In addition to the new look of the table in the room there is a new look about the table.

And first and most importantly we would like to welcome some new members to the Review Committee and I would introduce them to the other members of the Committee and to the Staff and guests in the room. Immediately to my left, Mrs. Maria E. Flood, no, I am sorry, down there. Hold your hand up so everybody can see Mrs. Flood. Who is from the Texas RMP. She is a staff person, a regional representative from El Paso. And immediately to my left then Dr. Grace James, who is a pediatrician from Louisville, Kentucky. And on Dr. Brindley's left is Dr. Bill Luginbuhl, Dean of the Division of Health Services, University of Vermont from Burlington.

He is on the Northern New England Regional Advisory Committee and is experienced in health care delivery systems

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1 and so on. So we welcome the new members to the Committee. I
2 warn other committee members that the three new members have
3 been working hard all yesterday afternoon. They have been
4 briefed and brought on board and made experts and I am a little
5 bit concerned that they may be a little more expert in certain
6 areas right now than the rest of it.

7 Is Henry here? Henry Lemon, our old friend, will
8 be with us for the site visit report to West Virginia. Henry
9 is on vacation and he kindly agreed to come in for this session.
10 And Dr. Simmons Patson, chairman of the North Carolina RMP,
11 will report on the site visit to Central New York. Dorothy
12 Anderson is ill. Dr. Andrum is ill and won't be with us for
13 this session.

14 Dr. Toomey is coming a little late. Dr. Brindley
15 unfortunately can be with us only today. Another announcement
16 is that Sister Ann Josephine is practically enroute to Rome for
17 a sabbatical year of study. She, this is her last meeting, there-
18 fore, and I really need not express to the group the loss that
19 this committee will feel when she is no longer sitting there
20 holding down the fort.

21 She has been in Salt Lake City for what did you say,
22 34 years? And this will really be a sabbatical for her. You
23 are really supposed to get one every seven years, not every 34.
24 But we thought this afternoon that we would celebrate what I
25 think is an exciting and happy event for her, and we will have

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1 coffee and a little celebration this afternoon. Mr. Parks has
2 resigned from the Review Committee, because of other pressing
3 priorities and time commitments and so on, and we will miss
4 Mr. Parks.

5 And finally this is the last meeting for Warren Perry,
6 whose term expires in December. I would remind the committee
7 of the confidentiality of the meeting. The confidentiality
8 statement is printed in your material, the discussions of the
9 Advisory Groups are confidential except as disclosure is
10 authorized by the Administrator of the Administration.

11 Dr. Margulies will review the policy regarding
12 review of application meetings.

13 DR. MARGULIES: There has been a new Executive Order
14 which was actually effective during the last meeting of the
15 council but the date coincided with the time the Council was
16 actually in session and it has not yet been made official. It
17 had not been then. It is now. This has to do with public
18 attendance, and it is meetings which are composed of advisory
19 bodies affecting policy which are working with the Federal
20 Government agencies. And it has been further defined since the
21 time of the Executive Order so that there is a reasonable level
22 of clarity now of what it means and how it is to be handled.

23 The second, Secretary Richardson, has defined it
24 for our Council as applicable to those parts of Council meetings
25 which are discussions of policy and which lead to advice on policy

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1 per se will remain closed, and that appears to be acceptable.
2 That means that when the council meets, the agenda will be
3 carefully divided between those portions which deal with policy
4 review which in the case of the Council takes up certainly the
5 majority of their time.

6 And those parts which represent review of applications.
7 The Review Committee is not changed in its function. It still
8 remains a closed meeting according to current definitions.
9 The Executive Order applies to all groups which act in an
10 advisory capacity and who represent non-governmental group
11 meetings.

12 It also means that there will have to be an appropirate
13 agenda available. It must be announced in the Federal Register
14 at the time of the meeting to be held. It has to be in the
15 Federal Register and there is a mechanism for members of the
16 public not only to attned but to have access to the written
17 materials, to the results of meetings and to the meeting, it-
18 self.

19 This applies to subcommittees, Executive Committees,
20 and applies for example to groups which we may pull together
21 to advise us on evaluation or on any specific phase of RMP
22 activities.

23 It applies to all Federal activities and will among
24 other things it seems to me keep a number of people extremely --
25 people managing all of the data which flows in, has to be

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reviewed and put out again. It appears very likely that there will be at least some similar kind of requirements placed on grantees.

This is likely to take place in the very near future. It will not seriously affect the RMP function, excepting that it appears highly likely that there will be a requirement for the regional medical program when it is preparing or submitting application to give public notice to that effect. The other requirement such as the maintenance of materials, the continuation of a library and an available information system for the public, are already in existence in regional medical programs.

So also is the maintenance of verbatim records of meetings which we have here, which we have at the Council. But it will change the environment and will create some interesting entries. I expect that some programs will be more directly affected by this than others.

DR. SCHMIDT: Fine. Are there any questions or comments for Dr. Margulies?

If not, then I would remind the group of the conflict of interest policy which states that Review Committee Members should not participate in situations in which a violation of the conflict of interest laws and regulations are likely to occur and I am sure that the new committee members know that we do not participate in discussions of applications and affairs of regions in which we reside.

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1 And so on. Also, a reminder of the future meeting
2 dates which are on your agenda, January 17th and 18th, 1973.
3 And May 16th and 17th, 1973. We have a, as usual we have a
4 very full schedule for these two days. We will have to alter
5 the order of review somewhat to allow for Dr. Brindley's de-
6 parture today.
7 And also to conduct a couple of experiments and infor-
8 mation dissemination to the Committee, kind of experiments in
9 easing the review process, and then we have obviously the
10 number of applications to get through, as well as the discus-
11 sions that are on-going about the function of the committee.
12 Probably a good part of the morning will be devoted
13 to report from Dr. Margulies about various things and other
14 staff members. Then moving on to one of the experiments in
15 information dissemination, and in the way that the Review
16 Committee fits into the total picture of the RMP Review process.
17 So that we will begin then with a report from Dr.
18 Margulies about the recent council meeting and other matters
19 that he sees fit.
20 DR. MARGULIES: Thank you. I think it probably would
21 be useful to talk in specific terms about the recent meeting
22 of the Council with the kind of feedback that the Review Com-
23 mittee which I think you will find helpful, and after that
24 and whatever discussion you may want to have on it, I would
25 like to talk with you about appropriations, legislation for

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1 regional medical programs and other programs, all of which is
2 of particular importance at this time.
3 You have in front of you a manilla folder which has
4 in its a status report to the Review Committee of the actions
5 taken during the last cycle of the National Advisory Council.
6 This is primarily designed to give you the necessary infor-
7 mation.
8 It looks like this, (indicating), the necessary
9 information regarding the action which the Council took based
10 upon the review and recommendations from this committee. You
11 will find as you go through it that the actions of the Review
12 Committee in terms of funding were held up all the way through.
13 So also were all other actions with two exceptions. One of
14 them had to do with the rather uneasy recommendation on the
15 part of the Review Committee that tri-annual status for Missouri
16 Regional Medical Program be withdrawn.
17 Let me interrupt myself at this moment to say that
18 everyone has been welcomed here excepting the new Chairman,
19 Dr. Schmidt. Welcome, Dr. Schmidt, as Chairman of the Review
20 Committee.
21 What made me think of this was the fact that I was
22 suddenly on Missouri and I realized that I had a new chairman
23 next to me. There was a strong recommendation at the time
24 the Review Committee met that there be a site visit to Missouri,
25 and that this site visit be for very specific purposes.

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#1 1 A number of things have occurred since that time in-
ɔa 8 2 cluding the Site visit which will be reported on later during
3 this meeting and has just been completed. The other change
4 in the recommendations had to do with some action on a kidney
5 project which you can find evidence of in Ohio, as I recall.
6 Otherwise the actions, the recommendations, the
7 criticisms of the Review Committee were those that were accepted
8 by the Council and which were an official part of our subse-
9 quent action in dealing with the regional medical programs which
10 were reviewed in that cycle.
11 Now there may be some further questions particularly
12 abou the Missouri program because this occupied greatly the
13 review committee meetings. I think they would be dealt with
14 better as we get to that recent site visit which I think was
15 completed just this week, wasn't it, Mr. Chambliss?
16 MR. CHAMBLISS: Yes.
17 DR. MARGULIES: Now you may want to spend some
18 further time going over these figures and over the information
19 so we can come back if you wish. I will spend, I hope, a rela-
20 tively brief time trying to bring you up to date on such things
21 as appropriations for regional medical programs and new legis-
22 lation.
23 We live so close to it that we sometimes assume that
24 everybody has the same kind of vibrations that we have but

25 obviously that is not true because if I go across the hall I

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find they don't get the same thing I do so let me at least tell you hwere it is from our point of view.

I think it is general knowledge that there was an Appropriations bill passed by Congress, vetoed by the President, and the attempt to override the veto failed so that it has been necessary for Congress to go back through the Appropriations process once more.

That is now being done. The recommendation of the President was that the Appropriations remain consistent with the recommendations which had been sent from the Administration to Congress so that there can be a orderly and acceptable management of the national budget, and since he made that recommendation to Congress there has been action by the House which represents a kind of middle position so far as I can tell between what the Administration had recommended and what was the final action of Congress in the bill that was vetoed.

What happened with RMP during that appropriation process was approximately as follows: That the recommendation of the Administration which incidentally was the highest any Administration has made for RMP was around $131 million. That was raised to something like $150 million as I recall by the House.

It was raised by the Senate to $184.5 million and then in the Conference Committee it was compromised around a

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1 figure of $164.5. There has been in the action of the House
2 a figure which is approximately as I recall around $149.5
3 million at the present time.

4 To my knowledge there has not been any Senate action
5 and certainly I have no knowledge about what might happen if
6 that passed and if the rest of the bill is at that level and
7 it again goes to the President.

8 That gets into some speculation which is well beyond
9 me. If the present bill does pass in whatever form it finally
10 emerges there will then be some further delay as there is an
11 analysis of distribution of actual allocation of funds, and
12 it takes a certain amount of time for a program like our own
13 to know exactly what its funding will be.

14 It is very difficult to estimate that time with
15 minor skirmishes like a national election coming up. But it
16 is not likely to be in the immediate future. That always poses
17 a problem. We are rather accustomed to it. It means that
18 in the interim this program like all programs in the Federal
19 Government operates on the basis of what is known as a continuing
20 Resolution.

21 A continuing Resolution restricts us to levels of
22 activity which are consistent with those that we had during
23 the preceding fiscal year. And it means that we cannot plan
24 on a large increase even though we think one is in the offing,
25 we are free to reduce our funding, but in general we are required

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1 to stay around the same general level. We do not have any
2 figure on the succeeding fiscal year. There will be a budget
3 submission. There will then be another round of reactions
4 between the Administration and Congress, and I think any
5 speculation on FY 1974 is pretty foolish.
6 On the other hand, we have to do a certain amount
7 of speculating because we can't very well make decisions
8 within this program or any other affecting levels of activity
9 for one year and ignore the next year, so we will have the
10 usual kind of calculated guessing games going on as we did
11 in the past.
12 I don't anticipate, but I really can't rule out,
13 another kind of a problem like the one we had during the last
14 Fiscal Year in which we had to deliberately plan around some
15 supplementary grant requests to make sure we could utilize
16 our funds effectively at the end of the year. You will recall
17 that what we had to do was anticipate, well, really at the last
18 minute, the availability of funds during the second week of
19 June, funds which had to be expended effectively and usefully
20 by June 30th.
21 We did that by using a supplementary grant approach.
22 We have no intention of doing that again. We have never
23 desired to do it because it is totally inconsistent with the
24 RMP approach to things. In the current round of appropriations
25 recommendations which have been under discussion to the best

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1 of my knowledge there has been no earmarking of funds by
2 Congress saying that there will be so much for this activity
3 and so much for that activity. There has been an earlier
4 decision which was based on the first appropriation process
5 to take some $15 million for emergency medical systems support.
6 Whether that will be sustained during the present
7 fiscal year, I do not know but I rather think it will be. There
8 is every indication that that will be done. That is a budget-
9 ary decision within Health Services and Mental Health Adminis-
10 tration, perfectly acceptable to Congress but not something
11 which was part of their Appropriations Act.
12 Early in discussions on appropriations there were some
13 earmarkings, these were all dropped for one reason or another.
14 But they often reappear or come out in a different form after
15 the Senate takes action, so we simply have to wait to see
16 what will happen.
17 I don't know that I could respond to any question on
18 this subject but if anybody has some later information I would
19 be glad to hear it. Let me switch for a moment to an associated
20 issue, on which I cannot add any further light, but perhaps
21 contribute to some speculation.
22 We have talked about this during the last meeting
23 of the Review Committee as well. This is the year in which
24 there has to be an extension of legislation for regional
25 medical programs and for a number of others of the key programs

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1 in HSMHA which are dealing with the delivery of health services.
2 Such joint programs as Comprehensive Health Planning, National
3 Standards for Health Services, R&D, Hill-Burton and so on.
4 This provides an opportunity for the Administration
5 to try to look at these many forms of legislation which have
6 varied histories in terms of their first passage, first intent,
7 later intent, and so on, and try to pull them together in a
8 kind of pattern of legislative activities which could be admin-
9 istratvely made rational and which could be used to subtend
10 a consistent policy on the part of HEW.
11 The people who are thinking about it in the Department
12 assume quite naturally and I don't say this for political
13 reasons, that they will remain in office for the next four
14 years. That is natural not because of the polls but because
15 there isn't much alternative when you are in the Department
16 except to figure you are going to be in for another four years.
17 However, I think that it is their assumption that
18 they will be in any case. Now if that is true and if their
19 calculations are based on high probabilities, it means that
20 there is a better opportunity now than there has been in many
21 years with the growth and understanding of health problems
22 for a consistent policy to be established, for this to be
23 based on a higher level of grants consolidations, on a higher
24 degree of activities which reflect the concepts of health
25 revenue sharing, on the anticipation of National Health Insurance

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1 and some of the other major issues which have been under dis-
2 cussion for the last two or three years, and to design legis-
3 lation so that various kinds of programs relate with one another
4 in an effective fashion.

5 That means that for regional medical programs an
6 isolated look at what RMP ought to do would be inacceptable.
7 There has to be an analysis within the Department of what RMP
8 can or should do with some very careful reference to what then
9 this would mean with comprehensive health planning, with the
10 development of manpower, with the development of insurance
11 systems, quality monitoring and so on, so that I am confident
12 that the basic recommendations which will finally come out and
13 they have not been completed, by the Department for Congres-
14 sional action will depend upon a total analysis of the related
15 legislative programs, and a better elucidation within the
16 Department of what its basic policies and intentions are.

17 There are certain currents which may be confusing;
18 for example, the development of stronger international heart
19 and lung institutes as a categorical activity, the National
20 Cancer Institute, as a categorical activity, and yet a simul-
21 taneously vigorous statement, restatement, constant statement
22 by the Department that it wants to avoid categorical activities
23 and to develop greater consolidation of programs.

24 I don't believe that there is the kind of inconsistency
25 in those kinds of comments that one might believe. There is

#1 some level of inconsistency because sometimes actions are taken which are political and which are accepted despite the fact that they may be inconsistent with other kinds of performances but I think that a good illustration of the kind of working respect which can be established between a categorical approach and what we are attempting to do is expressed by the present plans to develop a national hypertension control program.

Now I am not going to go into that in any great detail because it has not been fully developed excepting that the Secretary has permitted the Department -- every time I mention the Department I get feedback. The Secretary has committed a group of people for whom he is responsible to a program of hypertension control. But I think the differences in what is being discussed probably as illustrative as anything that I can find offhand of the ways in which one can deal with categorical disease and not commit the errors of the past.

If this were to be a hypertension program as we would have done it four or five years ago it would lead very rapidly to a number of grant requests to which we would have acceded to build hypertension clinics and special investigative units and other kinds of projects which allow people to pursue their hobbies in various ways.

And these would be designed around an elaboration of the methods for identifying renal hypertension, for doing various kinds of assays of blood levels which would associate

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clinical investigators with a better understanding of the specialized forms of hypertension which they currently don't understand.

What is being talked about in the present Secretarial initiative is not that at all.

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1 It is an approach to a problem with an epidemioloic
2 basis which argues that one can move from a very miserable
3 level of hypertension diagnosis and management to a much better
4 level by using motification withing the existing delivery
5 system rather than setting up separate disjointed units to deal
6 with it in a separate kind of a way.

7 The figures are approximately like this: That there
8 may be 23 million people in the country with hypertenstion;
9 that under the most generous estimates, 7 million of them have
10 a diagnosis and some kind of treatment. To go from 7 million to
11 something approaching 23 million cannot be achieved by setting
12 up a series of highly sophisticated hypertension centers.

13 It can be done only by simplifying the system, by
14 accepting the fact that what you are getting at is essential
15 hypertension, that it is particularly a problem among blacks
16 where the frequency of hypertension is far greater than among
17 non-blacks. That it probably -- although that is not sure --
18 has an accelerated rate among blacks, particularly among black
19 females. That it is the very major cause of disability and
20 premature death in many population groups including a large
21 number who have no access to reasonable medical care.

22 Under those circumstances, one caould and I hope we
23 will in RMP as a part of this general project, approach that
24 kind of a problem through the health delivery system and in the
25 process discover something more about how to approach similar

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1 kinds of problems by an elaboration of the system as it consists.

2 Quite clearly it will require not only better edu-

3 cation of the public, better education of the profession, but

4 the utilization of the resoruces and particularly of providers

5 of medical care in ways that we currently are not doing but with

6 which we have had some experience.

7 On cannot expect the overloaded physicians in this

8 country to suddenly jump from the current level of hypertension

9 control to a high level of hypertension control entirely by

10 their own individualized efforts. No one seriously thinks that

11 can be don.

12 So, I think it represents to us an opportunity to deal

13 with major disease entities in a way which is sensible and use-

14 ful and not in the patterns of the past. This will allow us to

15 work very intimately with the National Heart and Lung Institute

16 and there are plans to work out a long similar lines, a little

17 more difficulty, I believe, with the National Cancer Insitute

18 with some major cancer problems.

19 Back to the legislation.

20 At the present time I think that it is reasonable to

21 assuem that when the new legislation for regional medical pro-

22 grams is written that the department will have some specific

23 recommendations to give it a higher level of definition than it

24 has had in the past.

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25 Now, I can't really go beyond that because there is

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1 debate going on here and downtown as to what the definition of
2 RMP purposes should be.
3 I have argued as well as I can and some of my col-
4 leagues on the staff, that we have worked very hard in the last
5 two or two and a half years to develop a series of institutions,
6 regional medical programs, which are capable of functioning
7 effectively but which are currently not guided clearly enought
8 and in exactly what it is they are supposed to do; that they can-
9 not go on effectively doing as many different kinds of things as
10 are being asked of them and survivive; that they must have a clear
11 working relationship with such major elements in HSMHA research
12 and development, comprehensive health planning, a better defi-
13 nition of relationships with manpower activites in HSMHA and in
14 NIH, but more than anything else an understanding of where they
15 fit in what general HEW policy, a decentralized approach to
16 improvement in health delivery systems and the other kind of
17 legislative programs.
18 I don't believe that it is a matter of life or death
19 for us to have a stronger definition, but I think it would
20 serve everybody's prupose if that were the case.
21 I have personally argued very strongly in favor of
22 keeping as a minimum a strong emphasis and an expanding concern
23 in regional medical programs for quality assessment and quality
24 assurance, which is a broad subject, one which must be approached
25 vigorously and one where I think RMP considers a very useful

sw4 purpose.

But, I doubt that we can continue to deal with everything from review and comment which is being suggested as one of our functions, to the development of regional centers, to categorical approaches to cancer disease, to new forms of education, to new types of manpower utilization, to the development of a better world health delivery system, et cetera, et cetera, and retaining effective and strongly functioning institutions.

I think most people accept that concept.

What is not certain is how the final definition of legislation will be proposed. Whether that has been done on the assumption that it will be, there is still the matter of Congress to decide what it thinks RMP and the other forms of legislation should be so it should be an entertaining year.

At the present time there is a better understanding and a better appreciation of this program where there has been very little understanding than at any time in the past.

That is not surprising because the program is older, it has had better opportunity to be observed and more people have been involved in looking at it.

It is impossible for me, also, to give you any kind of idea of when legislation actions will start, but we do know that the Congressional committees, staff's of the committies, have begun their deliberation and some of the outside groups like one that Mac serves with, the Association of American Medical

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Colleges, have been carrying out their own deliberations and reaching their own conclusions for what kinds of testimony they will make when there is an opportunity for it.

Now, it may be there are some questions about these issues also.

What I have done more than anything else I think is simply try to bring you up to date. Let me get down to a couple of specifics for the moment then. We may want to come back to this.

There are two issues which were not part of the review committee -- one that was not part of the reveiw committee deliberations the last time and which was the subject of extensive council discussion -- and that was the utilization of R,P funds for support of health maintenance organizations.

You will notice that one of the things I did not speculate about was the passing of legislation for HMO's and I refuse to speculate to that, you can pick up any newpaper and the the latest speculation, but there has been, for those who are not keenly interested, no legislation passed yet for health maintenance organizations. There has been, however, an active program for the plannin gand development of HMO's.

There was agreement, after extensive debate within the council, that RMP funds could appropriately be used and should be used for the support of health maintenance organizations for planning and development purposes, with this to be limited to

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1 funds approved by the council during FY-72, that is in the
2 fiscal year which was just finished.
3 There was also an agreement that the review and
4 selection and general supervison of this activity should be the
5 responsibility of the health maintenance organization service,
6 which is a parallel service to regional medical programs in
7 HSMHA.
8 There was a reveiw carried out by the HMO process
9 which goes all the way from the initial application to the
10 review in the regional offices to a central review here in
11 HSMHA, wiht participation on the part of our staff and partici-
12 pation on the part of members of the National Advisory Council
13 prior to the official selection of HMO applicants for continu-
14 ation for planning and development.
15 And out of that was made the selection of a number of
16 HMOs which were then given further support by contract. That
17 was completed within the fiscal year. The activity is under way
18 and will be continued in that manner only excepting by whatever
19 individual action RMPs may elect to take as resource institutions,
20 until and whenever there is a further decision, either by legis-
21 lative process or elsewhere for HMO development.
22 That means that the funds are being used for that
23 purpose. They are not being managed by the regional medical
24 programs. The regional medical programs remain available as a
25 close resource and collaborator in it.

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1 There was enough debate on that so we finally had
2 to end up with a mail ballot because there was real
3 dissension within the Council itself about the use of the
4 funds this way.
5 But I think they made the right decision because
6 the HMO development does provide some opportunities for
7 things that RMPs ought to be dealing with that are very
8 striking, not the least of which is working on the whole
9 issue of quality assurance.
10 Then one final information item I would like to
11 bring to you which may get some further discussion. It will
12 certainly come up in a related way in one of the reviews.
13 You may recall that we have had for some time varying levels
14 of discomfort with territorial overlaps in various regional
15 medical programs.
16 The most prominent one came up during the last
17 review sessions with the Intermountain Regional Medical
18 Program which has its home base in Salt Lake City, mountain
19 states with a home base in Boise, and well, to the same
20 degree, the Colorado-Wyoming Program which has its home
21 base in Denver.
22 The difficulty there was that these programs very
23 sensibly are parts of several states. Each of them have
24 overlapping state areas which were designed around the
25 natural flow of patient care, the referral centers and so on.

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1 There occurred over time more and more uncertainty
2 about whose turf belonged to whom and it was very
3 striking with their proposals for educational and service
4 activities in one case coming from two regional medical
5 programs for the same community.
6 That suggested that there was indeed some confusion
7 over who it belonged to, although for some of those
8 communities it wasn't very exciting because they felt that
9 they would like to get funds from both regional programs,
10 which is a reasonable community attitude.
11 We were concerned for two reasons. One, because
12 there was adminstrative uncertainty on the part of those
13 programs, and two, because there are activities within states
14 like comprehensive health planning at the state level, and
15 other kinds of programs, Hillburton and so forth, which do
16 require a definition of state boundaries because of the
17 manner in which funds are managed.
18 So we felt that the programs should learn how to
19 deal flexibly, operate at the state boundary level when
20 necessary but be perfectly free to move beyond those
21 boundaries when it made sense based upon the way the delivery
22 system works.
23 In order to resolve that we asked that they meet
24 together which they did do on July 20 of this year, with
25 representatives of coordinators, of grantees, of regional

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advisory groups.

Our role was to be there to provide any kind of information necessary but not to make any decisions for them. We felt that they were perfectly capable, better than we, more capable than we of deciding how that should be worked out.

They have reached a working understanding of how this is to be done. And it includes some redefinition of the territorial limits to be involved. It involves the creation of a committee representing all of the programs, carfully defined, to decide any uncertain types of project activities where there appeared to be conflict or potential conflict.

They have devised an appeal process in case that doesn't work very well and have agreed to work along that line with some kind of reanalysis over a period of the next six months to a year of how effectively it is working.

It seemed to us that they went about it very sensibly, realized that they had to do something and have provided both the geographic limits and the kind of flexibility which is necessary for effective RMP function.

I do not believe that the solution they reached or the way they went about it can automatically be applied to another area because theirs was a special kind of situation. And I think as we get to the review of some of the other programs like those around Memphis and those

1 around Saint Louis that we will find that the issues may be
2 similar but the potentialities for a solution may not be the
3 same. They will have to be looked at in a different way.
4 The reason I report on the one from mountain
5 states is because it belongs there and only there and it
6 has been a useful way of doing it.
7 But the others are other kinds of problems. I think,
8 Mack, that that's as much as I need burden the Review
9 Committee with at the present time.
10 DR. SCHMIDT: I welcome Dr. Patterson to the
11 session who just walked in. Happy to have you here, sir.
12 Are there any questions for Dr. Margulies at the
13 time?
14 DR. KRALEWSKI: On this funding for HMO projects
15 then essentially are we going to go down a path where some
16 of the RMP money is going to be devoted to the support of
17 the office of HMO services and then some other RMP money be
18 funneled through this process to fund HMO applications? Is
19 that what you are telling us?
20 DR. MARGULIES: No, the agreement which was very
21 clearly in the record and which supported the statements the
22 Secretary made when he was testifying before the
23 Appropriations Committee was that this is one-time money only.
24 In fact, it was released for RMP by the Office of Management
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25 and Budget during that fiscal year with the understanding that

it would be used for that purpose or it wouldn't have been released at all.

It happened to be in the RMP basket but it was money that had been not released during the preceding fiscal year.

We are now on a one-year basis so that that kind of thing cannot occur but it is our understanding that this is the one time that that kind of a process would be used for RMP money to be used by the HMO service for grant or contract for HMO development.

I cannot tell you, though, that there will be during the coming year no additional effort at specific taps on RMP funds because that may occur. I have no evidence of it aside from the emergency medical activity which is pretty close to our interest anyway as is the HMO.

DR. SCHERLIS: Are you distinguishing in this report between that given by RMPs and that given by local RMPs becuuse a great many RMPs are obviously involved in HMO activities? You are distinguishing between these two?

DR. MARGULIES: Yes, I am. The actions of the HMOs locally have been defined in a memo of understanding which we sent out early in the year, very carefully, which was developed in common with the HMO service. This is to keep the line of development of health maintenance organization consistent with the HMO organization.

RMPs are encouraged to work as closely as they can and wish with applicants for health maintenance organization to give them the kind of professional, technical support they may need but the actual development for funding, further elaboration and so forth is to go through the HMO channel.

That would mean that an RMP which is being responsive in what it does would on learning of the interest of an applicant at an HMO, inform the regional office people so they would immediately begin working with the applicant. The RMP could do whatever it felt advisable to assist them in their efforts but if there is to be further funding and at the present time I believe, Gordon, I am right in saying that it is expended for the, at the present time for new applicants.

Dr. McCloud is here. You are not currently accepting new HMO applicants, are you, de novo?

MR. MC CLOUD: That is correct. The only way new applicants could relate at the present time would be through generator contracts. We have a number of contracts with the American Association of Medical Colleges, American Association of Medical Clinics, the National Medical Association Foundation, Health Association of America and others.

And if a new applicant is looking for technical

assistance he can apply to these organizations and actually participate in getting started but this is not the same thing that we have been involved with in the past year in providing money for planning and development activities.

DR. MARGULIES: Now, if there is available at any time in the near or distant future more money for HMO development thereby it is the responsibility of RMPs to get applicants in the pattern of that kind of funding and not to try to supplant the HMO activity or take over HMO responsibilities.

SISTER ANN JOSEPHINE: Dr. Margulies, we talked about HMO development and I may be wrong but my impression at the present time is that we have developed just one component of the whole concept of the health maintenance and that is the prepared group practice component within the HMO concept.

DR. MARGULIES: Well, of course most of the attention during the planning and development has been toward that particular aspect of it because in the absence of it you don't have anything else to work with.

But there has been very extensive attention given to the manner in which the HMO will provide services, to the kinds of benefits which will be required, and there will be, I would think, and perhaps Gordon would like to comment on this, a certain amount of investment by all of our programs,

1 when HMOs are well established in experimental approaches
2 toward altering the forms of health care delivery, in
3 increasing their productivity, further defining what is meant
4 by health maintenance, altering patterns of medical care
5 in a favorable direction.
6 One of the primary interests of RMP, and one of
7 the reasons I felt that the investment in this was reasonable
8 is because it does provide the kind of complete system in
9 which innovations can be considered and tested.
10 Is that a reasonable statement, Gordon?
11 DR. MC CLOUD: I think this gives me an
12 opportunity to say at least some remarks about Dr. Margulies'
13 earlier comments about the lesiglative situation. As of
14 yesterday the Senate, with 80 percent of those in attendance
15 voting for the HMO legislation,passed the bill . As of
16 yesterday the House Subcommittee reported it out
17 unanimously, which will go to the full committee.
18 There is a problem there with respect to getting
19 through Congress this late in the year. But the movement
20 has been in this direction. The problem that we face,
21 particularly at this time with respect to Harold's comments
22 just now, is that we don't know which bill will be passed
23 and what definition of HMO we will be dealing with.
24 By that I am referring specifically to the item

25 that was in the Washington Post this morning which points

out that, "Established health maintenance organizations to provide mental health and dental care as well as a wide range of other types of medical services for persons preparing a fixed annual fee on open enrollment plan."

Well, this has reversed the emphasis. We see a basic program as being the comprehensive range of services with an opportunity and wherever possible, mental health benefits, dental health benefits and drug benefits being included.

Now, if the Kennedy Bill is passed I think it is fair to say that we probably would see this kind of all-inclusive thing.

The Administration Bill, Congressmen Roy's Bill in the House, works with a more limited but basically comprehensive program and in every bill, the Administration's Bill, the Democratic Bill in the House, the Democratic Bill in the Senate, preventive health maintenance is mandated in the definition.

I think the area has just really begun to open up and I think we are going to see through the health maintenance organization an opportunity to develop preventive programs.

The work is proceeding, and that's about where we stand at the moment.

DR. SCHMIDT: Warren?

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DR. PERRY: What is the current status of the area health education centers' work and RMPs' relationship to it?

DR. MARGULIES: I will give you a very brief answer. You know some time or other I am going to discuss with this committee something that is all settled. But it hasn't come yet.

Very, very briefly, the current status is that what is called an area health education center is -- has been very sharply defined. It is something which is -- operates through a university health science center through a medical school on a contract basis, funds available from the Bureau of Health Manpower.

It is a derivation from the legislation which they operate under, the health manpower legislation and is operating without there having been passed yet a specific bill for area health education centers. It represents that part of their legislation which deals with what are called health initiative -- health manpower initiative awards, AMEA, they call them.

If there is new legislation passed dealing specifically with the area health education center it may both alter the definition and responsibility. But right now AHEC is a very specific, a little tighter than in the Carnegie definition report operated by the Bureau.

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1 DR. BRINDLEY: Are the VA AHECs related?

2 DR. MARGULIES: The VA activities will be related

3 if they are included in the application for contracts which

4 must be completed by the end of this month.

5 There have not been, to my knowledge, actual

6 contract releases from the Bureau.

7 Maybe some of the others here, who have been

8 working with the Bureau could respond to that but they

9 must be completed by September 30.

10 If the VA is included in an application from the

11 then it will be part of the AHEC.

12 On the other hand, if the VA is included, it will.

13 The VA has also been working intimately with the RMP activities

14 which are not Area Health Education Centers by that

15 definition, but which are reflecting the kinds of principles

16 which we develop during the general discussion over the

17 Area Health Education Centers.

18 We have some very close affiliations with the VA

19 for that purpose.

20 DR. SCHERLIS: Would you want to comment on

21 Emergency Medical Services, in other words, if a region comes

22 in for funds, is this considered as a total part of what they

23 will be getting or is it looked at separately?

24 DR. MARGULIES: We are going to have a separate

25 discussion on that subject and I think it would be easier to

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1 to it when we can go back over what we have been doing, but
2 we will get back to it.
3 DR. SCHMIDT: I would take the liberty of just
4 making one comment about what Harold said. That is that RMPs
5 in general, and certainly this review committee have been
6 agonizing for several years about two things I think we will
7 have to continue having noising about.
8 He mentioned revenue sharing and there is a lot
9 of talk about health revenue sharing and if you think through
10 the implications of revenue sharing in regard to decentraliza-
11 tion of programs, then the whole business of decentralization
12 of authority is tied very closely to health revenue sharing.
13 Might be the health manpower dollar for example. That is
14 decentralized, implications for a lot of Federal programs
15 will change.
16 And we have talked about what the function of this
17 review committee is in regard to, or as opposed to local
18 review and I think that we will be discussing this more in
19 the next year because of the obvious major interest of the
20 present executive branch of the government in decentralization
21 and revenue sharing.
22 The second thing really is what RMP is in its
23 function, and you have to do with now CHPRMP, the national
24 centers and regional offices.
25 These are sort of a cast of characters.

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1 A major question is when legislation is rewritten,
2 do you say, "Well, there are deficiencies in what these
3 programs are doing and we will either set them aside or let
4 them go on and build new programs."
5 This is a favorite technique of bureaucracies to
6 get a new program to do something that others aren't doing.
7 Or, do you take what you have got and change
8 them, strengthen them, make the regional offices better to
9 do certain things, make RMP do its things in addition, and
10 go with what you have got.
11 And these are the sorts of things that are being
12 discussed and will have implications for RMPs and what they
13 do and how they fit in the future.
14 We will go on then, if there aren't further
15 comments or questions to reports on some specific items that
16 have already been raised in questions so that it is
17 appropriate that we have some review of the health service
18 educational activities and emergency medical services
19 activities.
20 And we do have some handouts and remarks on [illegible]
21 these subjects.
22 Dr. Hinman?
23 DR. HINMAN: Thank you, Dr. Schmidt.
24 As Dr. Margulies mentioned,during this past
25 fiscal year, it became obvious that there would be a necessity

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1 for acceptance of supplementary funding requests for several
2 activities.
3 We are going to report to you on two very specific
4 activities that occurred subsequent to the last review
5 committee meeting prior to the National Advisory Council
6 meeting in June.
7 The Division of Professional and Technical
8 Development is organized around a series of task forces to
9 accomplish specific activities.
10 These reports will be given by the managers of
11 these forces.
12 The first will deal with manpower activites,
13 commonly known as the Health Services Educational Activities.
14 Dr. Conley is project manager of that task force.
15 DR. CONLEY: Dr. Schmidt, Dr. Margulies:
16 The Review Subcommittee to consider applications
17 for supplemental funding of Health Services Education
18 activities met on May 20 at Sun Valley, Idaho, just prior
19 to the RMP Third National Allied Health Conference.
20 The subcommittee consisted of representatives from
21 the National Advisory Council and from this committee,
22 the latter included Dr. Warren Perry, who served as chairman
23 of the subcommittee, Ms. Dorothy Anderson, William Hilton,
24 Elizabeth Kerr, and Dr. Hess. During the one day meeting
25 a total of 79 projects submitted by 19 RMPs was reveiwed.

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1 The subcommittee was impressed with the number
2 of RMPs who were able to respond in such a brief time with
3 well developed applications.
4 It was apparent that many RMPs had been moving in
5 the direction of Health Service Education activities for
6 some months previous, using existing funds in their initial
7 planning efforts.
8 The coordinators had earlier in the year given
9 their support to various concepts expressed in a position
10 paper which had been prepared by staffs of RMPs and RMPF
11 STAFF.
12 In this paper an approach was suggested by which
13 the RMPs might better systematize their ongoing manpower
14 efforts and by which they might bring about a better balance
15 bet ween the quantity and quality of manpower and identified
16 health services needs.
17 It was this position paper which largely shaped
18 the criteria used by the subcommittee in its review. And
19 copies of these criteria are available if anyone wishes to
20 see them.
21 In addition to the more fully developed applications
22 reviewed by the subcommittee, the National Advisory Council
23 had delegated authority to the Director of RMPS to fund a
24 limited number of planning grants, each of which was not to
25 exceed $50,000 in budget.

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1 This action brought the total number of funded
2 health service education activities up to 57 projects from
3 25 RMPs.
4 Now, we have distributed to you a three-page chart
5 entitled "RMPS Health Services Education Activities, May-June
6 1972."
7 In a sense this represents a profile of funded
8 activity in respect to how those projects conform to RMPS
9 concepts at the time of review.
10 The headings on the chart represent some critical
11 elements which the subcommittee emphasized during its
12 review.
13 If you will note on the chart, the RMPs are listed
14 alphabetically, followed by the total award.
15 The next heading is RMPS Consortium Concept.
16 The subcommittee members were interest in the
17 applicant's commitment to a consortium representative of
18 education, health procedures, health care facilities, and
19 others, as appropriate for that community.
20 The subcommittee was also interested in whether
21 that consortium would be moving toward independent status in
22 the future.
23 The next heading is"Documentation of Need."
24 The subcommittee was most interested in whether
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25 the documentation was expressed in terms of health services

1 needs, rather than exclusively in terms of numbers of
2 personnel.
3 The basis for that is that identification of
4 Health Services needs logically precedes judgments on how
5 many personnel we need, what types, what type of training,
6 how they should be utilized, and how they should be
7 distributed.
8 It is also obvious, as we move along the chart,
9 that only a few regions are in the operational phase of
10 the activity wherein training is being undertaken.
11 It is in this phase that a fully committed repre-
12 sentaiton consortium could provide the climate wherein more
13 effective manpower can be distributed and appropriate action
14 included.
15 The last column relates to belief that it is not
16 only good sense to involve the community in matters which
17 intimately respect it, but chronically resisted manpower
18 programs and problems may benefit subtly by the introduction
19 of different viewpoints and new forces for action.
20 In conclusion, there is a plan for an ongoing
21 followup and consultation of this project by DPED staff.
22 Of most immediate interest is the opportunity for
23 cooperation which may arise as AHECs are funded by Bureau
24 activities, in areas where Health Services activities are
25 already developing, and as of last night, Miss Conrath

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1 reported from a meeting she attended that as of yet, nothing
2 has been reported on sites of AHECs or how many will be
3 funded, though probably it wouldn't exceed 12 or 13, but
4 such decisions as Dr. Margulies mentioned must be made by
5 the 30th of September.

6 Finally, of course, RMPS staff is interested in the
7 further development of the 15 projects for Health Service
8 Education activities, which will be reviewed today and
9 tomorrow as part of the applications in this cycle.

10 Finally, what do we anticipate from this RMPS experience
11 in supporting Health Education Service activities?

12 We expect, of course, there will be an exchange
13 of information on the regions in findings of other regions.
14 Specifically, we expect to learn more about the nature of
15 consortium, their composition, organization and
16 operation.

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17 We expect to see developed in the RMPs models
18 for the identification of Health Services needs on which to
19 base sound manpower judgments.

20 We expect to see more attention given to the
21 continuum between basic education, continuing education, and
22 health services need.

23 Finally, the RMPS experience in the support of
24 these projects will help define more clearly the nature of
25 community involvement in a productive partnership with health

1 professionals and it will help us identify the educational
2 needs of consumers so they can be fully developed as a
3 resource for improvements in the quality of care.
4 Thank you.
5 Do you have any questions?
6 DR. THURMAN: Could you give us a little bit
7 of a feel of what Maine had to say?
8 MRS. SILSBEE: Well, it obviously has quite well-
9 conformed to the concepts which were promoted by RMPS.
10 DR. THURMAN: I agree with that. I guess what I
11 am really saying is for some of us, it is not quite clear
12 exactly what this program was designed to do in the absence
13 of AHECs.
14 MRS. SILSBEE: Well, this program differs somewhat
15 from the AHEC concept that the Bureau of Manpower Education
16 will be funded and emphasis on the community,
17 community involvement, community commitment, community
18 willingness to make the kind of investments that are necessary
19 to improve existing manpower problems.
20 DR. MARGULIES: One of the things that is not
21 readily apparent from this paper is that the funds which have
22 been released in some instances cover three years of funding.
23 We had to release them so that they could be all utilized
24 at the time of the grant award but they could be extended
25 over a period of time and kept separate from other kinds of

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1 funds.

2 The Maine program is particularly exciting to the
3 review committee and interestingly enough, despite the large
4 amount of money which was involved, probably engendered the
5 least amount of controversy as to its worthiness.

6 It is unquestionably a very bold undertaking.
7 What they are trying to do in Maine, which incidentally is
8 probably somewhere near the bottom of the 50 states in its
9 manpower resources, is a total statewide mechanism for
10 developing manpower around service needs with a collateral
11 development for which they will have other sources of
12 support of a medical school activity, which is a kind of
13 university without walls types of thing.

14 It will link together across Maine all of the
15 educational institutions, all of the treatment facilities
16 necessary to have an integrated education and health services
17 delivery system.

18 It is unquestionably bold.

19 The primary question we had in reviewing it was
20 do they have the people on hand to take on this kind of
21 undertaking, can they come up to the heavy demands for skills,
22 organization, and so on, and the committee came away convinced
23 that they could in fact do so, that they had been working
24 toward this effort for at least five years. The whole state
25 is committed to it, the governor, the nongovernmental people,

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1 the institutions, and it seemed like a very reasonable kind of
2 an investment.
3 But it is unquestionably bigger, bolder and
4 potentially more meaningful than the average.
5 DR. SCHMIDT: I want -- this probably doesn't
6 answer it -- I would like to conduct an experiment.
7 Would everybody at the same time please reach
8 for those mikes and turn them all off? They are all on
9 and flick the switch toward the cord. I will ask the
10 committee members to reach for mikes, turn them on, so that
11 the staff in the back row can hear.
12 It is really not fair to pose questions. I
13 wonder if it wouldn't be ppssible for Dr. Thurman sometime
14 today to see the Maine application, then he can get the answers
15 to questions and we will come back, if he wishes to pose
16 questions based on the bold application after he gets it.
17 MR. HILTON: I was going to say, I suspect new
18 members might have difficulty getting a feel for what we are
19 talking about. They are not going to suggest examples
20 specifically but we could review the application and get the
21 same feeling.
22 DR. SCHMIDT:Veronica will get an application to you.
23 DR. KRALEWSKI: I have a couple questions on
24 this, bothered me probably because I don't understand the
25 funding and all that bit.

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1 Well, it seems to me that at a time when another
2 agency is considering developing a similar kind of concept
3 that perhaps it wasn't the wisest thing to do for us to
4 initiate this kind of action which might preempt the field,
5 and I suppose because you know now the development of two
6 centers and you know Podunk, Colorado, certainly because they
7 will both be fighting over the city again.
8 And the second thing is that by this approach, of
9 course, we are taking this, this area of concern out of the
10 general triennium applications and we are funding, you know,
11 a separate set of activities that doesn't fit in with the
12 kind of thing we are attempting to get the regions to outline
13 in terms of their program and education as part of that
14 program, and so forth, for the region.
15 And thirdly, I am wondering how much we are tying
16 into here in terms of continuing funding because, you know,
17 particularly the one program that I keep site visiting,
18 we spent three years to try to get them out of a major
19 commitment to one specific area of continuing education where
20 they were investing 90 percent of their dough over a long
21 period of time.
22 I wonder if it is the intent that we are going to
23 help to set these up and someone else will take them over
24 and fund them or are we locked into this for a good many
25 years' support?

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1 DR. SCHMIDT: I will take the liberty of commenting
2 on won of your questions. America, United States is a pluralis-
3 tic society and the Bureau Health Manpower's effort and this
4 other effort are different. They are conceived of as being
5 complementary.
6 I think that they are two different approaches moving
7 toward the same end goal and whether in rewrites of legislation
8 and so on these different efforts will be brought together or
9 not, I don't know. In practical terms, we do have now two
10 different concepts moving from different directions, and short
11 of alterations in the legislative process and so on, I am not
12 sure that anything can be done about that.
13 I suppose RMP could voluntarily withdraw from this
14 avenue, but it is not thought that this really would help RMP
15 at all or help the problem. In terms of the long-time fund
16 commitment, who would comment on that?
17 DR. MARGULIES: Well, the basic principles behind
18 the funding is that this is the money required for a consortium
19 to be created which must then maintain its activities. This
20 money is for the limited period of time decided and there will
21 be further funds. In fact, when we provided this money, it was
22 a separate kind -- on a budget basis. There is enough distinctio
23 between what we are talking about and what AHEC is talking about
24 in the Bureau so that even though they may, well, if one argues
25 that they overlap, that still wouldn't make me uncomfortable.

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I think you need a certain amount of that.

But RMP operates through different kinds of community structure and through a different kind of constiuency, but if, in fact, you read the definition of the AHEC as it is currently designed within the Bureau, it is primarily related toward the expansion of numbers of individuals being trained, with a heavy emphasis on reidents in family practice and others who are concerned with primary care. It operates with a contract between the University Health Science Center, the medical school and a community. And the contract is over a specific period of time and most of the energy emminates from the University.

They have also accepted in the Bureau the kind of activity which we are carying out under regional medical programs, because they worked it out with us, but at the present time, they are not funding in the Bureau this type of consortium within the community developed on a community basis, which we have described in the RMP.

But you are quite right, that there could be, with new legislation, a definition of the area Health Education Center which includes what RMP is now doing, and which would go, say, to the Bureau for its development. I think nothing would be lost in that because what we are doing has produced good results and things of a different kind would have a different budgetary origin.

DR. KRALEWSKI: I wish I could be at ease that that

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1 will occur, I hope it will, I know there has been concern over
2 this over the past couple years, I know there has been a great
3 deal of conversation between HSMHA and, of course, Health Man-
4 power over the relationships of all these programs and that is
5 why, at the moment, you know, I hope that when we are going into
6 the field with this kind of investment, that they are fully
7 aware of how it might articulate with their efforts.
8 DR. MARGULIES: Let me say not only are they aware
9 with constant visits back and forth between members of the
10 staff, but even a cursory examination of the contract applica-
11 tions now under review, will demonstrate that most of them --
12 and I can also add, the best of them -- were written by the
13 regional medical programs.
14 Furthermore, there is a requirement even in existing
15 legislation that the RMPs, local RMPs coordinate with these
16 activities so that it will be required both at the local level
17 and at the federal level. But several were written almost
18 independently by the regional medical program, then adopted by
19 the applicant and utilized on that basis so the review and comment
20 which they failed to get around to in any case was not terribly
21 important.
22 MISS KERR: I would like to make a comment. I think
23 we are not at all incompatible, but rather compatible and from
24 the place where I sit wearing several different hats related to
25 regional medical program, the area health centers concept has

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1 not been opposed by our particular University. It concerns the
2 community as community planners that are very active.
3 I see a great cooperative effort potentially possible
4 and I further see the regional medical problem as the expiditers
5 of this. So I don't feel threatened by this. I think if the
6 cooperation can exist, it can really work both ways with no con-
7 flict.
8 DR. LUGINBUHL: What is the total amount that has
9 been awarded in these 57 projects over the three years?
10 DR. CONLEY: It is almost seven million direct cost.
11 DR. LUGINBUHL: What is the total amount under con-
12 sideration by the Bureau of Health Manpower for their contracts
13 for area Health Education Centers?
14 DR. CONLEY: Yes, they have a total of 11 million.
15 DR. LUGINBUHL: Are they going to be reviewing the
16 awards that were made last spring during the next two weeks when
17 they make decisions about the 12 contracts or so that they are
18 going to award? In other words, is there going to be an actual
19 review of these existing awards and will that be a factor in
20 their reaching decisions about their awards, so that we don't
21 get into the situation of duplication funding and hopfully we
22 might even get into the situation of complementary refunding.
23 DR. CONLEY: The RMPS staff has met with the BHMP
24 staff to discuss areas of mutual interest in the contracts.
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25 However, RMPS staff did not have the opportunity to look at the

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1 contracts so there was some limitations on how productive that
2 meeting was.
3 DR. LUGINBUHL: What about the reverse, is there going
4 to be opportunity for the Bureau Health Manpower staff to review
5 these awards?
6 DR. MARGULIES: They already have.
7 DR. LUGINBUHL: They already have?
8 DR. SCHMIDT: Warren?
9 DR. PERRY: I had the privilege of serving as Chairman
10 of this subreview group, also of presenting this series of
11 awards to the council. I believe those of us that had the
12 opportunity to look at the goals and objectives of these specific
13 projects were indeed convinced with the outreach activities that
14 were involved in these.
15 That these were in many ways quite unique from the
16 AHEC Centers that are being developed in Health Sciences Centers.
17 If you look indeed at the one in my own region that I am familiar
18 with, it is those activities away from Buffalo, in the outreach
19 area of community concern, of the ways in which smaller education-
20 al programs are indeed tooling up to do the job in rural areas
21 and such, indeed the ways in which the expertise and consulta-
22 tion of these people to help these others get involved that turned
23 us on to many of these projects.
24 These are where the Health Sciences Center perhaps
25 have not indeed one the job. They are bringing in other groups

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1 of personnel in to doing the job out of these areas and particu-
2 larly the community support and involvement. I think it was
3 of this that did turn us on in this. Indeed the council, al-
4 though I will say it was partially the fact that we were
5 following when this was presented the HMO controversy and dis-
6 cussions this HGO, accepted this entire area which is not indeed
7 the usual practice without a lot of controversy. This was
8 something at home that they were interested in and accepted
9 the entire recommendation as such, and I think you know, on
10 behalf of the council, they were most impressed with this as an
11 additional way in which RMP was developing manpower to do the job
12 within the areas of RMP objectives.

13 DR. THURMAN: One more, Mack, and I promise to shut
14 up. My concern about the Maine situation, going back to what
15 both Bill and John have said, is that sitting on another review
16 committee reviewed the Maine program as an AHEC. And that is
17 why I am really concerned. I go back to what Harold said, I
18 think it is a wonderful idea, I don't need to see the application
19 because I am sure I already read it. That leaves us in the
20 position of just what John said, and the concern that Bill
21 is listing. I am sure that Maine did not ask for double money.
22 This is going back to your term of pluralistic society.

23 All of us are use to cross supplying. Without it we
24 would be dead. I share John's concern that if we are talking
25 about what the role of a region should be related to education,

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and that is what this really says, then when we divorce those totally, my concern is that AHEC will not grow well with RMP and therefore with community support.

Going back to what Harold said, the Maine program is beautiful, it is a university without walls and it does have every Tom, Dick and Harry in the health field participating in continuing training in the need for the entire state, but it strikes me as rather odd that at one time when we are talking about it as being a good AHEC, we are also talking about it as being another good something else.

And that is my only concern.

DR. MARGULIES: You picked a good one for us because that happens to be a program which is probably as fully coordinated between RMPS and the Bureau as anything we ever had. It was discussed most fully during a period of time when the VA Bureau and the RMPS, had demonstrated their ability to work together, had laid out very carefully for the people downtown how we could do this in tandem. Something they have always urged us to do.

Having done that, they reached the conclusion that such a thing was impossible, that we really couldn't do it at all, and it was going fine. So they made a decision, in this particular case being OMB, that something should go one place and something else should go someplace else. Every element of the Maine program is fully understood, where it has to be

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kar 8 1 called an AHEC to get this kind of funding and where it has to
2 be called something else to get the other kind of funding and
3 the reason they come in in a different way is because it is the
4 only way we could provide them the kind of resources which were
5 available and which they needed, but the Bureau understood this
6 and we understood it.

7 DR. SCHMIDT: One question is still floating around
8 the room and that is the future of the review of these and the
9 integration of the review of these activities into the usual
10 process. Are these going to be kept separate or are they going
11 to be fed into the review committees --

12 DR. MARGULIES: You will find during the course of
13 the review that they are a part of the regular review process.
14 We did this kind of separate review as I indicated earlier with
15 maximum reluctance. There was no desire on our part to do it
16 this way, but just the discussion which was carried out here
17 illustrates why we had to do it at the last moment and under
18 conditions of unusual pressure.

19 Furthermore, we are in high hopes that we can enlist
20 the activity, the presence of members of the review committee
21 now in going to those which have already received some funding,
22 chart their progress, become a part of what is going on and
23 at the same time, to participate in additional understanding
24 of these types of applications when they are part of a total
25 review.

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1 DR. SCHMIDT: Well, I think we will then move on to
2 the next part of this presentation.
3 MR. HINMAN: The Secretary of Special Review and
4 Supplementary Refunding, since your last meeting was an Emergency
5 Medical Service Systems, Dr. Larry Rose, Project Manager, our
6 Health Care Systems Task Force.
7 Larry?
8 DR. ROSE: We are passing out now an a general
9 summary of what went on in the award which went through June
10 council. A very small introductory paragraph which goes with
11 that, most of you, I am sure, are well aware of the fact that
12 Emergency Medical Service has become very fashionable over the
13 last year and most fashionable over the last six, eight months.
14 We have had a lot of questions, a lot of comments
15 about what RMP is doing, what HSMHA is doing, what the Department
16 of Transportation is doing, all of these sorts of problems. Our
17 own history in this area pretty much began at the meeting of the
18 RMP coordinators in St. Louis, last January, followed by some
19 writing of their general guidelines to the RMPS to submit appli-
20 cations for supplemental funds, for emergency medical services
21 programs, these guidelines were written in February.
22 Applications were received by a special review
23 committee, and the action -- which committee was Chaired by Dr.
24 Schleris; the actions of this special review committee were then
25 presented to June council, and the results are what you have in

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kar 10 1 your hand.

2 The major activity at the moment, other than the RMP
3 program which I think I should probably mention to you, is a
4 contract program run by a special project office within HSMHA,
5 headed by Mr. John Greardon, which has written contracts for
6 five model emergency systems around the country. These five
7 are in San Diego, Jacksonville, State of Illinois, State of
8 Arkansas and Southeast Ohio.

9 They will be writing other contracts for what are
10 termed model sub systems. They are in the process of writing
11 those now. There is reason to believe that within the next
12 six months they will go on writing contracts for either total
13 systems or more likely, for other component systems, as well as
14 for evaluation of the Emergency Medical Services Systems.
15 Their time frame for writing these contracts could coincide with
16 ours, naturally, and this coincidence has lead to some of the
17 confusion.

18 Much more of it it turns out relates to the fact that
19 the Department of Transportation has been in what they consider
20 the emergency medical services business for a number of years.
21 And their approach, contract approach and our approach, is not
22 the same.

23 I think what I should mention is one impression of
24 what is happening in some of the RMPS which we have been a
25 little concerned about and hope to begin working on very soon.

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kar 1 Some of the EMS projects which are listed to that summary sheet
2 are being run as pretty isolated, rather separate activities,
3 separate in the sense that they are, they seem to be in some
4 measure apart from the rest of what the RMP is doing or what
5 the rest of the RMP is interested in doing. I think this is
6 inevitable because highway safety has caught EMS for six or
7 seven years now.
8 The AMA, many committees, many organization have
9 explained what emergency medical services is, so it is inevitable
10 that we would have fallen into the trap of allowing people to
11 accept their understanding of emergency medical services.
12 What I think is going to be emphasized is the matter
13 of the problems common both to emergency medical services and to
14 all other forms of medical services. What I am suggesting is
15 that one of the things that we will probably have to emphasize
16 a little more clearly over the next few months is the role of
17 emergency medical services activities in furthering the objective
18 of the RMP, helping the RMP to work in its areas of major interes
19 With this approach in mind, we are talking to a fair number of
20 the RMP coordinators.
21 We are planning to set up a series of probably rather
22 informal visits to some of the regions where the EMS programs
23 appear to be particularly splintered from the rest of the
24 activities. The other part of this EMS I mentioned is fashionab
25 is that a fair amount of new legislation is in the process of

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kar 12 1 coming out, some of it may be out before the end of next week.
2 Much of it probably will not, but it is pretty well known to
3 most of the people who are interested in improved transportation,
4 in more radios, better ambulances, these kinds of things, that
5 large sums of money are being discussed, hundred million, three
6 hunred million dollar type of programs and therefore, there
7 is a tremendous amoutn of pressure on many agencies, including
8 the RMPS to be sure everybody gets their slice of the action.
9 It is based on these kinds of pressures, but I think
10 we have a certain sense of urgency about being sure that the
11 RMP knows why it is in this business. Plus the fact that the,
12 hopefully at least, this separate isolated categorical type of
13 program will not -- since it is not the customary part of an
14 RMP activity, will not accur again and therefore the RMP will
15 have to be justifying their activities here based on their over-
16 all and primary problems.
17 We will be involved in some kinds of evaluation of
18 the activities to -- which are defined there. I say some kinds
19 because they vary in actual productivity. Some of hte RMPS are
20 involved primarily in setting up local EMS councils and they
21 measure success or failure on whether a council has been set up
22 whereas, some others have more components and the other things
23 which can be evaluated.
24 Much of the evaluation, though, will be carried out
25 in the contract program by looking at the progress in the model

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1 systems and a fair amount of that will be applicable to the

2 RMPS.

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1 DR. SCHLERIS: Reactions that I think I could make
2 to this but I would like to give you some of the points, for
3 instance the weaknesses of the program.
4 First of all the time-frame was one which did not
5 permit either the applications nor the review to have many of
6 the factors we would like.
7 I think at this point the staff should be compli-
8 mented on the fact that they did exhaustively review at least
9 the material given but at the same time all we had was with
10 the applications, no site visits were made.
11 It was suggested that although the sum of money
12 saved looks large over that requested, some $24 million
13 which I would like a certain return I think that we won't
14 see all of that eight million spent either for some time.
15 There is nothing more difficult than working out
16 a system for emergency medical services. This is a total
17 community effort. It should end up in a categorization of
18 emergency rooms, hospital services, it has to involve the
19 major people involved with emergencies, not just transport,
20 emergency medical technicians but all the emergency rooms,
21 coronary care units, burn centers so on, a real stratification
22 of care, various echelons of services and as I said categori-
23 zations of various hospitals.
24 Almost every agency in the community that you can
25 think of working together.

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1 Don't think one could pick out more than one or
2 two of these which really fit that. When you go to the areas
3 from which these applications arise you find many of the appli-
4 cations, I am sure, will prove to be nothing more than paper
5 applications.
6 They look good but really there wasn't the time to
7 have the necessary wide-spread community support.
8 When I review Hawaii later, I think it will become
9 apparent. This is one of the cases in point. This isn't
10 meant to be a pessimistic view but really to indicate that
11 I am sure different standards would be used and should be
12 used looking at new applications as compared to these appli-
13 cations.
14 It is relatively simple to put in applications for
15 action, millions of dollars for hardware, but to make sure
16 the hardware, those people in communications can work with
17 each other will work with each other and should work with
18 each other is something else.
19 And I think we have gone in this with a degree
20 that will bear very careful watching.
21 I don't know how large your office is or how large
22 the staff is but I think you need a very large staff in the
23 field to look at these.
24 I would assume everyone of these communities would

25 and should need a great deal of help in putting together not

1 just people and some equipment and hardware but if they're
2 going to have an emergency medical system for all types of
3 medical emergencies, the help they will need and the evaluation
4 and planning has to be extremely extensive.
5 I think that this is a dramatic area to look at
6 but one of the toughest to solve in a community because it
7 really gets at what the crux of the problem is in services
8 deciding who can best do what in the most reasonable and
9 in the best way.
10 Such things as deciding you can pass by the nearest
11 hospital which it gets to be a major point of contention
12 in the community and to decide why if you are going to another
13 hospital it is the better hospital to go to.
14 I think this raises the hackles of someone who
15 works in a hospital in the community. I am sorry you are
16 going Sister and, we could use you to work on this and you
17 could take your sabbatical right here.
18 SISTER ANN JOSEPHINE: I would have to agree with
19 the concerns you have raised and just to document one of
20 them I not too long ago, I sat in a meeting where this subject
21 was reviewed and the data that was used to support a project
22 was data from a publication, state publication.
23 It was never accurate to begin with. And that was
24 the data that was used to support their application and I
25 think that needs to be looked into.

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1 DR. ELLIS: I think, Mr. Chairman, that there is --
2 the interesting point that was raised here has to do with
3 the way regional medical programs can work, not only to
4 understand the best way to deliver emergency medical care,
5 but to look at what happens to the patients in the whole
6 process of care after the emergency care has been given.
7 And I really don't know of any other agency who
8 is in a position to do this. It really helps to get the
9 people to the care, but it certainly is important to look at
10 all of the things that have to happen to the patient after
11 the emergency care is over because many of the sequela
12 which result hampers what the person can do with their lives
13 and I think this is a point we must not overlook as we look
14 at the planning for delivery which has been so beautifully
15 emphasized here, in my thinking, by the presentation we just
16 heard.
17 DR. SCHMIDT: All right, are there other comments
18 or questions? I will ask that you keep them brief if we
19 can. Go ahead, John.
20 DR. KRALEWSKI: Just one question on the time-
21 frame here. Are these -- I notice most of them are one-year
22 grants. Are these essentially planning grants, they're coming
23 back then for another application for implementation?
24 DR. SCHLERIS: Yes, there are several other con-
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25 cerns with this, one is is that if these are supported for

1 only one or two years you are going to have a problem of the
2 maintenance of the system falling back on the State.
3 And I don't know if we have really looked that far.
4 I am sure that you have.
5 In our own state we have come up with a figure
6 which if we bounce it back to our state legislature is going
7 to be a large number just to maintain the system once you
8 put it into effect.
9 A lot of the single years are just planning,
10 assuming that the major expense is hardware but then training
11 gets ongoing and the assumption is -- inaudible -- you are
12 setting up communication's networks which require staff,
13 personnel to be ongoing.
14 You can't set up a system for one year then drop
15 it when our evaluations for all our projects are what will
16 happen after the two or three years support by RMP.
17 We are setting up something here we assume pending
18 legislation will take care of, is that right?
19 DR. ROSE: I think that is part of it. I think
20 the other real question that might be generated is whether
21 we know what an ideal EMS is for any community.
22 There are logically real differences between the
23 amount of equipment, the amount of hardware, the numbers of
24 people, the levels of training between various communities
25 relating to some extent to what the priorities for health care

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1 or in that area.

2 DR. MARGULIES: Until we decided to move in this

3 direction during the past fiscal year I had resisted all blan-

4 dishments from all sources that have anything to do with

5 emergency medical systems.

6 They came up regularly, they came up in RMP before

7 I was here, they always appeared and disappeared.

8 The surgeon-general would suddenly say this is the

9 most important thing to do, let's get plans and we will get

10 some money for it and six weeks later everyone had forgotten

11 about it.

12 We decided to move in this direction convinced

13 that this is now the time that people are really concerned

14 and something will happen as a consequence.

15 I think the evidence of the commitment to both

16 parties, the legislation which is developing, suggests that

17 there will be continuing support.

18 There is always a risk involved. And we also recog-

19 nized not as well as you do but to some extent that we were

20 getting into something which was going to require an unusual

21 amount of attention and supervision.

22 I would not suggest at all that our staff is

23 adequate to do this. As a matter of fact our staff is being

24 pilloried and slinging at the present time.

25 We will, however, have access to many consultants

1 and many people who can help us extensively in EMS activities.

2 I think we will have to use them more fully here

3 and in the education and service activities and as a matter

4 of fact all through RMP, than we have in the past.

5 I don't consider that undesirable. As a matter

6 of fact it will be of great advantage to us. We should

7 have done it, with the existence of adequate staff. Will

8 do it faster with a limited number of staff.

9 DR. HINMAN: A brief report on the pediatric pulmo-

10 nary issue.

11 During the process last year it was identified

12 that it was the will of Congress that the RMPs be active in

13 this area to the extent it had been previously. And I report

14 to you that we fulfilled this mandate.

15 One of our other major activities is in in stage

16 renal activities.

17 Mr. Spear is project manager for this and will

18 give us a report of exactly what is happening now and in the

19 next few weeks.

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1 MR. SPEARS: Last year, for instance, according
2 to our count, as accurately as we could make it, we think it
3 is quite an accurate count, there were, at that time, in 1972,
4 29 regions which, together, received a total of 6.4 million
5 in funds from RMP to do essentially dialysis, transplantation,
6 service capability expansion kind of things.
7 As these things were coming along, there was a
8 call about last November for what was called a Health Initia-
9 tive Paper, from the Administration. The Administration, at
10 that time, looking for areas in the health and other fields
11 in which it could take a stronger, make a stronger thrust
12 in science of technology -- kidney was one of those programs
13 permitted to respond to that call, and responded with a
14 document, which title frankly escapes me at the moment --
15 something to do with the ravages of kidney disease, but which
16 we call our life plan.
17 Taking the events as they transpired, taking those
18 things that we could identify as knowledge, facts we knew,
19 taking into consideration, the kinds of funds we had had,
20 and taking into consideration, the things we felt we could
21 do in a rational way with some focus, the last plan said,
22 we would like if it is your will, Administration, and with
23 $80 million to institute, a program nationally, that we believe
24 in, between five and eight years, will serve the provision of
25 care, renal care to all people who can use such care.

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1 Well, the plan was not adopted as one of the health
2 thrusts. But, it has done several other things. It was
3 attractive to the HSMHA Administrator, it has been attractive
4 to the Assistant Secretary for Health Assignment Affairs, it
5 has been known to be attractive to the Secretary.

6 There is a great interest in our undertaking this
7 kind of a program. So, it was, whether we had these additional
8 funds or not, it has at least focused our thinking on the
9 needs, desirability of moving along the in-state track until
10 that problem is reasonably overcome to the degree we can do so.

11 We stand at this moment, then with guidelines that
12 express our desire to fund as a part of a national RMPs
13 program in kidney in-state kind of projects and programs.
14 A contaminate document has come out also which is going to
15 have some impact on this program.

16 This refers to the requirements of Section 907F,
17 Title IX, which requires the Secretary to publish a list of
18 agencies. I know you have heard this before, and in connection
19 with the kidney aspects of the RMPs responsibility.

20 There has been a document produced through a con-
21 tract with National Kidney Foundation, which gives an identi-
22 fication or does identify through a group, which they called
23 together to consider this problem; the various levels of
24 care which could be provided for in-state renal care, and
25 the kinds of services that such levels of delivery would

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1 surely encompass.

2 Very simply, they identify those kinds of services

3 that are unique or characterize primary care in kidney disease,

4 those that characterize secondary levels of care, and those

5 that characterize tertiary levels of care, and those that would

6 define them.

7 The direct employment of this document is as yet,

8 unclear, although it is giving us a good statement to take

9 to people who wish to do kidney activities, to help their

10 thinking about the kind of facilities and services they should

11 be setting up, and what the relationships among them ought

12 to be.

13 The current kidney guidelines, the main body of

14 which were issued May 3, and addendum issued now on September

15 14, to clarify some questions about those, carried a require-

16 ment that we thought was critical to the Federal program; a

17 program with a Federally directed thrust to it, and that is

18 that we needed to have some review to be sure that the criteria

19 which we felt had to be met would, in fact, be a part of the

20 program as they evolved.

21 The requirement is that, as a new renal project

22 comes into being, it be reviewed by a minimum of three outside

23 party reviewers. In trying to implement this requirement,

24 we ran into, as usual, some snags. There are lots of people

25 out there who are quite qualified to do good review in so far

1 as medical competence is concerned. One question was, who
2 are they, and how do we reach them?
3 Another question was, would they consent to serve
4 in the kind of role we were going to ask them serve in? And
5 thirdly, how did we -- how would we know that we were getting
6 the best people in the estimation of the parties in the field?
7 To resolve this problem, we called together a
8 number of consultants who had sefved with kidney activities
9 for some years, and asked them to look at some rosters we
10 had, asked them to come up with some recommendations of their
11 own, and proposed that they join with us, having identified
12 at least, a first crop, a first cadre of potential kidney
13 program reviewers; coming together with us in an orientation
14 session in which we would sit down with people selected and
15 who say, yes, they will serve in this kind of a role, and
16 tell them some of the kinds of problems and this is what we
17 have to do in setting up a kidney activity.
18 Those kinds of problems are the things contained
19 in the opening remarks of Title IX, the coordination required,
20 what is the integration? What is the centralization unique
21 to the kidney, and how do you try to assure these kinds of
22 things are being done to the best extent of the locality you
23 are looking at?
24 Are they really outreach, going out further from
25 the centers than has been the case in the past?

1 Is there outreach in fact? These kinds of things,
2 people who have not dealt with us directly, are not so familiar
3 with, and are critical in review programs, and the evaluations
4 we need to have placed on them.
5 The outcome of this has been that On September 30,
6 and October 1, in a very short session of what is in two
7 pieces, it will be not more than about eight or nine hours;
8 we will meet with some ninety people, representing a variety
9 of expertise in the renal field, to discuss how to be a
10 consultant on regional RMP kidney programs and those people
11 for the forthcoming year will be the cadre from which we will
12 select consultants as the individual RMPs, when we are ready
13 to go with the kidney program, and we want somebody to look
14 at it and counsel with us.
15 Are there any questions?
16 DR. SCHMIDT: Questions, or comments?
17 Ed, do you have anything?
18 Thank you very much.
19 According to the schedule, we blocked out in
20 advance of the meeting, we are now running about 45 minutes
21 behind, which is a little better than average. We do have
22 a fairly heavy schedule of reviews, actual working type
23 business to get through today.
24 So that we will take a break right now, and I would
25 ask that it be, you know, aimed for 15, but we are going to

1 start in 20 minutes from now; even if nobody is here.

2 (Recess.)

3 DR. SCHMIDT: I believe we will begin. I would
4 like to warn the committee members that I think it would be
5 best if we had long work-sessions today and plan to go, you
6 know, perhaps beyond when the traffic congestion is on the
7 road.

8 We commissioned a study to show we waste time by
9 leaving here at five, anyway, so that we will go until we
10 do the necessary sorts of things, today. And, I will obviously
11 have to try to move things along and hurry people along, so I
12 will, from time to time, break into a discussion, and remind
13 whoever is talking, of the time that is going by and so on.

14 I will say, just once, that there is nothing perso-
15 nal here, but I have always worried that at the end of the
16 second day, we give some regions, at times, short shrift; and
17 I don't believe this is fair and I would rather be fair to the
18 regions than fair to the individuals on the committee, so that
19 I will take a perogative of moving the committee along, from
20 time to time, if that becomes necessary.

21 I have asked Mr. Chambliss to very quickly review
22 a few more informational items that will take five to ten
23 minutes.

24 Then, we will move on to a case study.

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25 Mr. Chambliss?

1 MR. CHAMBLISS: Thank you, Dr. Schmidt.

2 I would like, first, to just simply present a
3 status report on some of the significant personnel changes
4 in the RMPs throughout the country. There are 13 regional
5 medical programs that have had rather key staff changes, and
6 I would just simply like to take those off for you.

7 First, the Central New York RMP has had changes
8 in its Directorship and now, Mr. John Murray has been appointed
9 Director there, as of July 1st. In Delaware, one of our newer
10 regions, a coordinator has been appointed, Dr. Michelin. Dr.
11 Michelin is formerly affiliated with the University of New
12 York -- New York University in Community Medicine; also with
13 Albert Einstein College of Medicine and also Yeshiva University.
14 He comes very highly recommended.

15 There is an unofficial resignation of a coordinator
16 in the metropolitan Washington regional medical program. Dr.
17 Wentz, as I understand it, has tendered his resignation or
18 his intention to leave. At Rochester, Dr. Peter Mont has been
19 appointed as the new Director. He has a background in
20 private practice and medical school teaching. He has headed
21 a Neighborhood Health Center in Tucson, Arizona. He will have
22 a new Assistant Director, shortly, in the person of Dr. Chuck
23 Adair, formerly associated with the Kansas Regional Medical
24 Program.

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25 At Tri-State, Mr. Robert Murphy, has been appointed

1 as a replacement for Dr. Leona Baumgardner, and Mr. Murphy
2 comes to that RMP with a background in hospital planning. He
3 has formerly also been the Deputy Regional Director for
4 Health and Scientific Affairs for HEW, Region I.
5 Also, at the Colorado-Wyoming RMP, Dr. Howard
6 Dome has resigned as of July 1, and his replacement is Dr.
7 Thomas A. Nicholas. Dr. Nicholas has had background in pri-
8 vate practice in a rural area of Buffalo, WYoming, and he
9 has also served as Chairman of the RAG for the Colorado-
10 Wyoming RMP.

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1 At Intermountain, Dr. Robert M. Sadovick has
2 resigned as of August 1, and he has been replaced by Mr.
3 Richard Haglund, who was the Assistant Coordinator, and
4 Mr. Haglund is the interim coordinator until a permanent coordi-
5 nator is appointed.
6 In Oklahoma, the Oklahoma RMP coordinator has
7 resigned, Dr. Dayle Groom. Dr. Kelly West is acting now as the
8 interim coordinator.
9 And in Iowa, and you probably have heard this one
10 before, that Dr. Harry Weinberg retired some time ago and he
11 has been replaced by a coordinator pro tem, Mr. Charles Colwell.
12 There is a search committee at work now for a full time
13 coordinator for that region.
14 In North Dakota, Dr. Charles A. Arinson
15 has replaced Dr. Willard Wright as executive director there
16 as of August 1.
17 In Florida, a significant change: Mr. Robert Lawton,
18 who was formerly the deputy coordinator at the tristate RMP
19 has been made program developer for program development.
20 In Indiana, Dr. Steven Barry has been appointed as
21 acting coordinator; he has also been serving as associate dean
22 at the University of Indiana Medical School.
23 And, finally, Dr. Laas Dorin has been appointed as
24 coordinator of the newly formed Ohio Regional Medical Program.
25 He has a background in private practice and that ends the

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1 significant changes in personnel in the RMP's.

2 MR. CHAMBLISS: We think the Committee would like to

3 know that the staff of RMP has been engaged in a wide range of

4 review certification visits to all of the RMP's, or rather,

5 to most of them. Each of the RMP's will be reviewed in terms of

6 their review process, their review processes, and will be certi-

7 fied or partially certified or not certified before the end of

8 this year.

9 There will be, however, three RMP's that will be

10 carried over for review certification purposes and those

11 regions are California, South Dakota and Delaware. These review

12 certification visits will be conducted before the end of March,

13 1973.

14 And I might say that I think the Committee would like

15 to know that there has been a very high level of staff coopera-

16 tion in conducting these review certification visits, between

17 the DOD staff, that is the Division of Operations and Develop-

18 ment, and the Staff of the Division of Professional

19 and Technical Development, headed by Dr. Henman, and equally

20 by the Staff of the Planning and Development Office, headed by

21 Mr. Peterson.

22 These visits are now in their final stages.

23 There have also been conducted a wide range of manage-

24 ment survey visits to the various RMP's, and that schedule

25 of visits is moving along according to plan.

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1 And I am sure you will note some of the management
2 survey reports in the materials that you have. This activity
3 has been cited by HEW as being one of the -- a well performed
4 activity as far as management is concerned.
5 There may be some questions so far. If not -- if
6 there are, I will be glad to entertain them.
7 If not, may I just fastly shift to an item of
8 information for the Committee:
9 If you recall, at the last meeting of the Committee
10 the Committee indicated its interest in having for information
11 purposes the result of the staff anniversary review panel's
12 activities.
13 This staff of an anniversary review panel is
14 comprised of 11 key members of the RMP staff, including the
15 Division Directors, the Division Directors of the various
16 offices attached to Dr. Margulies'office, and the Operations
17 Branch Chiefs. All 11 engage in the staff anniversary review
18 of those applications, those anniversary applications, within the
19 triennium.
20 This panel this time looked at the anniversary
21 applications within the triennium of six RMP's. If you will
22 notice this long sheet, and at the bottom of the page under
23 the line you will see the regions that were reviewed by the
24 staff: California, Colorado - Wyoming, Georgia, Maine, Michigan,
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25 and Wisconsin.

1 The staff review is done on a formal basis. The
2 applications to be reviewed are known in advance by the staff,
3 presented by a member of the operations division, and there
4 are three reviewers assigned to look at that application in
5 depth.
6 The significant things that came out of that
7 review, in addition to the ratings that the staff submits for
8 information -- for your information -- are the fact that in two
9 of the regions the council approved level is recommended for
10 an increase by the staff. That's in the case of Michigan, where
11 the counsel approved level was 2.1 million, the funding level was
12 1.92456, and the staff or the SARP was an elevation of the
13 council approved level to 2,250,000.
14 You will see that on the spread sheet. You will
15 probably be interested in the rationale for that increase in
16 Michigan.
17 The staff considered it. There is a new coordinator
18 there, as I have mentioned. It was felt that there was funding
19 flexibility needed to further develop the program there. There
20 was a region with a very small staff and on that basis, staff
21 recommended an increase. Staff did not go along with the staff
22 panel -- the staff panel did not go along with the staff
23 recommendation there which was the region be funded at a level
24 of 2.9.

25 The other region that has a significant point to be

1 brought to your attention is that of Wisconsin, the council
2 approved level being 1.779 million; the funding level being
3 1.779 million, and the SARP recommendation came out at 2.1
4 million.

5 The region requested 2.176 million, and you see
6 the SARP recommendation. And the rationale, I am sure you
7 would be interested in, again, the staff felt that was an
8 excellent review process being carried out at Wisconsim. It
9 was impressed by the fact that the RMP plays a significant role
10 in the Governor's Commission on Quality of Care. There's a
11 functioning allied health council within the RMP. The EMS
12 proposal as reviewed by the special review group was approved
13 by council and committee. And the regional medical program there
14 had received an award of special merit, the Lambert Award
15 for "Innovations Designed to Improve Patient Care and Reduce
16 Costs".

17 This Lambert award, as I am given to understand,
18 is a national award which this RMP has won in recognition for
19 what it is doing in the area of innovation.

20 That concludes my report, Mr. Chairman.

21 DR. SCHMIDT: All right. Thank you for making it
22 so concise.

23 Are there comments or questions?

24 (No response.)

25 If not, then, what we thought would be best at this

1 point would be to move on to a case study.

2 Now, you will be subjected from time to time to

3 "Schmidt's dicta about life". The first one I think I mentioned

4 was that life is non-linear, and the second one is that you can

5 rarely get it both ways. And one of the things that the

6 Committee has objected to in times past is the lack of time for

7 discussion of general topics of concern to the Committee.

8 Very many of us often spend time doing things that we

9 absolutely have to do and neglecting the things that can be

10 put off, but turn out to be the most important in the long range.

11 And the Committee is engaged in times past about --

12 in a discussion of what is the committee, what is its function,

13 and what is it now doing in terms of the total review process,

14 local review, national review.

15 The word "emasculation" has come up from time to

16 time, "rubberstamping" and things such as this. And very

17 frequently at these meetings there simply has not been time

18 for a discussion, a good discussion, based on fact and so on

19 of how the committee has functioned, is functioning, and

20 probably should function in the future.

21 We can't have this sort of discussion without obviously

22 having to tighten up on the other side, and that has been very

23 efficient, in our review of regions this afternoon and tomorrow.

24 But we thought it important enough to engage in a discussion

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25 of the functions of the review committee, to make a special

1 effort this two-day meeting, to kind of integrate into the
2 discussion of regions the subject of the function of this
3 committee, so that we will begin with a case study that
4 is intended to demonstrate how a region develops, and how the
5 review committee is operated in the development of this region.
6 And this is a case study of the Rochester Region.
7 And we will move then, hopefully before lunch, from that discus-
8 sion into a review of the Rochester region -- Dr. Brindley --
9 and we will alter the discussion somewhat in that way.
10 Then I mentioned before in the case of Albany,
11 Hawaii, and Mississippi, we will be trying different ways of
12 presenting information about the region to the review committee
13 in an attempt to find out, you know, which way the committee
14 looks at it, and how can we be more efficient and effective
15 in getting the necessary information to the Committee to allow it
16 to make a judgement as a committee, rather than just listening to
17 what the principal reviewer says and in making a judgment perhaps
18 based on inadequate information.
19 So at this time we will begin presenting some
20 information that we hope will provide the basis of a better
21 discussion by the committee of its role in the total RMP
22 process, and Dr. Margulies and Elaine will lead this discussion.
23 And so who starts?
24 MS. FAATZ: The reason I am up here is because I am

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25 the only person who has been brave enough to go on three

1 successive site visits to Rochester.

2 (Slide 1.)

3 Dr. Margulies and Mr. Chambliss have asked me to

4 give you a brief historic overview of Rochester, because it

5 does represent a rather interesting case study.

6 It is a region for which everyone had originally had

7 tremendously high hopes. We watched it first with a little

8 bit of concern and then growing dismay as the region became

9 increasingly less attractive.

10 In fact, last year I think the review committee, if

11 it didn't assign its lowest rating of any RMP, it was as close

12 down there to the bottom --

13 DR. SCHMIDT: Elaine, just stop a minute: Is there

14 any way to put that speaker up here? Will it extend?

15 MS. FAATZ: Would it be better if I sat at the

16 table?

17 DR. BRINDLEY: We can hear find.

18 DR. SCHMIDT: Well, they are having trouble; they

19 can't hear back there.

20 Okay, go ahead.

21 MS. FAATZ: All right. I will fasten this thing

22 again.

23 Okay, can you hear me now?

24

25

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1

1 MS. FAATZ: Although Rochester did take the down-
2 hill grade in the last year or so, somethings have been
3 happening in New York that make our hearts beat a little faster
4 and that is what I am going to tell you about. All this is not
5 to suggest that Rochester is the best of all possible RMP's.
6 Dr. Brindley in discussing the findings of the site visit
7 team will tell you that although there have been tremendous
8 accomplishments there is still a long road to hoe in Rochester.
9 But I am hoping that what we can show you is that
10 a region, given sufficient reason, can change the direction of
11 its program. First of all -- this is the first in our light and
12 sound show. Let's look, see where Rochester is in respect to
13 the rest of New York RMP's. It is bounded on the west by the
14 lakes area RMP centered in Buffalo, on the east by the Central
15 New York program headquartered in Syracuse.
16 Tothenort of Rochester is Lake Ontario and to the
17 south is the State of Pennsylvania; there are ten counties
18 included in the Rochester area. These are the same ten counties
19 covered by the CHPB agency. Rochester itself is the third
20 largest city in New York State.
21 The only other city in the ten counties of any
22 substantial size is Elmira (slide 2) down in the southeast
23 corner and that is in Chemung County. Because of these two
24 urban areas statistically the population of the Rochester
25 region is about 60 percent urban but that is really misleading

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because the other eight counties are primarily rural and small town. There is fruit growing, there are the vineyards, there are the Finger Lakes over to the wast of the region which are resort areas.

The population of the ten counties is about 1.2 million. Of that about 5 and 1/2 percent are non-white although in the city of Rochester it is -- the figure goes up to about 18 percent. There are 27 community hospitals in the region the preponderance of them being in Monroe County up in the Rochester Metropolitan area, although each county in the region does have a community hospital.

Maybe it would be well to go back to the beginning and that was in 1966. When Rochester first applied for a planning grant, everybody was delighted, some were ecstatic for a couple reasons.

First of all this ten county area was one which in 1966 had already achieved an unprecedented degree of regionalization through the former efforts of the Rochester Regional Hospital Council. There were hospital linkages developed. And many people thought that this was, if RMP was going to succeed anywhere, Rochester was the place.

In addition there was the Rochester Health Planning Council out of which grew an extremely strong CHPB agency. Dr. Ralph Parker, who was the former Director of the Hospital Council, was appointed coordinator in Rochester.

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#8 1 Mr. Frank Hamilton, an industrialist who was active
2 in community affairs, and who was the past President of the
3 Hospital Council, was appointed regional advisory group
4 chairman and with the past history of the region and with these
5 two people in such key slots, everyone thought the situation
6 in Rochester was very auspicious. And things seemed to go
7 along reasonably well for awhile.
8 There was little concern because Dr. Parker originally
9 had trouble recruiting full time staff, in fact for nine months
10 he was the only person on the Rochester staff. But in 1968 when
11 the region applied for operational status, it seemed that they
12 had progressed to a point that it was reasonable to award
13 operational status to them.
14 Although we did say, we did not realize that we might
15 as well tape the message then and play it every year, the first
16 five projects that were funded in Rochester were in the area
17 of heart. And we suggested that maybe it would be a good idea
18 if they try to develop a little more balance in the program.
19 Over the next couple years as applications from
20 Rochester were reviewed at practically every review committee
21 people began to worry. For a number of reasons. And first of
22 all there appeared to be a growing concentration of activities
23 in the city, metropolitan area of Rochester itself at the
24 expense of the other nine counties.
25 Secondly, the administrative practices of the

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coordinates could probably best be described as laissez faire. He had no back-up administration and it was not a very tight organization. Thirdly there had been a problem in getting full time professional staff. There were a number of professional staff on the program.

Interestingly enough they were not full time, they were project directors of RMP funded projects. Consequently they had no practice in thinking of RMP itself as an organization.

Their loyalties lay with their projects and with the universities and to the extent that RMP funded their projects it was great but in terms of doing anything else they just were not thinking along those lines. And the fourth concern was the level at the categorical and continuing education oriented program. The region had developed and it was not even a program that was categorical in continuing education because the various activities were unrelated.

You did have, say, a cancer continuing education program coming out of the university into each of the community hospitals. You did have a hart continuation continuing education program coming out of the universities into each of the hospitals and this went you know bang, bang, bang for each categorical area and there was no meshing between and among the projects.

And at the same time the review committee was growing increasingly frustrated because every meeting which was at that

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#8 a 5

1 time three and four times a year, they would be looking at
2 supplemental applications from Rochester but they never did
3 get the whole picture.
4 All they would ever see was a project proposal and
5 they would say, yes, this is good or no, this is not good, but
6 they never got a chance to look at the whole program and to
7 see how it fit together.
8 So out of this discontent, in April, 1970, grew the
9 first of a series of visits and contacts between us and between
10 Rochester. And that chart that was handed out at the beginning
11 of this presentation shows the significant contacts between the
12 review committee and the staff, and the Rochester program
13 starting in April, 1970, through the site visit we had just
14 last Month.
15 In the April 1970 site visit Dr. Richard Spellman
16 of the Review Committee was the Chairman. This site visit
17 was really a forerunner of the program site visit we have now
18 because if we looked at the projects, we spent just a very
19 little time doing that. Mostly we looked at the program, how it
20 was operating and you know, was there a program.
21 We found out that all the difficulties we had
22 suspected were confirmed and one that we had not noticed, it
23 had not come through in the application. And that was the
24 passive nature of the regional advisory group. In fact at one
25 point the regional advisory group had an 11 month hiatus between

1 meetings. In fact the primary decision-making group at that
2 time was the planning committee which had 17 members, 13 of
3 whom were university people, three of whom were RAG members
4 and anything the planning committee disapproved was not sent
5 on to the regional advisory group.

6 The planning committee met monthly, the regional
7 group met as necessary and once as necessary was 11 months.
8 In addition, the technical review groups were almost all un-
9 dominated so it was pretty clear who was in charge, the coor-
10 dinates wasn't making decisions, the program staff were inter-
11 ested in their projects, the regional advisory group appeared
12 to be not interested in anything, and decision-making groups
13 were dominated by university people.

14 This was the first site I was on, may have been
15 the first one ever where there was a feedback session from
16 the site visitors to the program. In fact we were so astounded
17 by what we found in Rochester that Dr. Spellman arranged for
18 two separate feedback sessions so he could be rather frank.

19 He spoke to the coordinates then spoke separately
20 with the RAG chairman to make sure the RAG chairman would get
21 the message as well and we thought we would be really brutal
22 and we thought maybe RMP would never been able to go back
23 to Rochester.

24 And after all the frank advice we gave them we left
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25 Rochester expected you know, in the next few months something

#8 reba 7

1 really cataclysmic would happen. It didn't. For a long while
2 you know Rochester went on with business as usual. In the
3 fall of 1970, there was a management assessment visit conducted
4 that was triggered by the concerns of the review committee that
5 confirmed the site visits findings. The management assessment
6 visit found precisely the same thing the site visitors had
7 found, prepared a written formal report that did not mince
8 words, that went back to the coordinates that went back to the
9 grantee, that made precisely the same recommendations that the
10 site visitors had made.
11 Maybe something will happen. Next year in 1971, in
12 the spring of 1971, Rochester submitted a triennium application.
13 This application showed the same chronic problem areas as
14 before. So another site visit was scheduled in June of 1971, and
15 Dr. Schmidt was the Chairman of that visit.
16 The only difference we could find in Rochester
17 was that the undominated planning committee had been abolished
18 and an executive committee of the RAG had been formed but aside
19 from that there were the same chronic problems and nothing
20 seemed to have changed, in fact it was almost a re-play of the
21 visit the year before which had had tapes of the feedback ses-
22 sion.
23 Still no program leadership from any quarters.
24 We could not identify any program direction. In fact the
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25 region didn't really know how to come up with program direction

#8

bha 8

1 they would say things like "You know there is something we
2 could do, such and such an activity, but the CHPB agency
3 has already done it so we don't know what we should do."
4 It was that sort of atmosphere in Rochester all they
5 could think of was continuing education and central regional
6 services, there still was no program staff that was not project
7 directors. And at that time, the site visit team and the review
8 committee really had to sit down and decide, okay, you know
9 what are we going to do now, this has gone on pretty long.
10 I think it was decided that you can't make a revol-
11 ution with silk gloves, and although we thought we had been
12 tough the year before that must have been silk gloves so we
13 put on boxing gloves. And what the review committee finally
14 recommended was that the level of funding for the region should
15 be substantially reduced, that the region should be held to
16 one year approval only, with the warning that we are going to
17 come back next year and see what you have done.
18 Well these time and money limitations apparently
19 produced enough anxiety on the part of the Dean of the Medical
20 School that in September of 1971 Dr. Orbison, the Dean, and
21 Dr. Ernest Saward who is Associate Dean, for Intramural Affairs
22 came down to Rockville to have frank discussions with Dr.
23 Margulies about what was wrong with Rochester.
24 Then they went home. And we thought then maybe we
25 would really see some action. Just a word about Dr. Saward.

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#8 1 He was brought to the University of Rochester in the
Reba 9 2 I think it was the fall of 1970. He had been associated with
3 Kaiser-Permanente and the Washington Medical Program and one
4 of his main responsibilities at the University was going to
5 oversee the RMP activities.
6 He has not been very much in evidence and we really
7 had no evidence whether he was interested in RMP or not. I
8 think now we can see in retrospect that he was and he was
9 doing things behind the scenes but we were not aware of that
10 at the time. As I say they went home and things went on as
11 usual, so usual in fact that when Rochester received its
12 substantially reduced award it just stretched the award to
13 fund every single project that had been approved although at
14 a reduced level so at this time you had 17 projects that were
15 going on and I need not tell you what kind they were.
16 Some of them were actually kind of good but they
17 were all continuing education, central services and categorical.
18 Now maybe if we could take a look at this point at what
19 Rochester looked like for its first four years, (Slide 3).
end 20
8 21
fls 22
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CK #9
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1 Very briefly you can see that the allocation of
2 program dollars was pretty constant over the first four years,
3 about 36 percent program administration, which wasn't program
4 administration, about 26 percent in multi or noncategorical
5 and almost all that went for their early disease protection
6 unit which was a multiscreening thing which nobody had been
7 very well impressed with and looked like it might go on to the
8 end of the world and about 35 to 38 percent in categorical
9 activities which encompassed the litany that I have gone over
10 many times, nursing, continuing education, coagulation
11 laboratories and so forth.
12 In the winter of 1971, though, we did receive word
13 that Dr. Parker had resigned. And then we didn't hear anything
14 more until around February 1972 at the request of the region
15 there was quite a large program staff contingent that went to
16 Rochester to consult with the people. In fact we really laid
17 on everything we had as Dr. Pahl, Mr. Simon from our Management
18 Assessment Branch, Mr. Peterson from Planning Evaluation and
19 a couple others of us and we thought we were going up there
20 because Rochester really had something to tell us about how
21 they had changed.
22 Well, we got up there and we found that except for
23 Dr. Parker's resignation, nothing had changed. The Executive
24 Committee still was talking about the things that needed to
25 be done but things they had not done. They still weren't

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ty 2

1 able to determine how they were going to find a role for
2 themselves. So we gave them the same old advice that had been
3 given for the last two years. And came back to Washington
4 wondering, you know, why had we gone to begin with.
5 I think in retrospect we were mistaken or I was
6 mistaken at any rate. There was a lot more bubbling under-
7 neath the surface in Rochester than we could see. I think
8 people like Dr. Saward and others had been arranging their
9 pieces on the chess board but before they made that grand
10 swoop they wanted one final reassurance that this was really
11 the way to go because after we left in February a number of
12 things started happening in very quick succession and I think
13 maybe the best way to explain those is to compare the program
14 that Rochester is proposing this year for its 05 year with
15 the program that they initiated in their 04 year.
16 One of the main areas of the change has been program
17 leadership. As I say Dr. Parker resigned. A new director was
18 brought on board in May of '72. His name is Dr. Peter Mont.
19 And Dr. Brindley when he discusses the site visit will tell
20 you more about Dr. Mont.
21 The RAG has changed. The program has instituted
22 a system for the rotation of RAG members. Now that doesn't
23 sound all that swell until you realize that Rochester didn't
24 have a system like that before and so essentially the RAG
25 that you saw at the end of 1971, the beginning of 1972,

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1 except for deaths and resignations, was the same one that had
2 been appointed back in 1966. Thirteen new people have been
3 added to the Regional Advisory Group. The minority repre-
4 sentation has been increased from 2 to 5 of 36 members, and the
5 kind of consumer representation has taken on a different
6 character.

7 Mr. Frank Hamlin who had been RAG chairman since 1966
8 stepped down, his place was taken by Dr. Peter Warter who
9 is vice president of Research for Xerox in Rochester. As
10 I said before the old Planning Committee is gone and there is
11 an Executive Committee of the RAG.

12 Another interesting thing to look at is the changed
13 relationship between the university, the grantee, and the
14 Rochester program. When we were on the site visit, Dr.
15 Orbison, the dean of the medical school, assured the site
16 visitors that the university was content to have its input
17 to determination of program limited to that provided by the
18 six university members on the RAG, which seems reasonable.

19 Another interesting thing to look at is space. You
20 know the RMP had thought always it had to be housed with the
21 university, it was part of the university. The university
22 never could spare enough space for the Rochester program.
23 Consequently they were scattered in places, so the staff was
24 never put together you know. There would be a few over in this
25 building then you would have to walk across the street and

1 up some stairs to find the rest of the people.

2 Well, now with the support of the dean, the program

3 is moving into a building about a block up the road. It's

4 university off-campus space and you know they will be able to

5 hang out their shingle that says "Rochester RMP" and they will

6 be all in the same place.

7 Finally though this doesn't tell the whole story,

8 I think it is kind of interesting to look at project sponsor-

9 ship.

10 (Slide 4.)

11 This is determined by the allocation of dollars

12 by project sponsors. At the beginning of the 04 year every

13 single project, every single of the 17 projects that Rochester

14 supported was sponsored by the University of Rochester.

15 What the program is proposing for the fifth year,

16 you can see that 44 percent are sponsored by the university

17 but the others are divided, health and education associations,

18 like the education consortium, the Rochester Alliance and

19 Health Association of Rochester, 13 health care facilities,

20 a couple hospitals and a health center. Ten percent are spon-

21 sored by community organizations; the VA is sponsoring one,

22 another by the OEO Poverty Agency in the central part of

23 Rochester.

24 I think another thing is program direction. If

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25 we can go back to the chart we had before --

(Slide 3.)

Now you can see the fifth year. You can see the allocation of dollars by percentages remain pretty stable for a program administration but this time it really is program administration. They are going to have a program staff that is more traditional in our terms. It will have program specialists, that sort of thing. They will monitor projects; they will be full time and not project directors.

The former program staff, the various members have left to pursue their own interests which apparently were not RMP and Dr. Mont is assembling a new staff.

At the bottom, see, only 3 percent of the dollars are going into categorical activities, that is a regional kidney program. That blue block got pretty big, 61 percent of the money going into multi noncategorical. 16 of the 19 activities that were going on in the 04 year have been terminated and Rochester has been able to initiate new things.

Now we can look at that 61 percent maybe in another way. If we can break up --

(Slide.)

-- the program into four thrusts that Rochester has defined, health care services, education to improved care for underserved, health care systems analysis and, finally, formal education of health professionals.

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We can compre the fourth year and proposed fifth

ty 6

1 year. You can see where the two big changes have been In
2 the fourth year about 40 percent went into health care services,
3 now about 60 percent is going into health care services.
4 Actually that is more of a change than it looks like on the
5 chart even because the region's definition of what a health
6 care service is has changed.
7 Now what went into making up that 38 percent last
8 year in health care services was things like regional
9 coagulation laboratory, telephone EKG consultation, cancer
10 clearinghouse. The kinds of things being called health care
11 services this year are EMS activities, coordination of home
12 care services in rural counties, rural family medicine
13 practices and that sort of thing.
14 The other big change is the decrease in the amount
15 of money that is being allocated for continuing education
16 activities. The red blocks. And as I say, even the tenor
17 of continuing education has changed somewhat. That 37 percent
18 last year was physician's and nurse's continuing education
19 programs, many, many activities in the categorical things.
20 That 14 percent represents two activities, one, educational
21 alliance, the other is subsistence level combination of all the
22 formal nursing continuing education programs.
23 The program is designed -- as it is, it will fund
24 through June '73 only, that is to give the school of nursing
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25 in Rochester an opportunity to decide do they want to pick this

ty 7

1 up in their priorities or do they want it to just go down the
2 drain?
3 Finally, I think another interesting concept,
4 back to the county map --
5 (Slide.)
6 -- is how in Rochester the programs idea of what
7 regionalizations have changed.
8 Now last year 90-some percent of the activities
9 that the program undertook were designed to cover the entire
10 10-county area. In fact most of them were things that were
11 emanating from Rochester and going out to do good in the other
12 counties like the continuing education and the laboratory ser-
13 vices. This year about a third of the activities they
14 propose are designed to take care of the 10 counties. But the
15 region apparently has seen a need to design activities that
16 respond to the needs of particular areas of the region.
17 For instance, in the southern tier down there it
18 is Steuben, Schuyler, and Elmira Counties. There is an
19 effort in emergency medical systems. For instance the
20 five counties there in the center, are the subject and
21 activity trying to coordinate home health care services?
22 Another example is Dansville Hospital down in the bottom
23 part of Livingston County. There is a family practice program
24 coming out of Dansville to serve the rural areas of Steuben
25 and Livingston Counties.

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ty 8

1 There is a training program for bilingual allied
2 health aides to serve the Spanish speaking community of
3 Rochester itself and it is centered in the intercity there.
4 I don't think I need to talk any more about program staff.
5 We know what it is. We are not sure what it is going to be
6 but we think it will be better than what it was. They will be
7 doing things that program staffs ought to do. That is
8 Rochester.
9 You know, I have a feeling you may be saying to
10 yourself you know this is all very interesting but why have
11 you taken up half an hour of our time? Well, I don't know.
12 I think it proves for one thing a program can change, we can
13 document this. We can look at the charts, look at last
14 year, this year and see it is changed. What maybe isn't so
15 obvious is what is the impetus for change?
16 Well, I am not sure but I think what we have seen
17 in Rochester is a disapproval of the old adage that revolutions
18 are not made, they come. I think it is quite clear that if we
19 hadn't made the revolution in Rochester, it wouldn't have come.
20 The program direction, the way it was being adminis-
21 tered was satisfactory to everybody in Rochester. It was
22 certainly satisfactory to the university. Satisfactory to the
23 coordinates. It was satisfactory to the program staff as long
24 as their projects kept getting funded and if the RAG ever
25 thought about it it was probably satisfactory to the RAG.

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1 So what it took was dissatisfaction from some
2 quarter and that was down here. And I think the irritants that
3 were provided by the Review Committee in terms of you know,
4 you got another site visit; we are going to come up and look at
5 you again and also finally the question in terms of the time
6 and money limitations are what brought about the revolution in
7 Rochester. If the Washington Redskins didn't, you know anyone
8 can.

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1 MS. FAATZ: Dr. Schmidt knows what it is like and
2 Dr. Brindley knows what it is like to have questions.
3 DR. MARGULIES: I think the presentation probably
4 is adequate to prove its point. I think it requires your
5 reflection to determine what it all means in terms of staff
6 function, Review Committee. Eileen is perhaps being modest
7 in not also pointing out the fact that one thing which should
8 be fairly clear from all this is that there is a level of
9 staff dedication involved in such an undertaking without which
10 it just doesn't happen. But the Review Committee can get
11 a sense of what all this means only by occasionally stepping
12 back and seeing what the results have been.
13 Now, I could not tell you that this all happened
14 because of the Review Committee. I couldn't tell you that
15 it all happened because of what we did here. For example,
16 the appearance of the -- of a remarkable man who first was
17 on the Executive Committee and then Chairman of the regional
18 advisory group in Rochester has a great deal to do with it.
19 You can't say this did it. But it is a combination of
20 activities in which the absence of any one of the elements
21 would have been ruinous, but consistently it was from the time
22 that the Review Committee and RMPS, with it, began to look at
23 it as a total program and the way in which it functioned that
24 it began to make some difference.

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25 Now, I was talking with Sister and about what I

1 personally believe is the primary merit of regional merit
2 programs and saying to her at the same time that there is no
3 way in which I can sell this to budgeteers, there is no
4 way which I can necessarily prove my point but it appears
5 to me that what we do most effectively when we are effective
6 produces a change in attitude which allows for some change
7 in behavior. That occurred in Rochester.

8 Now, it could not occur if there were not the
9 potentials for it. It could not occur if there were not
10 needs, if there were not people who cared. But it is a change
11 in social perception. It is a change in the way in which you
12 interpret the manner by which you apply your efforts to what
13 principles you hold. There was nothing unprincipled about
14 the old pattern. There is nothing profoundly different about
15 the principles in the new one but there is a change in the atti-
16 tude toward how one preserves effort and moves to a specific
17 kind of a goal.

18 It also reflects a changing attitude within the
19 Review Committee not the least of which, which I think you all
20 know I strongly support, is a little tougher approach to
21 a program which is doing poorly. I can remember, Mac, that this
22 is one of the several programs in which a suggested remedy
23 was associate coordinators, a deputy coordinator, something of
24 that kind.

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25 Well, we went over that jump several times. When

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1 a coordinator is inadequate, the best solution is another
2 coordinator. In fact, it is the only solution. One of the
3 reasons we listed some of the changes which we listed to you
4 earlier during this meeting is to demonstrate that that has
5 occurred in a number of other places and I think the changes
6 are meaningful to a number of members of this committee who
7 have been onsite visits and who have reported here.
8 Now, I recognize that this has taken a considerable
9 amount of your time. It may not be a characteristic case
10 study. There is no characteristic case study but I think it
11 puts some of the dynamics of a program management in a conten-
12 tion which is worth your time.
13 DR. SCHMIDT: Before you comment, I would just
14 like to say that I have watched Harold and some of his staff
15 during the last year and have seen them really kind of be
16 surprised at the vehemence of some of the remarks of the Review
17 Committee members about the ineffectiveness of the committee
18 or the felt ineffectiveness of the committee in achieving
19 its purpose. And I think that, and Harold and the staff have
20 been surprised by this because as they are looking at the forest
21 they see the great impact that the committee has had and this
22 case report obviously is an attempt to answer at least some
23 of the questions that have been posed around this table
24 about the impact of a committee.

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25 Through site visits and through what the committee

1 says it has recorded by staff, it is carried back to the regions
2 by staff that we kind of don't know about, committe has
3 had voice and a strong one and it has been influential. Our
4 trees have very often been the projects and the details of
5 things as we get into the nitty-gritty, and this was an attempt
6 obviously to retreat back to a point where we could view the
7 forest.

8 Bill?

9 DR. LUGINBUHL: Under the recent clarification
10 of relationships between the grantee and the RAG, it spells
11 out the way in which the coordinators are appointed. They are
12 nominated by the RAG and appointed by the grantee if I am not
13 mistaken. Who has the authority to fire a coordinator?

14 DR. MARGULIES: Grantee.

15 DR. LUGINBUHL: Thank you.

16 DR. SCHMIDT: Now, I would like to have any
17 discussion right now before we move on to Dr. Brindley and
18 further discussion in a more treesy way of the Rochester
19 region. I would like to stay with the forest just for a moment
20 and see if any committee member has any comments about the
21 presentation or interaction of this committee and the Rochester
22 committee or any that has to do with the functioning of
23 this committee in the review process.

24 Now, it might be that you will need overnight to
25 think of a come back or something to say, so that we aren't

eak 5

1 closing down on this issue but I would ask for comments right
2 now if there are any. Well, if not, we will table this
3 until we get through some of the work of the committee and then
4 we will come back to it. And it is the hope of staff
5 and Harold and so on that we will be able to use this as a
6 kind of a framework to hang comments and discussion on during
7 this two-day period about the Review Committee function.
8 And I would like to compliment Eileen on a
9 beautiful job of reviewing the region. Having been up there,
10 I can appreciate how clearly she presented the picture. We will
11 turn then to Dr. Brindley and our first really work part of
12 this session then and we will take up an anniversary
13 review procedure to triennium of Rochester.
14 DR. BRINDLEY: Thank you. I also would like to
15 compliment Eileen on a very fine job. I wish she had
16 taken about four more minutes then I could have just given
17 you a proposal regarding funding. They have made a complete
18 change in almost everything. The goals and objectives have been
19 changed, they now are much more compatible with national
20 goals. They seem reasonable, possible of attainment.
21 There are three major intermediate goals that they
22 list, are the establishment of methods of restructuring
23 of primary health services in rural areas with particular
24 emphasis on hospital out-patients facilities, emergency
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25 rooms. Can you hear me all right? Is this on?

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1 The joint assessment of new health care systems
2 in the region and improving the care of the chronicly
3 ill including those in the rural areas. Right off hand
4 as soon as we saw those, the question was, well what are you
5 doing about the city. Looks as though practically most
6 of the emphasis was being placed upon the rural areas and perhaps
7 they were forgetting that a large part of the people were
8 in the Rochester area and that there were some problems
9 related to the urban poor. We discussed this with them and
10 they had two good answers.
11 One, that there already is a system of neighborhood
12 centers that were initially proposed by the medical school
13 faculties and by the comprehensive health agencies, and that they
14 thought that these centers would be capable of caring for the
15 urban poor health problems.
16 One of the proposals as you can see a little bit
17 later is going to be evaluation of systems of health care delivery.
18 And it was interesting in our -- and I will digress there a
19 minute. They have a Monroe plan which is the foundation
20 for medical care, Tennessee Valley Group Health
21 Association, which is the Blue Cross sponsored program, AOEO
22 neighborhood health centers network and family practice
23 program at a Highland hospital. They are proposing
24 that these four programs be evaluated as to effectiveness
25 and that the RMP is going to have its input perhaps into the

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1 efficiency of health care delivery by evaluating the systems
2 of health care. An interesting problem came up there. How do
3 you evaluate quality? And who is going to do the evaluation?
4 And we never did receive a very good reply to that. Dr. Berg
5 is Chairman of a committee that will be evaluating quality. And
6 I am sure that is a hard thing to determine, what is quality
7 of care. But they propose that this would be an ongoing
8 assessment and that perhaps the rules and modifications will
9 continue to develop as progress ensues. As we look down to
10 accomplishments and implementation, of course they haven't
11 accomplished very much because this is a whole new ballgame
12 with them. They have proposed 19 projects and of these there
13 were only three that were there before and those three are
14 the Family Counselor Program, the primary care analysis
15 and the kidney program, which already had earmarked funds.
16 They do have a continuing nursing education program
17 which will require some funding until the middle of next
18 year, and they are hopeful that by that time, other sources
19 of funding for the nursing education program will be
20 available. We did feel that there were some deficits in their
21 establishment of intermediate goals and objectives.
22 They had not clearly pointed out how you were going
23 to evaluate progress, what were the milestones going to be that
24 you would look at as you went along with the program. And they
25 also have not established a definite way of determining

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1 priorities. They said they had themselves listed with
2 priorities but there is no clear-cut way of how priorities
3 will be assessed or determined or evaluated. We thought
4 it was very important that they write those out so everyone
5 would know how you are going to determine priorities. That had
6 not been done at the time that we were there.
7 However, the new goals do seem like good ones
8 and they do seem to be consistent with their needs. They
9 showed us a number of studies in which it would imply that
10 actually the rural communities are the ones that need the most
11 action at this time by the Rochester Regional Medical Programs.
12 Some accomplishments have developed. Eileen has
13 already related to most of these. Of course, they have a new
14 coordinator. He is an impressive young man. He is obviously
15 intelligent. He is charming, has a lot of charisma. I did
16 have two reservations.
17 Dr. Warter, who is the Chairman of both the RAG
18 and Executive Committee is a very agressive domineering
19 finite individual that is accustomed to really running the show
20 and he is going to -- Dr. Mott is going to have to get up
21 early and assess himself pretty clearly to be sure he gets
22 his vote in because Dr. Warter is accustomed to running the
23 whole picture.
24 Otherwise, though Dr. Mott has many attractions,
25 he has a lot of good ideas. He has a nice tactful way of being

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1 a good liste er and I think that he will have many possibilities
2 of accomplishing his goals. But he perhaps will need to be a
3 little bit more agressive. The continued support -- oh, they
4 have changed the composition of RAG. They have elected
5 13 new members and they do seem to be more representative
6 of the committee. They have done a better job of having the
7 minorities represented on the RAG. They are trying to get
8 some more true consumers. That will be represented on the RAG.
9 They have some deficits there. They do not really have allied
10 health professions really represented and need to add more
11 in that area. They have established new goals, terminated
12 old programs. They have a closer relationship with the
13 CHP. They have a superb CHP.
14 In fairness to the regional medical people, the CHP
15 were there earlier and they have the whole ten counties
16 well organized, good committees in each county that have
17 evaluated needs. As I have mentioned, they have
18 already organized the neighborhood health centers in the city.
19 They have outlined priorities of their programs of development.
20 They are overlapping directorships of RMP and CHP. They seem
21 to get well together and that will be a good person to have on
22 your team.
23 The CHP is strong in the area. Minority interests,
24 well they have some deficits there but they seem to be trying
25 to improve that in all sincerity. This is a new ball club. They

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1 have no one on there in the program staff that represents
2 the minority interest buy they say they are trying to obtain
3 those and of the three, they were seeking at the time we
4 were there, one of them was a black person. They are hope[illegible]
5 RAG will be more represented by the minority interest and
6 certainly programs are being related to the minotiry needs [illegible]
7 the regional medical programs.

8 Dr. Mott tells a good story to us about how anx[illegible]
9 and eager he is to really see that this is fulfilled. Now,
10 in fairness, the executive committee is all male and all white.
11 They are trying to reduce, though, the responsibilities
12 of the executive committee and really have RAG take over more
13 of those responsibilities. If I am leaving out some things
14 about that, do you want to comment more about that, Eileen?

15 MS. FAATZ: No, I don't believe so.

16 DR. BRINDLEY: We did ask them to go to the black
17 committee and ask them if there could be someone there that
18 would be hopeful and they took the pledge and said they would
19 try it. The program staff, they have some nice boxes written
20 down and it looks good on paper and you almost have to vote
21 for them as to what they intend to do.

22 Now, there are some glaring errors on what they
23 presently have because they don't have many. They have got
24 about three batters and then they are out of hitters but they
25 propose to get this new assistant director and I heard you say

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1 a while ago, Mr. Chambliss, that they now have one so it will be
2 good to have him. They seriously need to have a person in
3 charge of program development. They have a temporary, we
4 think he is temporary, evaluator, Czechoslovakian. He doesn't
5 seem to be wholly adequate for such a big problem to me and
6 perhaps he will need to have someone else there. Then there
7 is no one who has been selected for a lot of these other
8 hearings they have on their program. But if they fill all those
9 slots, they will be able to do it very well. They say that
10 these will all be full-time people and they no longer will be
11 directors of projects and that the technical consultant will
12 come from truly people that are experts in their field.
13 They have made a number of feasibility studies
14 and they have cooperated with the CHP in these feasibility
15 studies and actually have put on the board for us areas
16 of responsibility pretty much over the entire region, about
17 what CHP is going to do and what RMP is going to do and how
18 they will relate with each other.
19 Some areas the major response would be RMP and
20 other areas the responsibility would be CHP and how they
21 might dovetail the program. I am a great believer in that so
22 I hope that will be able to work out. The regional advisory
23 group says now that they are going to take on more of the
24 responsibilities.
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25 Dr. Warter is a great believer in taking his regional

1 advisory group and dividing it up into a number of committees,
2 and these committees would consist of two or three members
3 of the regional advisory group and one man from staff. And
4 that these committees would be given responsibilities
5 of reviewing projects and looking at programs and evaluating
6 funding and evaluating progress and that they would then
7 relate it back to the entire RAG for consideration and approval.
8 There was some fear that maybe Dr. Warter was
9 dominating this to a degree but he says not. I talked to him
10 about it privately and he doesn't think that that really
11 is a serious problem. Their review process consisted of
12 sending out about 600 letters inviting proposals and then they
13 got about 45 of those that they thought looked pretty good. They
14 had a special review committee that would look at each one of
15 these and the CHP reviewed it before. The parent review
16 committee chairman reported it back to the regional advisory
17 group for final approval. The grantee organization,
18 I think, deserves a lot of credit because they were pretty much
19 the whole show up before right now.
20 And their part has been greatly reduced, their
21 proportion of the projects has been largely diminished. They
22 will have six representatives now on RAG where they were most
23 of them before. But they seemed very interested. They think
24 this is a good way to go about it. They indicated a
25 desire to help the program. And the people we talked to all were

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1 unanimous in their commendation of the University of
2 Rochester and its present approach to the change that had
3 been made.
4 Participation, it was good. I talked to the
5 doctors and also talked to a lot of the hospital administrators
6 and they are enthusiastic. One real good thing that they are
7 doing is the medical school is relating to each one of these
8 community hospitals in their training programs, and particularly
9 in their family practice training programs, also, in the
10 allied health training programs.

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They are sending these boys out, or women, out to the communities to actually serve as primary health care providers under the direction of the staff community hospitals and they are even going so far as to say after you have been out there a while, you find somebody you think will make a good secretary and bring her back to the community hospital and we will train her, too.

By doing this, they have been able to get a number of these boys and girls that have stayed in these smaller rural communities and have gone into practice, which was refreshing, and it looked as though they actually were providing a better quality of health care to the region by the sharing of facilities.

Their assessment of need has been done, as I mentioned before, largely through the CHP and their ten-county committee programs which seems to have done a good job. Really I wouldn't know how effective the new programs are until we have had a little time to see experience, but on paper it looks pretty well. We spent a lot of time on evaluation, and they have kind of an unusual way of evaluating things.

Two members of RAG and one member from staff, along with a program director, will evaluate a program or project and then this project committee will report quarterly through an assistant director to the RAG and then on the recommendation of the project committee the assistant director may change the

1 budget up or down up to 20 percent; unless an appeal is made
2 to the project director, and then to the full RAG.
3 And talk to Dr. Warter about that, he says I need
4 to get the RAG involved, I need to have these people know
5 what is going on, they are the ones that ought to have some
6 active interest. I think this should be a management function.
7 Well, you kind of wonder, you know, where does
8 the coordinates come in and assistant director come in, and
9 when does he get to vote so he asked Dr. Mott about this and
10 Dr. Rudolf, was it, and they said, well, now, all of
11 these proposals and recommendations come through them and
12 that they have the right of changing some things or improving
13 them before they actually get to the RAG for full approval.
14 They seem satisfied with this recommendation.
15 We suggested to them that we thought the burden of
16 proof was upon them. If they showed that this system was a
17 good one and can make it work, why, then, that was fine. If
18 this didn't work, why, maybe they needed to look at another
19 method because it is a little unusual plan that they have
20 proposed, and they have three levels of funding that they
21 suggested to us.
22 One was what they thought was just rock bottom.
23 One was one they thought was -- would do a better job; and
24 three, I sure would be thankful if they gave that to us.
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25 We looked those over and we will talk about that

at the last minute. Dissemination of knowledge, they haven't disseminated yet because they haven't gotten to work yet, but if they do, the things they are saying, it should be very purposeful and I think succeed.

Utilization of manpower and facilities on paper again looks really good. They have made some good suggestions, improvement of care, it should be significant because they are really going to get out with the community, particularly in these rural areas and make a lot of changes that should be helpful. And I have all those projects down, which ones they will be doing, if you want to look at them, but I don't think you need to look at them right now. If you go back to the level of funding, last year, as you remember on the picture up there, they got $858,000. They have a kidney program that is, has been funding out of separate funds for, I believe, $35,000.

We felt it would probably be well to suggest the $900,000 level of funding, plus the $35,000 for kidney, that this would do several things. It would permit them to increase their program staff, to add the men and women they need to have for this; it would show some optimism in the development of their program.

And if the program they had last year was worth 800,000, this is sure worth a heck of a lot more.

We are ready for questions.

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1 Eileen, did I leave out some footnotes?

2 MS. FAATZ: The only thing is I have talked to

3 the region recently. In the box was one of the two main

4 divisions, program development, Shawkadeary is coming

5 in as assistant director for program development. There are

6 four slots for program development specialists under him.

7 You will recall Miss Clark was one of them. They have three

8 new people who have accepted offers for those slots, so

9 that part, they are getting on with bringing on the staff.

10 DR. BRINDLEY: One other thing I didn't mention

11 that is very important, they did not have any bylaws while

12 we were there. We thought it was extremely important for

13 lines of authority not to be talked about, but to be down on

14 paper. So we asked them about that and so the day that we

15 left, why, they said we just got through writing it last

16 night. But nobody had reviewed it, their RAG had not

17 approved it, so we said we are going to recommend a level of

18 funding contingent upon the bylaws being sent and being read

19 and approved by staff.

20 But it was very important for them to have some

21 bylaws because everything was just kind of coming off the top

22 of your head. He is responsible. Well, he is. You ought to

23 go this way. But nothing was written down.

24 DR. SCHMIDT: All right, then, your recommendation,

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25 would you repeat the recommendation, please?

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1 DR. BRINDLEY: We are recommending a level of
2 funding of $900,000 exclusive of the 35,000 of the kidney
3 program. This is a one-year level of funding.
4 DR. SCHMIDT: Is it contingent upon acceptance
5 of the bylaws and --
6 DR. BRINDLEY: Yes.
7 DR. SCHMIDT: One-year funding with then another
8 application due in a year, is that right?
9 DR. BRINDLEY: They said they hoped that after this
10 year of kind of regrouping and getting going that next year
11 their program would be mature enough where they could apply
12 for biannual status, but they were not ready to be considered
13 for that now.
14 DR. SCHMIDT: I'd like, before comments, to remind
15 the committee of the RMP review criteria and the score sheets
16 that you are to be filling out. Are there any comments before
17 we go on to the second reviewer, or let's say are there any
18 questions directly to Dr. Brindley?
19 DR. SCHLERIS: I was interested in the emergency
20 service award of $141,000 to Rochester. I was wondering
21 if you were able to get any on-site impression of how they
22 are moving with that in terms of their planning or in terms of
23 how it relates to RMP in that area?
24 DR. BRINDLEY: I asked Eileen a while ago about that
25 so she could tell me how much had been funded out of the

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1 funds you were looking at and that is for which programs,
2 Eileen?
3 MS. FAATZ: Well, they have about four separate
4 AMS components, some two of which I believe were funded
5 from the special supplemental funds, two of which are funded
6 from the regular program, Rochester RMP funds.
7 One of the components is for overall planning and
8 development of EMS and two of the people responsible for
9 that are coming next week to meet with Dr. Rose.
10 We didn't get any on-site experience, no, they had
11 the money for such a short time there wouldn't be much to say.
12 DR. BRINDLEY: Leonard, there was one other pretty
13 glaring weakness in it, that was who is going to provide
14 the continuity of care. I asked Dr. Berg that because it is
15 important for the patient to come in the emergency room and
16 say he had diabetes. Who takes the ball from there? He said
17 that is an interesting problem and we are sure going to work
18 on it.
19 DR. LEWIS: I won't take up very much of the
20 committee's time. I won't take up very much of the
21 committee's time because I think that this region
22 has been reviewed by as thoroughly as any other since I have
23 been here.
24 I think in reviewing the site visits, reports
25 and present application, one gets the impression that you

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1 are reading a psychopathologic conference complete with
2 autopsy. I don't know where we are with this union insofar
3 as not having participated in the site visit, the application
4 is essentially an application for a new region, and in the
5 application it is perfect, I really enjoyed reading it,
6 which was surprising.

7 Dr. Brindley, I think, describes for us exactly
8 what I needed to know. I think that some of the things that
9 are in the grant here that are questionable. For example,
10 they discuss the issue of active recruitment and redistribution
11 of physicians and the possible role that RMP can play in this
12 which I think would be a rather sensitive area, and I am not
13 sure they are ready for that, but it reads very well.

14 The way in which they are going to distribute their
15 funds certainly appears to be more in concert with what
16 RMPs should be doing. The only questions that I have in
17 reading the application, is with regard to how much the award
18 should be. It is very difficult to know what their budget
19 has actually been because of the -- the figures we get for
20 their previous fiscal period is 9-71 to 12-72 and I suppose that
21 if you assume a constant distribution of expenses over 15
22 months, then you could just divide it out and get a 12-month
23 figure, but at any rate, the suggestion of $900,000 budget
24 for this coming fiscal period based on the fact that it is a
25 much better program, if the previous programs were $800,000

1 I don't think is irrational judgment because I don't think
2 the previous program was worth $800,000.
3 In fact, $4-1/2 million has been poured into this
4 region in the last four years which I think is a shame.
5 The core budget was $326,000 from September, '71 to 12-72,
6 which might break down to 280,000 for the previous year,
7 and the present core program staff budget would go up to
8 $415,000.
9 I just wondered whether this was not a rather large
10 step up considering -- I share everybody's hope that what is
11 down on paper is going to work out, but the past history of
12 this region has been bad, and I just wonder whether that is
13 not a very significant increase considering the amount of
14 activity that is going on there.
15 So that I would like to hear a little more discus-
16 sion with regard to the amount of step up in the core staff
17 program cost and also what they really need to get started
18 in expanding the program with 13 new projects.
19 I think certainly the money they asked for was
20 far in excess of what they should be getting. I think the
21 $900,000 may be in excess also.
22 DR. SCHMIDT: Dr. Brindley, would you like to
23 comment on the rationale or background of the arrival at the
24 $900,000 figure?

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25 DR. BRINDLEY: The core staff expenditures in our

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1 opinion were important primarily as related to the program
2 staff and program staff development, evaluator, and
3 perhaps improvement in their financial accounting.
4 They did have a rather large staff before, but it
5 was not a very effective one, and it was accomplishing
6 mostly the administration of projects from the medical
7 school and medical school faculty.
8 Maybe this was an erroneous judgment, but it did
9 seem to us to be one of the major things they needed to do,
10 was to have a good program staff, and that the core was a
11 pretty important part of their program.
12 Frank, do you want to comment on that?
13 MR. NASH: No, I think one of the other reasons
14 the site visit team recommended the 900,000 was to show this
15 region that they have made progress and to reward them for
16 accepting recommendations and making changes that they have.

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1 DR. SCHMIDT: I think that it is certainly the
2 feeling of the site-visitors and staff that substantive changes
3 have, indeed, occurred.
4 The Coordinator and Project Site -- or the Project
5 Directors, not being staffed, the building of the staff and
6 so on. And that the region has done now, for sure, absolutely
7 at least, some of the things that it was told to do.
8 So, then, do you now pat them on the head and say,
9 "Good boy," and give them some money; or do you then, say,
10 "Bad dog," again?
11 I am trying to train a puppy, so you know, and
12 where does that get you?
13 DR. THURMAN: Gets you a wet rug sometimes.
14 DR. SCHMIDT: Well, Bill, you are bothered.
15 DR. THURMAN: I guess I have had too many wet
16 rugs. I would share Dr. Lewis's concern about adding a
17 hundred thousand more to what amounts to a cesspool. And,
18 too, I doubt seriously that if we think constructively, about
19 what this region can accomplish before they come back in
20 with another year's application, that they are going to be
21 able to meaningfully attract people that they need, particularly
22 in the area of evaluation. to really use this money.
23 I think that Dr. Brindley has brought out some
24 very important points; who is running the program? It has a
25 long history of nobody running the program, now we have either

1 a RAG Chairman or Coordinator and we don't know. And, I would
2 just, I think, if Dr. Lewis were making a substitute recommend-
3 ation for Dr. Brindley's idea of tag along with it because
4 granted anything would be better.
5 The $800 thousand we already spent; let us make
6 sure the $800 thousand we plan to spend this year are worth
7 at least 800 thousand because last year's 800 thousand was
8 not; so I am a wet rug.
9 DR. SCHMIDT: All right. Dr. Lewis?
10 DR. LEWIS: Well, I don't really feel competent
11 to make a substitute recommendation on the basis of having
12 read the documents but not participating in the site-visit,
13 but I would like Dr. Brindley and the people who participated
14 in the site-visit at this point, to reconsider the possibility
15 of keeping the funding at the previous level, and what its
16 impact would be, because I feel that the recommendation of
17 $900 thousand is in excess, but I don't feel competent to --
18 DR. SCHMIDT: I mean, what specifically was the
19 previous level?
20 MS. FAATZ: Annualized -- it was $800 thousand
21 plus 58 thousand earmarked for kidney. What the recommenda-
22 tion is, is an increase of 900,000. We are talking about an
23 approved level, too, not necessarily a funding level.
24 They sometimes differ. Nine hundred thousand,
25 plus $35 thousand for kidney.

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1 DR. SCHMIDT: Okay, we are not, the Committee in
2 its past, has often spent the most time over the smallest
3 amounts of money.
4 This is, that is proper if principles are involved.
5 So the, what I am hearing now is, do we keep them at the same
6 level as sort of a, you know, okay, we are satisfied, but,
7 you have still got to show us, or do we give them a little
8 more as a pat on the head?
9 Other Committee members have comment?
10 DR. BRINDLEY: In fairness, this is really kind of
11 a promissory note, they have not done these things, but they
12 are trying to do all the things we asked them to do; or at
13 least, most of them, and we felt perhaps, it was worth
14 saying, with some encouragement.
15 This, we think this is a good step and we do like
16 to see you try it. Eight hundred would be fine for me. They
17 haven't proven they can use that 800 well. They have not
18 gone up to bat yet, and have not filled those slots but, I
19 don't want them to say, "We could not fill them because we did
20 not have the green stops.
21 DR. KRALEWSKI: Has this been increasing in the
22 previous years, Brand?
23 DR. BRINDLEY: It has.
24 DR. SCHMIDT: In your loosepleaf books, these
25 illustrations, I think, are included.

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1 MS. FAATZ: There was an increase going into the
2 second operational area and it has decreased steadily, since
3 then.
4 DR. BRINDLEY: A million, eight.
5 DR. SCHMIDT: I sense that the site-visitors and
6 so on, feel some resistance to dropping this --
7 (Slide.)
8 -- although then, you kind of say that the 800
9 thousand would be fine. Let me try to move this along by
10 saying, there is a motion on the floor, it was not seconded,
11 so I will revert to Robert's Rules, by which I hope we will
12 operate.
13 There was a motion on the floor for approval that
14 a one-year level of 900,000 exclusive of the 35 thousand for
15 kidney, is there a second to that motion?
16 DR. KRALEWSKI: I will second it.
17 DR. SCHMIDT: All right, it is seconded.
18 I will ask Dr. Lewis or Thurmond if they wish to
19 move a substitute motion, or amendment to the motion on the
20 floor?
21 Dr. Lewis?
22 DR. LEWIS: I would move substitute motion that
23 they be approved at the level of funding, exactly as the
24 previous year.
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25 DR. SCHMIDT: Okay.

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1 That is 858. We will test, then. Send them to
2 the Committee, there is a substitute motion, is there a
3 second?
4 Luginbuhl?
5 DR. LUGINBUHL: Second.
6 DR. SCHMIDT: All right, It is seconded. We
7 will discuss the substitute motion.
8 DR. KRALEWSKI: What you are recommending, then,
9 is a slight increase, it would be 858 and actual need for the
10 kidney project is going to be less this year than last?
11 DR. LEWIS: I think that I, I think that the
12 kidney project should be considered outside of their budget,
13 since in their proposal, they consider it outside of their
14 budget, and I meant for this proposal to be $800 thousand,
15 plus whatever their kidney project is going to be.
16 DR. SCHMIDT: Eight hundred thousand, plus the
17 kidney? I presume your substitute motion includes the other
18 parts of this?
19 DR. LEWIS: Yes.
20 DR. SCHMIDT: Continued on bylaws for one year and
21 so on?
22 DR. HESS: Just like to have us go over the budget
23 sheet, the next to the last sheet, page 23.
24 Seems to me that this pinpoints the difference
25 at least as they see it, between the $800 thousand program and

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1 the 900 thousand, is that correct, Doctor? Doctor Brindley?
2 So this would cut back 25 thousand for staff, people on the
3 right hand side, in the lower column. It would not enable
4 them to increase -- or to do as much with the delivery systems
5 evaluation and it would -- it would eliminate the enrichment
6 program and place some limitations on the program. That is
7 what we voted for the substitute motion?

8 DR. BRINDLEY: All right, are there any other
9 comments but Dr. Bridley, or staff? Is there any kind of
10 damage that this substitute motion might possibly -- are there
11 any concerns about the level of 800 thousand?

12 MS. FAATZ: I think one thing we have to consider
13 is that one of the strongest recommendations that came out
14 of the site-visit team was that the region might well want
15 to increase its program staff abaove what they projected in
16 the application, because the site-visit team frankly, did
17 not think that was adequate. They thought that was a bare-
18 bones approach to program staff. So, we, you know, you might
19 want to think about some words to relate to the region if
20 you are willing to recommend the 800 thousand, and at the same
21 time, recommend they increase the program staff, over what
22 they have projected.

23 DR. SCHMIDT: Thank you.

24 Are there any other comments?

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25 MRS. SITSBEE: I would like, Betty -- I would like,

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1 Betty, to consider the site-visit recommendations, and also
2 we have talked about the $800 thousand, not accomplishing
3 anything this year and yet it was, this year that this change
4 was occurring and I am thinking of it from the standpoint of
5 the Division of Operations for Development and not for the
6 individual region, but when an attempt is made to try to
7 follow the Committee's recommendation of last year, and staff
8 assistance developed; the region responds and they, and the
9 Committee comes back with the same level of funding; I think
10 this is a message that may undermine staff attempts in the
11 future.

12 DR. SCHMIDT: I would think that if the Committee
13 goes with the 800 level, it would be obligated to state why,
14 so there would be a specific message perceived and received,
15 and they would not be left with the idea that what they had
16 done was wrong; which would be one interpretation, or the
17 staff had misled them, or the site-visitors had misled
18 them, which would be another bad message to be received by a
19 cut.

20 I think we would want to be specific as to why the
21 level was chosen.

22 John?

23 DR. KRALEWSKI: I don't want to take too much time,
24 but one question, and one comment.

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25 Are they going to have a fair amount of surplus

ter-8

1 funds this year?

2 DR. BRINDLEY: Will they have any?

3 MS. FAATZ: No. I think there -- no I don't think

4 they are expecting surplus funds.

5 DR. KRALEWSKI: they will be able to expend out

6 that eight hundred thousand?

7 MS. FAATZ: Not having to be very much left over.

8 DR. KRALEWSKI: They are then up to expending the

9 eight hundred thousand, and if they have made the changes,

10 you have indicated, I would speak in favor of giving them

11 some increase in funding to recognize those changes and to

12 allow them to progress in their pattern, over the next year.

13 DR. SCHMIDT: I think the Committee is ready to

14 test the motion.

15 I will call the question, unless someone wishes

16 the floor?

17 Dr. Ellis?

18 DR. ELLIS: I would like to see them have some

19 increased funding if they are expending the 800 thousand,

20 because otherwise, they will have absolutely no flexibility

21 for growth.

22 DR. SCHMIDT: Comment from staff?

23 VOICE: Cannot hear.

24 DR. SCHMIDT: We will then vote on the substitute

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25 motion.

1 MS. FAATZ: I think people count here, Dr. Ellis.

2 DR. ELLIS: I thought we were voting on motion, I

3 was just speaking.

4 DR. SCHMIDT: Speaking against the substitute

5 motion?

6 DR. ELLIS: Yes, I was speaking against the sub-

7 stitute motion and supporting -- had said and that was that

8 they should -- if they are expending up to 800 thousand dollars

9 and have no surplus, it would be impossible for them to have

10 the flexibility for growth, which they need.

11 And, therefore, I would think that some higher

12 funding should be made available -- increase in funding, should

13 be made available to them.

14 SISTER ANN JOSEPHINE: I would like to say one

15 more thing in support of funding by way of encouragement. I

16 think the report indicated the great mobility of these people

17 and it may well be that in a program of this type, which is

18 on the -- seems to be going in the right direction, now,

19 shows promise, if there were no increase in funding, they

20 might well lose some of the people who could make the

21 program go.

22 DR. SCHMIDT: Thank you.

23 I think we are ready for the question then, on the

24 substitute motion. All in favor of the substitute motion,

25 which is voting for the reduced level, please say "aye."

1 (A show of hands.)

2 DR. SCHMIDT: You don't follow instructions very

3 well.

4 DR. SCHMIDT: Opposed, please raise your voice.

5 All right the substitute motion is defeated.

6 The motion then to be considered, is the original

7 motion.

8 All in favor of the original motion, please say,

9 "aye."

10 Opposed, "nay."

11 All right, it is not unanimous. "Nays" are recorded.

12 DR. SCHLERIS: I think the illustration is of

13 value in showing the Rochester program has followed the smoke

14 signals from Washington, as they have interpreted them as

15 far as reduction in categorical areas are concerned.

16 Whether or not the smoke signals will be different

17 in the future, I don't know, but at least, they harkened to

18 the message.

19 DR. SCHMIDT: Bill is going --

20 DR. LUGINBUHL One more negative comment -- that

21 is going back to what Mr. Scherlis said.

22 The grant shows how well we fertilized their

23 program, and how much we got from them by giving them an

24 increase, we just voted to give them in the years past.

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25 They didn't do anything for that increase of

1 200,000. They didn't take a message from a decrease or an...
2 decrease, so I am not opposed, except for the principle of
3 money.

4 DR. SCHMIDT: I think the staff does have enough
5 from these comments to be able to warn the region that the
6 Committee was aware of the changes, we will be watching very
7 carefully.

8 It is now 12 minutes to one.

9 I think we should take a lunch break at this point,
10 and I believe that 45 minutes will be adequate for lunch.

11 So, we will reconvene in 45 minutes.

12 (Whereupon the meeting was recessed for lunch, at
13 12:45 p.m., to reconvene at 1:30, p.m., this same day.)

-12/s-13

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1 AFTERNOON SESSION

2 (1:33 p.m.)

3 DR. SCHMIDT: If the Committee could please be
4 seated I think our 45 minutes are up. And we are arranging
5 the sequence this afternoon as follows:
6 We will lead off with Central New York. And follow
7 up then with Virginia, West Virginia, Alabama, Hawaii and
8 Mississippi.
9 And Albany and Hawaii and Mississippi have kind of
10 different sorts of presentations and I'd like if possible to
11 get through with those today so the maximum number of reviews
12 committee members will be here and will be able to comment on
13 the variations of presentation of material to the review
14 committee.
15 Also like to remind committee members that the
16 scoring sheets can be filled out with any number between 1.0
17 and 5.0, but the system won't take anything below the unit
18 number 1 or above 5.
19 You can use one decimal place between 1 and 5 if
20 you have problems with just the four categories. I'd like to
21 recognize Henry Lemon and welcome him back to the group.
22 He interrupted his vacation and as I said earlier
23 and came down from the North Country to be with us.
24 So at this point we will begin with Central New
25 York and I believe that we will begin with Dr. Patterson.

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1 DR. PATTERSON: Thank you very much. I believe
2 Dr. Ellis wanted to say a word before I begin.
3 DR. ELLIS: I don't, Mr. Chairman, have anything
4 new to say. I was assigned to review, that is why I looked
5 at you and I was simply going to take the opportunity to say
6 that we had Dr. Simmons Patterson with us who had the good
7 fortune to make two of the review visits and was in a better
8 position perhaps to speak on the more current information
9 than I.
10 DR. SCHMIDT: Let me interrupt right now and say
11 you were primary reviewer and that was understood.
12 My instructions, by somebody who I can't name right
13 now, were that he would lead off then we would turn to you.
14 DR. ELLIS: I see, well fine.
15 DR. SCHMIDT: But however you want to do it.
16 DR. ELLIS: Would this then be all right if he
17 just went on and gave what was seen on the -- okay.
18 DR. PATTERSON: I was fortunate enough to one-year
19 ago attend as a member of the site visit team to Central
20 New York and was pleased to be able to go back the second time.
21 Regret very much Mrs. Anderson is not able to be here today.
22 Mrs. Anderson was Chairman of the Site Visit Team
23 and was going to make the report which I will make today and
24 she asked me if I would speak on her behalf.

25 I thought probably since you had most of the

information sent around to you as I understand concerning the comments or different points made by Dr. Brindley concerning those priorities so forth, probably I'd give an overall picture of my impression of this site visit and then could come back to the review sheet and possibly go through it quickly or answer any questions that might arise.

In many respects it was hard for me to believe when I went back this year that it was the same regional medical program that I had visited the previous year.

The former director, Dr. Lyons, and many of his staff departed this past year, through resignation. It was very obvious from the beginning that the program in recent months since the time of the departure of these individuals, that the program was vastly understaffed.

Both John Murray who was elected unanimously by the regional advisory group as coordinator and Mr. Walt Curry who was his more or less deputy, in my opinion, ought to be commended greatly for the heavy load that they have carried in the recent months.

In fact when we were present at the site visit Mr. Murray had just recovered from an illness due to overwork. He had just gone beyond the point of human endurance and we quickly made him aware that this was not the right way to go at this job. It's clear that they can't continue in an understaffed manner in the future.

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1 Unquestionably in my opinion and in the opinion of
2 most of the staff of the Site Visit Team, the top priority
3 probably of this program at this time is the recruitment of
4 additional qualified individuals.
5 At the present time the staff is really in reality
6 so small in number that they cannot adequately handle the
7 duties and responsibility concerning the projects they now
8 have.
9 Doing my homework before this meeting I went over
10 the recommendations and -- that we made last year as to what
11 we found they should do.
12 And I believe sincerely that efforts had been made
13 to meet the requests of the previous site team. It was recom-
14 mended at the time that a physician associate director be
15 appointed, a man that had administrative capabilities, that
16 had rapport with the medical profession, and as yet such an
17 individual has not been recruited.
18 They do have a physician by the name of Dr. Carhart
19 who had been recruited to be more or less of a coordinator of
20 what is known as North Ridge.
21 This region is devided into four areas and they
22 have particular problems in this northern area because of the
23 isolation due to weather, et cetera.
24 Dr. Carhart is doing a magnificent job in a liaison
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25 capacity in arranging for medical students and so forth to go

1 out to the hospitals.

2 But still, Mr. Murray in my opinion needs a physician

3 associate director and we advised him so very emphatically.

4 We have told him that he shouldn't rush into this, that he

5 should be very careful in his selection.

6 Another thing that is most essential is to have

7 an organized staff. From an instructural standpoint. They

8 need people in key positions such as assistant directors of

9 operations and administration, evaluation.

10 One of the staff is carrying a dual hat, which is

11 bad. I -- they have several staff members that are -- they're

12 on the staff, the program staff, as being in the capacity of

13 project directors.

14 We recommended to them that these people should

15 be made in reality full-time project staff members and not

16 capacity of project directors.

17 This holds true as well to an individual who is

18 coordinating the education. A year ago they had 11 position

19 evaluators. Part-time men. No one knew what they were doing.

20 In no uncertain terms we recommended this be done

21 away with. They heeded our advice and they do have an evaluator

22 now. There is some question as to whether he is the right man

23 for the job because he is attempting to get a Ph D degree and

24 I feel probably he is not able to spend the time with the

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25 program that he should.

1 And Mr. Murray is cognizant of this fact.
2 Mr. Murray is a very dedicated man, hard working, has the
3 respect of his entire staff, and it is hard to believe that
4 he is becoming engaged in as many activities as he can.
5 Questions have been asked me as to my opinion as to his ability
6 to administer this program. It is difficult to say. But my
7 feeling at the present is that he can do the job if he learns
8 to delegate authority and if he gets a well-organized
9 structural staff.
10 He must learn to delegate authority. We talked
11 very frankly to him and I think that he got the message and
12 I think that this is the most important aspect in as far as
13 the future of the program is concerned.
14 Last year recommendations were made concerning
15 improving representation on the regional advisory group.
16 This advice has been heeded. Participation by members of
17 this group is excellent.
18 They have a very dedicated physician, Dr. Case,
19 who is the Chairman of the Regional Advisory Group. Dr. Case
20 spends much time with this program. He works closely with
21 Mr. Murray.
22 There is no question of competition, Dr. Case
23 advises and he is not trying to run the program. He is a
24 very clear-thinking individual.
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25 He wants to do what is best for the program, and I

1 think they're indeed fortunate to have such a man as Chairman
2 of the Regional Advisory Group.
3 I was particularly impressed and gratified by the
4 many and varied health activities that the staff members were
5 participating in.
6 Particularly gratifying was the relationship with
7 the -- "B" agencies. "B" agencies have procured emergency
8 medical service, coordinator is from the areas and regional
9 funding program is funding their salaries.
10 The representation by the regional medical program
11 staff is on all the "B" agencies. The "B" agencies have
12 representation of course on the regional advisory group and
13 the relationship between these two bodies is very very
14 commendable.
15 Dr. Scheiner, who I understand is not here today,
16 gave an excellent evaluation of the kidney program. The Kidney
17 Program has been sorely lacking in planning and help from the
18 program staff.
19 They have underestimated the needs of the area
20 and there has got to be more cooperation not only with the
21 program staff but with other groups, agencies and so forth,
22 in this region.
23 Dr. Schneider gave a very excellent report at our
24 session at the end of the site visit and I think ge got his
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25 point across very clearly.

1 I got also the impression that possibly the program
2 needs some assistance in their fiscal management but I think
3 this is being taken care of through the State University of
4 New York, upstate medical centers through their business
5 affairs and also through the research foundation of New York
6 who has a branch office in Albany.
7 And I think with help from these two groups that,
8 and Mr. Murray realizes that because of his undermanned
9 staff that he needs this fiscal support and he is taking
10 steps in that direction as an overall picture and inclusion
11 it is my opinion that this program needs help and not dis-
12 couragement.
13 And I emphasize this. And I enjoyed very much
14 hearing Dr. Brindley's presentation previous to this one,
15 and the remarks that several people made.
16 I think that this group really felt like they were,
17 had received a blow last year when they were funded, at quite
18 a low level.
19 They for some reason weren't too satisfied with the
20 site visit. That came out loud and clear this time. We tried
21 to give them the impression and it is an honest impression
22 that we wanted to help them but I think this program is at
23 the brink now where they, and I am trying not to let emotionalism
24 take over but I think that this group is honestly trying to
25 do what we recommended last year.

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9

1 I think that when Dr. Lyons left it put an added
2 burden on the staff. I think the staff did some things that
3 weren't too wise.
4 One was these mini-contracts. Had the opportunity
5 to read about the mini-contracts, they share my opinion.
6 When you think about these mini-contracts it is an effort
7 on the part of program staff to get people in this region
8 involved and they went out and requested projects for up to
9 six months period with a maximum sum of $5,000.
10 And they received requests from over 300 individuals.
11 And in reality, what the program has been doing is dispensing
12 funds for these contracts as if the program had the authority
13 to use developmental component funds.
14 And since this program has not been approved it is
15 not justified in use this way. Furthermore I do not think
16 these mini-contracts related to the overall program goals
17 and objectives.
18 Many manpower hours were required to supervise
19 these feasibility studies and an undermanned staff is incapable
20 of doing this.
21 It would be much wiser to have coordinators, I
22 mean four individuals that they are thinking of placing one
23 in each region, each area of the region. To have coordinators
24 determine the needs rather than let people come in with varied
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25 ideas.

1 On this basis money could much more wisely be
2 spent in completing these, carrying out these needs than would
3 be involved in a hit and miss mini-contract idea.
4 Another think I think in the program is that there
5 needs to be additional minority members on the program staff.
6 We discussed this thoroughly with Mr. Murray and Dr. Case.
7 They do have one minority member that is working
8 with the Spanish speaking individuals in the area. But the,
9 they need minority members on the program staff, they need
10 minority members on the regional advisory group.
11 We found out there was some, I am just not satisfied
12 with their priority system. We discussed this thoroughly with
13 them. I was not too impressed by their appeal mechanism.
14 I think this should be clarified. I mention all
15 these things not in a negative fashion but just things that
16 I think need to be improved. But the program staff does need
17 help and not discouragement.
18 I emphasize that again. You have a dedicated group,
19 the program staff, although inadequate in number to have done
20 a yeoman's job. All the lines of authority have led to
21 Mr. Murray and he has been as I said before overworked.
22 It is absolutely essential that he fill the
23 vacancies in this new structure with well-qualified capable
24 individuals as soon as possible. Well-qualified staff,
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25 adequate number, if it is carefully recruited I feel that

11

1 Central New York Region probably will be ready to submit a
2 Triennial application a year from now.
3 It is important, however, to carefully review
4 the projects submitted in this present application and to
5 approve only a sufficient number that the program staff can
6 adequately develop, supervise and evaluate.
7 To overburden the staff in the next year with too
8 many new activities would revert the program in my opinion
9 to the same status that has existed in the past six to nine
10 months.
11 It is the feeling of the site visit team that we
12 would recommend $429,000 for staff and, let's see, a total
13 of $889,000, with $429,000 of this to be for the program
14 staff and direct cost to January 1, 1973.
15 We feel this amount would accommodate an adequate
16 staff and would not overburden them with unreasonable program
17 activities.
18 Also, this amount should give them a vote of confi-
19 dence that would improve their morale which is most important
20 and deserving at the present time.
21 Now that I have tried to use as an overall picture.
22 We have comments that we will be glad to make on the review
23 sheet that we have concerning goals, objectives and so forth
24 and I'd be glad, I know, I think this was sent to you and
25 therefore I hesitate to go through step by step unless you so

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12

1 desire.

2 DR. SCHMIDT: I think that it would be probably best

3 in view of all things to hold off just a bit and use that in

4 response to questions that might be, might develop.

5 So if you would remain there I will turn to

6 Dr. Ellis for any comments she might have then I'd like a

7 motion.

8 DR. ELLIS: Thank you Mr. Chairman. He has dis-

9 cussed this very well.

10 I would like to ask one question. How did you find

11 Dr. Patterson, how did you find the neighborhood health

12 center which was one of the problems that we talked about when

13 we were there on the first visit?

14 I notice it has been transferred but --

15 DR. PATTERSON: I am going to be very honest it

16 didn't come up in our discussions at all, doctor.

17 DR. ELLIS: Well you see the neighborhood health

18 center was one of the things that we talked about because

19 this was a way to provide services to many of the poor people

20 who lived in the community and also the way to use new kinds

21 of personnel in order to get the services to them.

22 But perhaps it was around this discussion and

23 Dr. Lemon was there too, and made the visit to the neighborhood

24 center, that Dr. Lyons had some feeling of insecurity. I don't

25 know. Was this your impression?

13

1 DR. PATTERSON: Well at the time Dr. Lyons, frankly,
2 didn't know much about what was going on in the neighborhood
3 health center, that was our impression.
4 And then unfortunately several members of the site
5 visit team during the visit went and visited the neighborhood
6 health center and this invoked much criticism from the people
7 that we visited.
8 I feel like I am answering this just from my
9 thoughts. It occurred that the region was not involved
10 in the neighborhood health center at all at the time and
11 because they were so undermanned and so overworked I feel
12 like probably their activities with the neighborhood health
13 center, Dr. Ellis, have been practically nil lately.
14 DR. MARGULIES: I could add a little bit to that,
15 just purely by coincidence I was in Syracuse in the last two
16 days. And not particularly, not on a site visit activity
17 but some other purposes with the RMP.
18 Met with the staff and with the director of the
19 neighborhood health center who was very intimately a part of
20 the regional medical program.
21 Wherever I went he was. And it was quite obvious
22 that the working relationship between the two at least as I
23 observed them casually were very intimate.
24 Of course, Murray was in that kind of an activity
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25 very deeply before he became the current director of the

1 program up there so it's becoming a natural part of their
2 interest.
3 DR. SCHMIDT: Miss Kerr?
4 MISS KERR: My response is strictly from the written
5 word not having been there as a site visitor and I do have
6 as a result of my reading and study some major questions,
7 some of which I think Dr. Patterson has answered quite well.
8 I still have some questions in mind. And I will
9 express them and if he or one of the review people will help
10 me, I will appreciate this.
11 I think there is no question but what Mr. Murray
12 as a new coordinator has improved working relationships with
13 agencies throughout the region.
14 My question about the leadership of the coordinator
15 is not one of public relations and not one of motivation
16 necessarily. All through the report it seemed to come to me
17 that there was an indication that he was a person apparently
18 unable to delegate responsibilities.
19 And that in several instances said he feels he must
20 do everything himself, and I am wondering, and basic to the
21 weaknesses which have potential for strengthening, if with
22 the enlargement of staff, and this permeates the whole report,
23 the need to enlarge staff and expertise and competency needed
24 to carry out the vision they have, but if the staff is enlarged
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25 to the point needed, is the coordinator going to be able to

15

1 develop the ability to delegate responsibilities and the
2 authority that goes with it?
3 This is a major concern that I have.
4 Secondly, the region has been advised about the
5 addition of minority representation on the RAG and while there
6 has been some it seems to me it is in the nature of tokenism
7 and I think we need to stress this again.
8 There are many other areas. More specifically there
9 are two proposed projects here having to do with nursing homes,
10 improvement of personnel in nursing homes in the areas of
11 medication administration and, something of this effect.
12 I am wondering how aware leadership is in this
13 region as to the vast amount of funds now available through
14 other sources for nursing home personnel.
15 And I question the amount of money that they are
16 requesting in those two particular projects for this reason.
17 DR. PATTERSON: I will try to answer the first
18 question. Maybe Dr. Margulies knows more about this than I do.
19 Of course the only two times I have seen Mr. Murray are the
20 times on the two site visits and it is impossible for me to
21 answer some of the questions you asked.
22 From a personal standpoint, I don't believe I was
23 any better off than John Murray as far as ability for desire
24 to delegate authority. I thought I had to do everything and
25 I soon learned that that was an utter falsehood.

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1 We had a very very frank talk with him about this.
2 And I don't think it was too frank but very forthright
3 and just told him what happened to him from a, from physical
4 exhaustion was a good example.
5 And I told him that of my experiences and so forth.
6 And all I can say is I think he got the message. He is the
7 type that will carry these things out, I don't know but I
8 think so.
9 That is a personal impression.
10 Dr. Margulies, maybe you could answer that. I just
11 can't go any further than that. If I had to say yes or no
12 I'd say yes I think he can do it.
13 Second question you asked about concerning allied
14 health. When we first had our first site visit great emphasis
15 in this region was on nursing.
16 There are health services, education activities and
17 so forth involved in nursing more than anything else. The
18 site visit team a year ago recommended involvement of more
19 than just nurses and did not recommend the funds they wanted.
20 Whether this led to the resignation of the nurse
21 coordinator, I forget her name, Miss Soebia, I don't know.
22 I know she is trying to get her doctorate degree now.
23 Whether this led her to resign, I don't know whether
24 she was upset about the decision or the recommendation of

25 the site team, decision of the review committee I don't know.

1 But I think when she left they lost a very excellent
2 person in the field of nursing and allied health. I think
3 that condition still exists.
4 I think they have to make strides forward in involve-
5 ment of allied health. People not only in their proposals,
6 their programs, but also in their regional advisory group
7 and so forth.
8 Here again we had very very heart-to-heart talks
9 about this matter. It sounded like this was the sole site
10 visit business but it in reality was one and I think they
11 were satisfied and took our recommendations very well.
12 Now concerning these two proposals I am going to
13 ask Gary.
14 MR. STOLOV: This was done as a core staff activity
15 and there is no requested project directed. It was --
16 they were working fairly close with the New York State
17 Department of Health in reference to the nursing home business.
18 DR. PATTERSON: Do you think they realize they have
19 --
20 DR. SCHMIDT: You all are giving the reporter fits
21 here. Speak within about an inch of the mike, would you please.
22 MISS KERR: In summary now that my questions have
23 been responded to I would support Dr. Patterson's recommenda-
24 tion that this region be given encouragement rather than
25 discouragement through the funding level.

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1 DR. SCHMIDT: Would you make that in the form of a
2 motion then to support the recommendations as outlined by
3 Dr. Patterson?
4 MISS KERR: I would so do, yes.
5 DR. ELLIS: I will second that.
6 DR. SCHMIDT: Oh, good doctor. Our primary reviewer
7 then goes along with that. As a second. So we do have a
8 motion on the floor. Remind you it is for a one year
9 approval at the rate of $889,000 with $429,000 for support of
10 staff.
11 MR. STOLOV: Dr. Roberts reminded me to say that
12 the site visitors included in the $889,000 is $16,000 to
13 continue their home hemodialysis program one more year so I
14 was unclear as to whether the $889,000 included kidney but I
15 wanted to make that for the record that this includes a $16,000
16 earmark.
17 DR. SCHMIDT: The record will show it does include
18 kidney then.
19 DR. SCHLERIS: The present core budget is --
20 DR. SCHMIDT: Should be on that big long sheet you
21 have there.
22 DR. SCHLERIS: Looking at the core personnel.
23 MR. STOLOV: Could you repeat the question please.
24 DR. SCHLERIS: Yes, the question I asked was what
25 is the present support of core personnel as of 6-30-72.

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I read that as being 309,000 and if I add correct,

there are 18 vacancies on that, that leaves 29.

DR. SCHMIDT: The correct figure given down here is $341,745. According to the yellow sheets, the fourth, back of the fourth yellow sheet.

DR. SCHLERIS: I pulled this out of the original grant requests and there was an insert in it that was apparent an update from the old one.

Am I correct on that? I guess the question, what?

MR. STOLOV: Yes.

DR. SCHLERIS: In other words they have 18 vacancies now and you are increasing their core by a significant amount of money. They already have 18 to fill.

Is this part of the source of their mini-contract funds, unexpended course.

DR. PATTERSON: That's right, from resignations of last year, that is where they got their assessed money, from mini-contracts. But some of these people are being paid as project directors and we are recommending that these people that are project directors be brought on the staff and paid as full staff.

DR. SCHLERIS: The question I have really has to be answered by your judgment. Do you think that they can fill not only some of these positions but additional positions as recommended because that seems to be a healthy increment

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20

1 to existing core not to a planned core.

2 DR. PATTERSON: I personally do.

3 MR. STOLOV: However, grants management officer

4 asked me to call to the review committee's attention that

5 there is a large unexpended balance that was made available

6 to us. And we have as a site visit team recommended a manage-

7 ment survey go over this but we feel this is quite significant,

8 this unexplained balance.

9 DR. SCHLERIS: I would think so with the number of

10 18 vacancies in 29.

11 DR. PATTERSON: I am sorry I neglected to mention

12 we have recommended very emphatically that the management

13 assessment team visit in the early part of this coming year.

14 DR. LUGINBUHL: As a new member I'd like to ask,

15 when we approve this level, that is a maximum level that we

16 are recommending is that not correct?

17 And that the actual level of funding will be deter-

18 mined by decision of Dr. Margulies and staff, that our recom-

19 mendation is a ceiling, is that correct?

20 DR. SCHMIDT: Yes, our recommendation goes to

21 Council who then approves a figure that is in fact generally

22 accepted as a ceiling, then depending on monies available,

23 principally, staff can award money or Dr. Margulies, or surgeon-

24 general or now the secretary or President Nixon can award

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25 actual amounts.

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1 Based on dollars available and so on. Generally,
2 staff does not unilaterally make a decision more or less
3 arbitrarily on the basis of disagreeing with the review com-
4 mittee or Council and give them less than we recommend.
5 If they do give less it is usually because funds
6 aren't available or budget cut.
7 DR. SCHLERIS: I think the reassurance is if they
8 get the money theywill spend it. The mini-contracts bother
9 me because they shouldn't have been core expenditure.
10 DR. MARGULIES: Again by coincidence I discussed
11 this with them when I was there yesterday, indicated to them
12 that the use of funds this way either in the endeavor to spend
13 it because you have it or to initiate contracts because you
14 think you have a chance to do it is not looked on very
15 favorably.
16 If they came back to us and said we miscalculated
17 and we have not spent as much money as we thought we would
18 that that would get a much more favorable hearing.
19 In answer to you question, Bill, what we would
20 normally do if this committee takes action and Council confirms
21 it, would be to make the grant available to them based on
22 of course our available funds, but also on an assessment
23 following a management survey and the state of progress in
24 that program so if it looked indeed like the point being
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25 raised is an important one, that they cannot utilize the funds

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1 as they had anticipated then the grant award would actually be
2 adjusted around the facts.
3 It is so difficult to be sure of these things at
4 the time of review.
5 MR. TOOMEY: I believe you said RMP funds a number of
6 CHP was that correct?
7 DR. PATTERSON: No, sir, what I said, and Jerry, I'd
8 like for you to correct me if I am wrong but it was my under-
9 standing that a coordinator for emergency services was re-
10 cruited for each area by the CHP agency and then was paid
11 through RMP funds, is that correct?
12 MR. STOLOV: Dr. Rose just had a technical consul-
13 tation and before I answer I just wondered if he discussed that
14 Mr. Murray is using the CHPS as a recruiting arm and then
15 these personnel now become part of RMP personnel and may be
16 housed at the CHP office.
17 DR. JAMES: As a point of information I would like
18 to know in circumstances where the region may have quite a
19 few problems, has it been a policy of the review committee
20 to make a recomendation for the total years allocation based
21 upon possibly the fact that many of the problems be resolved
22 within a period of months, for instance, contingent upon three
23 months improvement, then one may be assured as to the steps
24 that the program is going to take.

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25 Or is it usually the policy that the total year

23

1 award be made and then go back again a year later perhaps and
2 find that the program has either stood still as we heard this
3 morning, or has even regressed.
4 I wonder has there ever been consideration in giving
5 three months, six months approval.
6 DR. SCHMIDT: That is sort of tough because regions
7 have to plan, recruit and so on and breaking the year down
8 has not generally been done.
9 But what has been done is that awards have been
10 made contingent on something that could happen fairly quickly,
11 such as the set of bylaws being approved and so on.
12 But you have just about got to make an award and
13 let people go ahead and perform or not perform. What we do do
14 is send back very strongly worded messages that you must do
15 this and this and this.
16 And you know the year goes by very quickly and in
17 this particular instance they will be back in a year. But
18 everybody from the OMB on down has to plan their budget and
19 so on more or less on the basis of the year.
20 We have not made three monthly awards or six
21 monthly awards.
22 DR. MARGULIES: Can I just add to that for a moment?
23 DR. JAMES: Yes, because I think you missed my point
24 a little bit. What I really was saying, that the total year
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25 allocation would be available.

24

1 However, the approval of the project or the region
2 would be based upon a three-month period of time dependent
3 upon -- this is not to dissipate their funds or to piecemeal
4 funds going into the region.

5 In other words the total allocation of money would
6 be there. However, at the end of six months or whatever
7 arbitrary period of time depending upon how quickly they came
8 together with improving the deficiencies, the money would be
9 totally awarded for the whole year.

10 I don't know whether that clears it or muddles it.
11 But I am aware of some agencies, not necessarily in this
12 particular group, however, being on a three-month watchdog
13 basis. And if they haven't come up to standards, then their
14 annual budget is cut and withdrawn.

15 DR. MARGULIES: The closest I could come to a
16 response to that is to tell you that when programs receive a
17 grant award and the funds are made available to them, we do
18 follow the rate of development and rate of expenditure, if
19 they get, well say $800,000 and it appears that those funds
20 are not going to be utilized during the course of the year
21 those funds do not remain available to them.

22 There was a practice in past years of letting them
23 carry over funds from one year to the next. That's not the
24 case. Unexpended funds are a part of RMPS general funds and
25 are then placed somewhere else.

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1 If it's apparent that they may expend it at a rate
2 of half what they anticipated then we make an adjustment in
3 our budgets according to the rate of expenditure.
4 DR. SCHMIDT: That still doesn't get to I think
5 what you are looking for. If I understand what you are looking
6 for we haven't done that. In the past. And particularly
7 with an established region with the sorts of activities that
8 are going on here, cooperative arrangements and these sorts
9 of things, three months, and recruiting and so on, three or
10 six months, an awfully short time.
11 A year is a block of time for RMP that might be
12 equivalent to three months with some action program with more
13 discreet and finite objectsives.
14 DR. JAMES: The comment I would like there was based
15 upon the experience we had this morning and the review of the,
16 first program I believe, Rochester, in terms of three or four
17 or five, six years going on with a total expenditure of
18 money which does in the long run amount to a great deal.
19 And I had understood that strong worded messages
20 had been sent back but they did not result in change. And I
21 wonder would the review committee want to consider going on
22 and on and on for a number of additional years without some
23 assurances that important changes in program would not be
24 forthcoming and not having to wait anot her year for the changes
25 to come back.

1 DR. MARGULIES: There is one exception to what we
2 have said to you. The only time that we have felt that a pro-
3 gram was in such desperate straights that it needed to have
4 shorter-term funding, we have acted that way.
5 I think we might have done it in the past in the
6 program that was presented this morning. But I think those
7 who were on review committee before recall that we in fact
8 in the State of Ohio put three programs simultaneously on
9 six month funding, at the end of which time they had to show
10 evidence of progress toward what we had outlined for them,
11 went on from there.
12 It did have a good result. But when there is a
13 good potential within a program and it is moving, it is a
14 terrible hindrance to tell them you can't be sure of this
15 money unless you meet such and such a mark, and it is a kind
16 of character role with the regional medical programs that
17 we have tried to avoid as much as possible.
18 DR. LUGINBUHL: I think the concern we have is
19 that there are vacant positions and if they indeed were
20 funded at this higher level we might end up with either those
21 funds used for other purposes as they were in the past or
22 that they would simply be carried over and I feel I have
23 gotten the assurance that it is possible through administrative
24 control to make sure that doesn't happen.
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25 So I feel that it is perfectly acceptable from my

1 point of view to approve this level with the understanding
2 that it can be managed through the administrative role.
3 DR. SCHMIDT: I think that and I think once again
4 the record will show the committee's concern that the staff
5 be built up and the monies provided for the core staff be
6 utilized for such.
7 John?
8 DR. KRALEWSKI: One final comment in that regard.
9 To read through this the recommendation was that you higher
10 a deputy coordinator with talents and public relations
11 indicating you feel they need something to reach out and balance
12 of administration which means you know you think you need
13 some administrative talent within which really doesn't leave
14 much left for the coordinator and doesn't leave me with a
15 great deal you know leave me very comfortable with him.
16 Then coupling that with the fact we have got 18
17 vacancies and we are giving them another $150,000 on top
18 of those, for core, you know it just doesn't seem to follow
19 in terms of recommendations.
20 I wonder if the -- if this whole surplus bit
21 really did come up during the site visit or maybe that is a
22 new piece of information for your group and would perhaps
23 influence your recommendations and amounts of money?
24 DR. PATTERSON: Maybe I misrepresented my feelings
25 about the position of the site visitors impression about this.

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1 I think that what I should have said they need a
2 man that does have some administrative ability. I think
3 that anybody in the position of associate director or deputy
4 director does have some administrative ability but I think
5 they need someone that can become more closely associated with
6 the county medical society, the state medical society, so if
7 you have got a man, administrator who is not in the position
8 I think that is a moot point whether it's wise or not.
9 But accept the fact that this administrator is
10 in that position. I think it's wise to have a physician in
11 this position, if something should happen to Mr. Murray from
12 illness or if he is away this man would be the one who would
13 be in charge of the program and therefore I think he should
14 have some administrative ability.
15 That is my concern, it's hard to find a person
16 like that but I think they need closer relationship throughout
17 the region with other groups, allied health, physicians, and
18 so forth that such a man could give them.
19 DR. SCHMIDT: Seems part of your answer to the
20 question would be that management visit was strongly recom-
21 mended and if the committee would wish the motion could include
22 something to the effect that pending the results of the manage-
23 ment assessment visit, somebody, staff or Dr. Margulies,
24 could reduce the award by some amount of funds that they
25 obviously weren't going to be able to spend or some such.

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1 We are lacking some information I feel. I feel it is
2 necessary to answer some of the questions about the surplus
3 and what they will be able to spend and so on.
4 Presumably that is the reason for the management
5 visit. Like to be sure that all the issues are clear.
6 We are spending a little bit too much time on the
7 same issue here that I think is before the committee. Are
8 there other issues to be brought up.
9 DR. ELLIS: --
10 DR. HESS: One of the things that's concerned me
11 is the combination of staff and expanding project activity.
12 And the question as to whether or not some priority ought to
13 be given to building program staff before project activities,
14 is in a better position to manage it.
15 And a related question is about the quality of
16 some of the new projects, if in your opinion they were good
17 quality projects. And then the second question is, what are
18 the decision-making mechanisms and guidelines which they will
19 use in deciding which of those they have to select from will
20 in fact be funded if they get reduced funding.
21 How they go about picking the ones they think will
22 give the most mileage given their resources.
23 DR. PATTERSON: Well in reality we are recommending
24 just that, sir, this they do not undertake hardly any new
25 activities. Continue what they are.

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They have gotten into the field of emergency medical services which is going to take quite a great deal of time. What we want them to do is try to continue what they are presently doing with only a few additions which would keep them from being overburdened.

I think you are absolutely exactly right. That is the word that was passed along.

MR. STOLOV: They have ranked each one of their projects on a basis. And the site visit team felt that the -- because of the ranking situation we felt that no new activities should be carried on through this period but built on the PMS and also education until activity is that do demand a lot of staff time.

DR. HESS: If I am reading these figures right, I am looking at -- at, on the yellow summary. And the new projects appear to the right of this double standard dividing line sort of comes down through the middle of the page.

Those new projects come to substantially more than $200,000, and that's the difference. If you turn to Page 4, about $200,000, current level of operation projects, you are recommending 460, so it's about 260,$270,000 difference and it seems to me that there is more new ones there on the, on Page 5 than can be accounted for here so it looks to me as though they are getting into some new things.

MR. STOLOV: The region has merged some projects

1 that were originally started and put a new number on it.

2 So that accounts for project 44 and project 46.

3 And projects 23 to 31 have been merged into health systems

4 Northwest 45.

5 Because we got no report of phasing this out this

6 is the way it turned out to read.

7 DR. SCHMIDT: Dr. Ellis, did you have a comment?

8 DR. ELLIS: Thank you, Mr. Chairman, I just wanted

9 to say that Ihad the opportunity to see Mr. Murray once and I

10 was extremely impressed with his administrative capability.

11 I felt he really related to all aspects of the

12 community and had the, -- he could work very well with all

13 of the disciplines within the framework of mutual respect.

14 I could not see anything wrong with having a person

15 who is a non-medical person in an administrative position.

16 I felt he had a much better understanding. I

17 thought it would be interesting to know that he did not have

18 the opportunity to make final decision on many of the things

19 when he was not in the director's role.

20 DR. SCHMIDT: We have a motion on the floor and

21 the points brought out by discussion. I think we must come

22 to a decision point. If we continue at this rate we will be

23 here until nine o'clock tonight before we get done with what

24 we ought to today. Are there any issues that haven't come up

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25 that anyone wants to discuss before we do test the matter.

1 We have a second motion for the one year approval
2 at the level of $889,000. We had a management assessment
3 visit coming up which would provide staff with some information.
4 We have the obvious sentiment of the committee
5 that building staff is there first priority. Warn them against
6 utilizing their energies in other areas until they have staff
7 competencies built up.
8 Are you ready for a vote on the motion? All right,
9 all in favor, please say aye. Opposed, no. I ask for a show
10 of hands, all in favor, please raise your hand.
11 Seven is. And opposed? Five No's.
12 So the motion is carried. Thank you very much,
13 Dr. Patterson.
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Take 14

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DR. SCHMIDT: We will move on to Virginia.

Again, I remind everyone to fill out your sheets, using number 1 through 5, nothing lower than 1, nothing higher than 5.

You can use decimal points between 1 and 5.

The order we want to get through this afternoon is Central New York, Virginia, West Virginia, Albany, Hawaii, and Mississippi.

So we are on number 2, Virginia.

There was a site visit. Sister Ann Josephine.

SISTER JOSEPHINE: Thank you.

The site visit was made to the Virginia Regional Medical Program on August 3rd and 4th of this year, and I had the opportunity to chair the program and Dr. Benjamin Watkins was a member, as were Dr. Morton C. Creditor and Dr. Vaun.

We had hoped they could be here to also review the program with me, but it wasn't possible for them to arrange their schedule in this way.

The members of the staff were Mr. Frank Nash, Clyde Couchman, George Hinkle, Marjorie L. Morrill, and Joan Ensor, and they were most helpful to the Staff.

I had an opportunity to visit the program last year as a site visit team. At this time it was apparent that there were a number of problems related to magnitude as well as a number of problems related to the program itself.

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1 There was little opportunity for us to make any
2 significant changes in the arrangement of the schedule
3 planned for the site visit. We asked for a number of changes,
4 hoping it would give us an opportunity to evaluate the
5 program a little more effectively.
6 However, it became very apparent that members of
7 the program were defensive and were somewhat hostile.
8 Doctor, that is true. I had to check on this
9 because is changed and I don't want you to do to me what you
10 wanted to do to Albany.
11 You know, I keep being afraid of time because,
12 as I look at Dr. Schmidt, I see somewhat my own Bishop who
13 recently stood up and said the prayer in the middle of a
14 sentence I was making, so I want to hurry up.
15 (Discussion off the record.)
16 SISTER JOSEPHONE: The program when we reviewed
17 it in 1971 had categorical thrust to the program and I say
18 these things because it is kind of interesting in mind of
19 what was said about Albany and in mind of our own experience
20 and probably experiences other programs are going to have.
21 I think some programs [illegible] have coordinators who
22 have attracted staff, who have more quickly moved along and
23 felt comfortable in programs that do change its smoke signals
24 frequently.
[illegible] Reporters, Inc.
25 Also, I think some programs have probably been

1 able to attract to them staff, people who have developed
2 expertise in grantsmanship and I think all this does make
3 a difference in the climate of the programs and I think this
4 has to be taken into consideration and this program is a slow
5 learner.

6 These kinds of things did not exist a year ago, but
7 during -- also, this program is unusual in that there is a
8 minimum amount of domination from the two existing medical
9 colleges.

10 In fact, there was very little interest in this
11 program.

12 Also, the RAG was very weak because all the decision
13 making process really existed in the Board of the corporation
14 that was the grantee agency.

15 This year it became apparent that a number of
16 things had changed.

17 Between the time of the site visit in '71 and our
18 site visit in August of 1972, staff has worked very hard
19 with the members of the core staff and with the coordinator.

20 And they simply are to be complimented on the
21 success of their efforts.

22 Their efforts, however, were successful because
23 core staff and coordinators responded to their efforts, and
24 I think all this exists in Virginia Regional Medical Program
25 at the present time.

The goals and objectives which this program has developed during the past year reflect the goals and objectives of the program nationally and reflect a much better understanding of the latest mission statement of the Regional Medical Programs.

It was our impression that they reflect regional needs and problems, although the site visit team felt that the core staff need -- the core staff under the direction of the coordinator, need to develop ways and means to better identify the local needs.

This, however, the difficulty of identifying local needs,however, is bound up with the fact that they have at the present time a rather inadequate data base in Virginia, and so they don't have this type of information to draw on.

But on the Regional Medical Program, it is going to participate in the accumulation of this type of data and will have it available as time goes on..

The triannual application which they presented, we felt, was not as well written as we had hoped. In fact, there is so much duplication in it and repetition, and it is presented in a way that might be confusing to the reader.

It is interesting in the first evening we met for discussion, I think all of us felt that the program had not made the advances that we had anticipated they would in response to the directives and help given from staff.

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1 But as time went on, we realized that the triennium
2 application was probably written by someone who did not
3 have the expertise that may exist in other programs where
4 better applications are written.
5 However, as we took time to sit down and talk
6 with the people involved, we found that their program was a
7 much better program than was reflected in the written
8 document.
9 The region has endeavored to prioritize the goals
10 and objectives as well as proposed activities. And this has
11 not been to their advantage.
12 So the site visitors felt that they would do
13 better not to try to prioritize objectives as well as
14 programs, but rather to show how the programs were related
15 to objectives.
16 The evaluation process as it exists in the
17 Virginia program has many things to be desired.
18 The young man who is in charge of the evaluation
19 has some of the limitations that were indicated existed in
20 the Albany program.
21 And in discussion with members of the site visit
22 team and hearing ir reviewed here today, that my recommendation
23 and the recommendation of the group was that if at all
24 possible, the Regional Medical Program Services be given to --
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25 through their staff capabilities, be given to develop

1 evaluation criteria and evaluation programs that can be
2 turned over to the different regional medical programs,
3 maybe even as a canned program or as a model, that they
4 could use for evaluation to -- for their own process, and
5 they could modify it in their own process.
6 It was our impression, it continues to be my
7 impression, that we have too much energy that is being put
8 into developing techniques and skills almost in a competitive
9 atmosphere that should be shared between the programs and
10 probably we could move further ahead, and I think that
11 Virginia R etional Medical Program, the young man who is
12 doing the evaluation could profit by this kind of help.
13 Evidence of significant program staff activities
14 was manifested by involvement toward imporved care for stroke
15 patients in underserved areas, development of skills in
16 utili zing medical audit as an educational instrument to
17 improve quality of patient care, and activities related to
18 rehabilitation consulting teams for nursing homes, educational
19 programs in sickle cell anemia were beginning to be pahsed
20 out of Virginia Regional Medical Program into Public Health.
21 In the past, one of the problems that existed
22 in the relationship between the Department of Public Health
23 and the Virginia Regional Medical Program was that the head
24 of the Department of Health was also chairman of the RAG, of
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25 Regional Medical Program.

dor 7

1 And I think that with his resignation from that
2 position, I think a better relationship, more effective
3 working relationship will be developed with the Department
4 of Public Health.
5 The program staff activities have stimulated
6 or directly resulted in greater involvement of dentists,
7 pharmacists, and allied health personnel.
8 There is a measure of accomplishment in the
9 building of relationships in five subregional districts
10 staffed by community liaison officers and eventually they
11 hope there will be representatives from Regional Medical
12 Program in each of these subregional offices. And this is
13 envisioned by the coordinator as one of the functions of
14 liaison officers in coordinating activities in the state.
15 In some areas the activities of comprehensive
16 health planning and activities of the Regional Medical
17 Program are all intertwined but as I listened to them
18 talking, as I thought about them, the things that were
19 said later at this point in time, this may not be all bad.
20 There is one thing that is very evident in this
21 program and it may exist in other programs, but may not be
22 so evident, and I would like to comment on this and that
23 is that as we sat and listened to their explanation of the
24 program, we sensed that there might be some hidden agenda
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25 that wasn't on the table.

1 And as we continued to pursue with questioning,
2 we found that there really wasn't a hidden agenday in the sense
3 that they didn't want to share it but the planning that they
4 were doing was long-range planning, and while they were
5 describing the projects they had at the present time, they
6 already had their plans laid for the future, but weren't sure
7 that you disclose this.
8 And I think that it was not in an effort to be
9 secretive in any way.
10 And then I thought also about the climate in this
11 particular state. I think this is a very conservative
12 culture in this state and I was reminded of the time when I
13 was working with kittens as experimental animals. The
14 pharmacist said to me, "If you keep moving the hand so fast
15 to get at the kittens, you are going to be clawed to death,"
16 and I think this is the same here, and I think Dr. Perez is
17 very sensitive to the people in the area, he moves slowly
18 and he moves consciously and as a result, he is able to plan
19 ahead and then when he sees it is the right time, he implements
20 his plans.
21 I would not have realized all these things had I not
22 returned for a site visit within a year and saw what had
23 happened, and he felt much more comfortable with me, it was
24 much easier to begin to see this.
25 This may be true in other programs and if it is

1 just a one-shot deal, maybe I get the wrong impression. I
2 don't know.
3 They have currently ten projects ongoing. They
4 are still in the initial year of support and there is no
5 positive indication of future sources of funding.
6 And one of the criticisms that could be made of
7 this program in the past is that as they have developed
8 projects, they have not built into the project design
9 possibilities for phase out funding. However, this will be
10 true in the new projects, the 15 new projects, that they are
11 recommending.
12 Like the Albany program, the 15 projects for the
13 most part show -- indicate an anticipated activity rather than
14 ongoing activity.
15 And in support of these projects, I would say
16 that the change in attitude, the change in climate, the
17 change in attitude, the new members of the core staff
18 who have been brought on board, indicated to us on the site
19 visit they were capable, they were knowledgeable about what
20 was going on in the area, and their willingness and under-
21 standing, the new direction in which the Federal government
22 anticipates that we shall make the programs go, as well as
23 their success in identifying phase-out funding, will
24 probably be supportive of the 15 projects they are
25 suggesting although there is no evidence of past success,

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1 there is no, little evidence of past success in all of the
2 areas.
3 We talked to Dr. Perez about the need for a deputy
4 coordinator.
5 We used that term because this had been suggested
6 on several previous visits and it became apparent as we were
7 talking that probably we were really saying, it is necessary
8 that you delegate more authority and -- or I suppose you
9 delegate responsibility and give people authority to carry
10 it out.
11 I think the concern we were expressing is that
12 if anything happened to Dr. Perez, there is really no one
13 to take over the rein, and this is a program that has
14 come as far as it has because of the leadership and strong
15 control that he has exerted over the program.
16 He was a little resistant, initially, to the idea
17 of a deputy coordinator, but was receptive to the idea of
18 another member on the staff who would, to whom he would
19 delegate responsibility.
20 It is -- I think maybe in the past semantics
21 were the kind of thing that stood in his way, but I think
22 this is very important in this program because if anything
23 were to happen to him, it just isn't going to move without him.
24 And this recommendation came through again from
25 the site visit team.

1 The program staff is all full time. We felt they
2 were competent personnel. We were impressed with the number
3 of them.
4 And they had an adequate range of professional
5 disciplines, management skills and administartive capabilities.
6 As I commented before, the young man who is in
7 charge of evaluation really needs help from RMPS staff.
8 The regional advisory group was considered to be
9 adequately representative of all key health interests,
10 institutions and groups within the region, and one that is
11 actively participating in setting program policies, establish-
12 ing objectives and priorities.
13 The new chairman of RAG is a young doctor, a
14 Dr. Munoz, a surgeon, who is from Valencia, Spain, and who was
15 educated, I think it was at Duke. He married a girl from
16 Virginia and so settled there.
17 He is a very energetic young man who is very
18 interested in regional medical program, and during the
19 closing session in which we talked to Dr. Perez and the
20 chairman of the Regional Medical Program and the program
21 representaitves, he was very eager to find out what kinds of
22 things he should be doing as chairman of the Regional
23 Advisory Group, and it became apparent to him that he needed
24 to be better informed.
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25 And as a result, I think that Dr. Perez saw a need

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1 for better communication with the chairmen, the chairman
2 of the RAG who, in turn, will be able to do a better job
3 with RAG, but I feel he may well be one of the very good
4 chairmen that we have of the Regional Medical Program RAGS.
5 The Virginia Regional Medical Program is an
6 incorporated entity governed by a 12-member board of
7 direcors and since their incorporation, three of the original
8 board of directors have once again accepted membership on RAG
9 and this has been good because it is assured knowledge and
10 understanding of the separate functions of each of the two
11 groups.
12 And it may be as time goes on that one or two
13 others will rotate onto RAG. However, in discussing this
14 with Dr. Perez, the site visit team pointed out that too
15 heavy a concentration of this group on RAG would destroy
16 the benefits of a more diversified representation.
17 The Virginia Regional Medical Program has
18 established closer interrelationships with the major
19 health oriented organizations within the state and Mr. Hinkle
20 will comment on some of the meetings that have taken place
21 since we were there on the site visit, which would indicate
22 that they are pursuing closer relationships with different
23 agencies, so that they can be more effective in providing
24 their, or in functioning in their role of catalysts.
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25 I think they do not have the problem of seeing

13

themselves as broker although they have been sensitive to areas in which they can provide seed money for some of the projects that would be supported by Comprehensive Health Planning.

It would appear that the region's political and economic power complex is actively involved with the participation of all three medical schools, CHP (a) and (b) agencies, the State and Local Health Departments, both the Medical Society of Virginia and the Old Dominion Medical Society, Virginia Academy of General Practice, and others, were present each of the two days of the site visit and it was possible for Dr. Watkins to become aware of how he could possibly provide better services for the Black people in Virginia than he was providing at the present time.

The doctors who are working with this group of people in Virginia are overworked and are unable to do all that they really want to do, but in the past, they have not seen other organizations as providing the capacilities for them to expand their services. They have simply concentrated on doing it themselves.

This is one of the things that came out of the meeting and it might be interesting next time the program is evaluated to see how successful they have been in this area.

The Region has established mechanisms for obtaining comprehensive health planning and review and

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1 comment but as is true in many other programs, the projects
2 are sent through on too short notice and the Comprehensive
3 Health Planning doesn't really have an opportunity to review
4 the programs adequately.

5 At the present time there is no systematic,
6 continuing method of identifying needs, problems, and
7 resources, and as I indicated earlier, this may be related
8 in some way to the fact that there is a very important data
9 base available in Virginia.

10 And this is one area where the program needs
11 help, and needs to continually be monitored.

12 The management blueprint followed by the
13 Virginia Retional Medical Program appears to be conceptually
14 adequate.

15 The fiscal management review that was made in '71
16 found the program adequate in this area and we called earlier
17 today and found out that at the present time that there are,
18 I think it was May or June reporting, the program is $10,000
19 in excess of its budget, which isn't all that bad.

20 It was the consensus of the team that the workload
21 and responsibilities of the review and evaluation committee
22 should be delegated to a larger base of people who had more
23 technical expertise and maybe some of their money should be
24 invested in consultation.

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25 Since the last site visit, Virginia Regional

far 15

1 Medical Program has established a RAG program committee
2 whose responsibility is to review and update goals,
3 objectives, strategies and concepts for the Virginia Regional
4 Medical Program, along with providing guidance to the
5 executive director for program activity and project
6 development.
7 And they are beginning to move along in this
8 direction. I think that there is quite a gap that exists
9 betw een the knowledge of core staf f and coordinator and
10 knowledge of RAG.
11 But this gap will, if they continue going in the
12 direction they are going, should gradually be decreased.
13 They are utilizing their manpower and facilities
14 in an efficient manner so far as we could see and their
15 programs by the testimony of some of the people who came
16 have led to a better utilization of personnel, to better
17 disseminiation of knowledge, better quality of patient care
18 and in some instances, a containment of costs.
19 They are moving along with regionalization,
20 and are beginning to develop better cooperative agreements
21 in various regions and they are also beginning to be able to
22 identify funds that can be used as matching funds for
23 Regional Medical Program funds.
24 Before I comment on the recommendation of the
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25 site visit team for funding, probably the second reviewer

1 would have some comments to make.

2 DR. BRINDLEY: I have not had the opportunity

3 of having a site visit.

4 I know the area, know many of the people there,

5 and Sister, perhaps I read the wrong things while you were

6 speaking, but it sounds as though you made many apologies

7 for the program as you were going through it and indicated

8 some hopes for improvement in a lot of areas.

9 My only point of difference really was in your

10 funding level in which I just wondered and I want to ask some

11 questions about that when we get to this.

12 If I may, I have nothing else pertinent or

13 that would be helpful to the discussion but it seems to me

14 that there are many areas that are weak and we hope will get

15 getter and in the program that you have indicated are

16 probably going to be improved but have not yet.

17 DR. SCHMIDT: All right, let's go on then, to

18 the recommendations of the team.

19 SISTER JOSEPHINE: The site visit team spent

20 some time in discussing the funding level and I think that

21 had we made the decision on the first day, our decision would

22 have been somewhat different than it was after we had an

23 opportunity to visit it with the group the second day and to

24 find out that there were more things that were going on

25 than were really reflected effectively in their application.

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17

1 That is a very poorly written application.
2 Accordingly, the site visit team recommends that the Virginia
3 Regional Medical Program be approved for triennium status
4 at $1,800,000 direct cost level for each of the three years,
5 and the developmental component, which was requested at
6 $80,000 level to be funded within this total $1.8 million.
7 DR. BRINDLEY: May I ask questions about that?
8 DR. SCHMIDT: You put this in the form of a
9 motion, I presume?
10 SISTER JOSEPHINE: Yes, the site visit team
11 recommends that the Virginia Region Medical Program
12 be approved for triennium status at $1,800,000 direct cost
13 level for each of three years, and approval for a developmental
14 component in the requested amount, which was $80,000, to be
15 funded within the total $1.8 million level.
16 DR. SCHMIDT: Is there a second for this motion?
17 DR. SCHLERIS: Second.
18 DR. BRINDLEY: About core personnel and in their
19 budget, I know the current year has listed $501,000, in their
20 request for the first year, it is a million sixteen. I can't
21 see where that million sixteen is coming from but maybe I
22 don't have all the information.
23 Here is core personnel over on form 6 where they
24 presently have budgeted $351,000 and they have 12 more people
25 that they hope to employ and if they include their salaries,

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1 it will be four sixty-eight sixty-eight.

2 That still leaves me about six hundred

3 thousand.

4 What are they going to use that for?

5 DR. HINKLE: Now, Dr. Brindley, on your form,

6 if you will look past personnel, you will se the other, it

7 calls for supplies, contracts with about 340 some thousand

8 dollars.

9 Now, during the site visit we found out this

10 item is not for contracts in the normal sense of contracts

11 but it represents funds they have budgeted for feasibility

12 and planning studies and program staff services, which they

13 are going to conduct.

14 The program staff will have primary responsibility

15 for awarding and monitoring these particular funds.

16 The other items are for rent, for the facilities.

17 I think it is about $48,000, $36,000 for the office spaces,

18 computer processing, communications, all these things are

19 listed and all that adds up to $1,016,000.

20 SISTER JOSEPHINE: But that is what they

21 requested.

22 Actually, the recommendation then would, this

23 would be lower.

24 DR. HINKLE: Yes, going through the

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25 recommendations we made, I guess we wrangled over that for

about two hours.

Then finally we ended up ten of us in about three or four different groups and we came up -- we tried going through project by project and we couldn't get anywhere on that basis, because they asked for almost three million dollars and we knew they were only around a million now, and I guess that made it not feasible to take that approach, so we got into our separate groups and first of all, I personally came up with about 1.6, someone came up about 2.2, and we thought we would have to work some more and we did, and then finally, someone else came up with 1.6 and the first evening, after about two hours, that was the support level we thought we would recommend.

Now, this is after the first day.

The second day, we met with the program staff and then following the session after that, but during the program,staff, as the site visitors, consultants, primarily, had opportunity to quiz the program staff, what they were doing, what they were planning on doing, how they were going to do things, things that weren't in the application or at least, we couldn't derive it from the application.

As soon as we got through, about an hour and a half session with them, one of the consultants again, as soon as we broke, said that one point six isn't enough, let's make it one point eight, so that is how we arrived at it.

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1 DR. LUGINBUHL: I am sorry, but I am lost. I
2 don't have the application.
3 What I have got is the yellow sheet.
4 Well, the yellow sheet shows $500,000 for program
5 staff in the current year.
6 $536 for operational projects.
7 A total of about a million dollars.
8 And then in the request for the triennium, their
9 request is almost $3 million for the first year.
10 That is three times as much and they are doubling
11 the amount for program staff and they are increasing fourfold
12 the amount for operational projects.
13 SISTER JOSEPHINE: Actually, their current
14 funding now is $1,037,000.
15 They are asking for $2,989,000 and we are
16 recommending $1,800,000.
17 Unfortunately, the recommended amount isn't in
18 here for the first, second and third year, but this is their
19 request, which on this seet, oh, yes, is for $2,989, $80,000
20 developmental.
21 We are recommending one eight.
22 DR. BRINDLEY: Can you see one eight, you think
23 they can use one eight effectively?
24 SISTER JOSEPHINE: Yes, we felt they could.
25 There is a certain element of risk, but we felt they did it.

21

1 DR. SCHMIDT: Let's give it back to Bill and
2 let him finish because he isn't done yet, I can tell.
3 DR. LUGINBUHL: My problem is they are going to
4 double their core staff between this year and next year,
5 and they are going to increase then their operational
6 projects also.
7 They are going to double those. That seems to be
8 a very rapid buildup in a program in which there seemed to be
9 some reservations and without looking at the projects, I
10 obviously have no way of knowing how this money is going to
11 be spent but it just seems to be an awfully rapid increase
12 in a program budget.
13 SISTER JOSEPHINE: As we go to those 15 projects,
14 there are a number of them which could well be incorporated
15 and they could probably be stronger projects, so that I think
16 the 15 is a larger number than they will finally come up
17 with.
18 Insofar as the cor e staff goes, I think that they
19 realize that it will not be possible to fill all of those
20 vacancies but they have as an alternative the possibility
21 of purchasing services with some of these funds in the
22 absence of being able to fill these positions which would
23 be an alternative way to go.
24 DR. SCHMIDT: First Joe, then John, then --
25 DR. HESS: I had a question related to the

1 previous one asked. That is, does the site visit team have
2 any recommendations as to how that one point eight might be
3 split between two program staff and operational projects?
4 Togehter the contracts are all contracts for core staff
5 support services of one sort or another.
6 SISTER JOSEPHINE: Yes.
7 DR. HESS: Some of what he said sounded
8 like developmental component, feasibility studies, that kind
9 of thing.
10 I just wonder if they are getting the two mixed
11 up.
12 SISTER JOSEPHINE: No, I don't believe so.
13 DR. HINKLE: Dr. Hess, the contract, 379,000,
14 I did a little analysis on that and what they are asking
15 for, 342 thousand of it I could identify, that is
16 for central type regional services which they want to continue.
17 One of them happens to be their stroke project for
18 rural stroke rehabilitation, which was a project. They
19 don't want to review the project. They think they should
20 continue a little vig.
21 Another consumer project, at a reduced amount into
22 their core until they can get the state health department to
23 take it over, they think they have a firm commitment.
24 Feasibility study done in the prior year, the year they are in
25 now, they anticipate two of those will be completed, two

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of them are, have evolved in program proposals, and six of those are ongoing now, again, moved over into the central regional activity.

I have a list of them. It is staff library health data, survey of continuing education needs, career enhancement for allied health.

One of the big one is -- well, I punched a hole right where it is, but it is health care and -- the last three of them.

And another one, they have a physician and residents activity which they claim to put six thousand in that, to their core, those are big items plus a few that run two thousand, twenty-five hundred, and up to about 342 thousand.

We feel that the funding level or the site team did recommend that they will have to cut back on some of these.

If some of these are marginal since they have prior year experience on them, they may just decide not to continue them at all but we don't feel they can come anywhere hear a million dollars into their core based on a million eight hundred thousand funding recommendation.

DR. HESS: Well, I would just like to comment on what this kind of think suggests to me or at least, the question ir raises, that has to do with their readiness for

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1 triennium status.

2 It seems to me if we accept the sit e visit

3 team's judgment as a kind of measuring stick, objective

4 measuring stick, it is very disparaging judgment between

5 the region judgment and site team judgment as to what capa-

6 bilities in the region are.

7 I just wonder perhaps the funding level is all

8 right, but I am not wondering about their assurety in terms

9 of managing capacility, whether or not they are eligible

10 for triennium status.

11 SISTER JOSEPHINE: Did I hear you say that the site

12 visit team feel they are but the region doesn't, is that

13 the impression I have.

14 DR. HESS: No, you recommended triennium status.

end 14

15 SISTER JOSEPHINE: Yes, sir.

16

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kar 1

1 DR. HESS: Obviously, the region believes they are
2 ready. But I am questioning the readiness in view of the
3 rather substantial disparity between your estimate of what they
4 are ready to do and their estimate of what they are ready to do.
5 Seems to me there is a very substantial weakness
6 there in terms of if we accept your judgment as correct, what
7 they are really able to do and I just wonder if there isn't some
8 more maturation desirable before they go triennial status.
9 So I am questioning that particular part of your recommendation
10 SISTER ANN JOSEPHINE: Well, you know, it just may be
11 that I didn't -- I am really very sorry that Dr. Creditor or
12 Dr. Vaun, one or the other, aren't here because it may well be
13 that I just didn't reflect this very well. I think what I --
14 I sm sure that they, you know, do need more maturation. I
15 think the question is not whether they made more maturation,
16 but are they at a point where over the next three years they can
17 handle triennial status. And I think that is somewhat different.
18 And I would say that that is true. That they do,
19 they have indicated at this point. You see, they have within
20 the course of a year really changed from a totally categorical
21 focus to a service focus within the framework of the categorical.
22 I think, realistically, they have done as much as anyone can
23 do, but the way they have done it and the way they talked about
24 it as we were there, indicated to the site visit team, and I
25 am usre I am reflecting accurately when I say this, the site

kar 2

1 visit team felt that they would develop considerable maturity
2 during the coming years, but that they had attained a maturity
3 of judgment and a demonstration of competency in the way they
4 had moved this far and in the way they anticipated they were
5 going to move with their programs, that they could handle
6 triennial status at this point in time.
7 DR. SCHMIDT: I would like to move us along because
8 Dr. Lemon is going to have to leave about four. And that means
9 that we will have to have our little party and give Dr. Lemon
10 time.
11 So that I will ask John to be brief, and Mrs. Flood,
12 but we will want to cover the points.
13 DR. KRALEWSKI: I will indeed. It is still not clear
14 what kind of increases we are offering. I wonder if we might
15 go back to Joe's question again, that budget, how much are we
16 offering them for staff, how much for core-staff activities,
17 and how much for projects. And that will give us an idea of
18 what the increases are.
19 Maybe they are not as substantial as maybe they look
20 on the surface.
21 DR. SCHMIDT: George, can't you do that quickly?
22 MR. HINKLE: Yes, sir, we anticipated that type of
23 question, but unfortunately at the time we were there, we would
24 say well, suppose you get a million and a half or two million,
25 how would you allocate it? That is the only way we could get

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kar 3

1 a feel of whether they would take a cut in program staff or
2 whether in their projects.
3 DR. KRALEWSKI: Where did you think they should take
4 it?
5 MR. HINKLE: I think a little out of both. They
6 about doubled both. We asked them what procedure they had
7 set up, you know, what plans they had made and they said they
8 were waiting. Now, at that time, they said they were waiting
9 to get their funding level, then they would have to meet and
10 almost start and retrench again. That is the reason we mention
11 our concern about prior advertising their projects and their
12 goals with no indication how they were going to use them, but
13 I was on the phone with them the other day and they indicated
14 to me that they are ready, since we were down there, and I think
15 this indicates their receptiveness.
16 They have come up with four alternative plans for
17 funding. A, B, C, and D is the way they identified them. And
18 whichever funding level they hit is the way they intend to go,
19 and I didn't have the nerve to ask them what range they were
20 looking for. I thought about it, but I was afraid to ask, but
21 they are working on it.
22 DR. SCHMIDT: I think in this particular area, it
23 would be safe to say that the information you are after we really
24 couldn't get until after they know how much they are going to
25 get, then they will make a decision so that way we are back to

kar 4

1 Joe's question. It is a matter of our judgment as to their
2 judgment and it is clear that the site visit team did feel that
3 they had the porcess for making the wisest judgment, given
4 Virginia and so on, but I don't think we will know how they will
5 spend the money because they don't know how much money they will
6 have to spend, and their decisions will, obviously, be made in
7 part depending on how much money they get.
8 Mrs. Flood?
9 MRS. FLOOD: Well, I appreciate the opportunity to
10 address the point that I was going to make, but it has been well
11 covered now because it was the same question, the same concern
12 for recommendations from the survey team as to which level
13 for what. Thank you.
14 DR. SCHMIDT: Are there --
15 DR. LUGINBUHL: I see in their first year request
16 that there is $376,000 which is labeled as post-contract money
17 which is an alternative with expenditure as core staff. Would
18 it be possible since we don't have a very clear understanding
19 of how they would react to a cut in budget to make that item in
20 some way a contingency item?
21 DR. SCHMIDT: To make the contract money a contingency
22 item?
23 DR. LUGINBUHL: On clarification on how they would
24 spend that money or built to spend it at core staff, getting
25 back to the flexibility that seems to exist for staff decision

kar 5

1 after we have approved an upper level funding.

2 DR. SCHMIDT: It is my understanding that area was

3 fairly well blocked out, that the contractual money was to be

4 used for fairly definite and specified feasibility studies and

5 so on.

6 George?

7 MR. HINKLE: Within the application, those funds are

8 explained even with the narrative, a little porposal narrative

9 of what they area going to do on form number 12 in the applica-

10 tion. There is 11,000 on the form 11 at the feasibility study,

11 but they are both covered under central regional activities

12 under form 12. I have the complete list and balance if you

13 would like to run down --

14 DR. SCHLERIS: I think we can discuss any application

15 before this review committee on an item-by-item basis. I think

16 a great deal of the decisions that go on really relate to the

17 advantage of a site visit group having spent a considerable

18 amount of time getting to what really amounts to certain levels

19 of confidence and how well a region can really handle the funds

20 which it requests.

21 I don't think it is a reflection of immaturity for

22 a region to ask for three million and you say sorry, we are only

23 giving you one point eight. That is the name of the game.

24 So I don't question the fact that there is disparity

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25 in the judgment of the site visit group as opposed to the amount

kar 6

1 requested. I think all of us on the site visit find that befor
2 we, when we read the document before meeting the group, we com
3 up with conclusions that prove to be totally fallicious after
4 you have met with the group and had an opportunity to sample
5 the opinion there.

6 I suggest we have a vote. I have serious questions,
7 but I think most of those have been resolved by the nature of
8 the responses that have been given and they really result in
9 the fact that after you have visited with a group, you have
10 confidence if they have answered the questions that have been
11 raised.

12 DR. SCHMIDT: All right. The vote has been called
13 for then. We will do so, unless someone urgently requires the
14 floor. If not, then the motion is for approval, again, at the
15 level of 1.8 direct cost for three years with the developmental
16 component to be founded within this. All in favor please say
17 I. And opposed, no.

18 And the motion carries with dissent.

19 It is 3:23 or 3:24. And we will, within this room
20 right now, have a little celebration in tribute to Sister
21 Josephine who is leaving for Rome. The occasion is dedicated to
22 her.

23 Coffee is dedicated to Warren Perry. This is his lin
24 we wrote on the cake and tried to write on the surface of the
25 coffee and the sugar stuff melted, so there is no message on the

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kar 7

1 coffee. But we won't have any speeches or anything, but over
2 in the far corner of the table is our coffee and cake and before
3 we do get up, Dr. Margulies will say a word.
4 Before I relinquish the microphone, in order for
5 Henry to make his plane, we will reconvene in ten minutes after
6 we stand up.
7 Harold?
8 DR. HARGULIES: I actually had prepared a very long
9 speech about Sister Ann, but sitting next to Mack, I can't do
10 it. I would like to say just a couple of things. One of them
11 is that this decision for her to go to Rome was at no time
12 cleared through us. I was a little startled by that. I suppose
13 the Vatican recognizes itself as a higher authority than this
14 one, but we haven't always felt that way about it.
15 Sister Ann, for those of you who are unacquainted
16 with our experience with her, has always, for some reason,
17 inherited some of the toughest programs to review that anybody
18 ever has to take on. She has a great capacity to cut through
19 the mirk. She looks extremely gentle, but the main reaction
20 of the staff which told them that she was going to Rome was,
21 well, is Rome ready for her?
22 I don't know what she is going to do there. I do
23 know that she requested that the review criteria be translated
24 into Latin. And so we expect to see some kind of reasonable
25 change by the time she returns.

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1 We also had a popularity vote on her as a member of
2 the review committee. And we did a control study, she turned
3 out to be one of the most popular members of the review committee
4 we ever had, and we took this for nonsecretarian purposes as
5 a vote both on and after Yom Kipper, and it came out the same.
6 You can't say better than that.
7 And so I do want to wish you God's speed, but before
8 I do so, I would like to attempt that if anybody attempts to
9 hijack your plane, he is in trouble.
10 SISTER ANN JOSEPHINE: Well, you know, to respond to
11 your question about, well, wondering why I am going there, when
12 I heard about this, I said to myself, you know, life is not a
13 series of problems to be solved, but mysteries to be lived.

E # 14-A

14 (Break.)

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the official litany or liturgy, whichever is the right word, of RMP.

SISTER ANN JOSEPHINE: Ritual, maybe.

DR. SCHMIDT: Ritual.

Moving on then to Albany, if I am counting correctly.

Right.

1 DR. KRALEWSKI: This consists of 24 counties
2 made up of 21 counties of northeastern New York, two counties
3 in Vermont, one in Massachusetts. We have a slide here that
4 shows that block of counties.
5 It interfaces with four other regional medical
6 programs, northern New England, Tri-States, metropolitan New
7 York and the central New York that we reviewed, today.
8 They have a committee put together that attempts
9 to iron out the interface problems between these different
10 programs and in general it seems they do not have a lot of
11 difficulties in relating the programs to their needs. Now
12 this group of counties in the Albany REgional Medical Program
13 is made up of rural and urban centers. The compilation is
14 generally pretty much split. It is about 53 percent urban,
15 46 percent rural. In the rural areas we have generally the
16 problems of rural health care across the nation.
17 We have a number of small towns. Some of them have
18 lost their physicians and have not been able to attract new
19 physicians. Some of them have physicians but they are aging
20 and they are overworked and they have not been able to bring a
21 lot of additional talent.
22 That is the headquarters of the program is located
23 in Albany. The program is one of the older ones formed under
24 RMP guidelines.
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25 It was formed by the Medical College back in 1966.

1 They had an initial grant for planning in 1966, and in 1967
2 got an operational grant. And at that time the Dean of the
3 Medical School at Albany became the Chairman of the Regional
4 Advisory Group, and it was largely through his initiative and
5 the Chairman of the continuing education program or department
6 at the university, a fellow by the name of Woolsey, that the
7 program got off the ground and Dr. Woolsey then became the
8 coordinator of the program (Slide).
9 That essentially is the background of the program.
10 It covers a population area of about two million people and
11 it has about a six or a seven percent of minority groups.
12 And the population area. Now the history of the program is
13 mixed. As I mentioned it was started in 1966. It was spawned
14 by the Medical School, had a strong orientation toward con-
15 tinuing education, and as a result a great deal of their
16 initial effort and our money went into education continuation
17 programs dominated by the university.
18 This was of great concern to several site team
19 reviews through the history of the program. And they gave of
20 course advice to the program to broaden their program input.
21 Many times it did not result in any substantial
22 changes. Now this past year in 1971 we site visited the program.
23 Then at that time they were applying for triennium.
24 Again we looked at their projects, the very narrow program they
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25 had, some other points we looked at in the program, and we

1 decided at that time we probably should fund them for one
2 year and then they should come in for triennium after they
3 attempted to implement some of the changes we believed were
4 necessary and that they said they wanted implemented in order
5 to strengthen their program.

6 These included phasing out of some of their very
7 narrow projects, particularly a two-way radio communications
8 program they had for continuing education that they had not
9 phased out, was just an on-going project funded by RMP.

10 We thought they should fund that out before we looked
11 at the triennium application. We thought they needed to strai...
12 out their rapport with the medical school because the program
13 was quite dominated by the medical school. The Dean of the
14 Medical School is Chairman Brag. They had a weak regional
15 advisory group, a weak executive committee, they met only once
16 or twice a year.

17 Attendance was fairly low at those meetings and it
18 clearly was a question as to who was running the program. We
19 thought they needed strengthening on their program staff. They
20 lacked a Deputy Director, the Administration was mixed to
21 say it in its kindest way, and the program staff generally
22 were acting on their own volition, taking other kinds of
23 tasks they wanted to do with very little overall direction.

24 There was question over the location of staff. They
25 were located in several different buildings so they never were

able to be pulled together, there was question over some of the talent on the staff. They regionalized their area into six different regions in order to be able to reach out to the population a little better and they developed a program where they would have people on their staff who most of them, who were formerly drug salesmen, detail men, that would act in the capacity to handle these regions and interface RMP with the different agencies in those regions.

Always there will be some question as to the effectiveness of that program and the relationship of the people they had in that capacity to the individuals assigned to program management and program projects. Again that was a question we raised a year ago, one we thought they had to face.

They had 28 people on their staff. They had many capable individuals we thought, they would pull them together. They had a great deal of potential the way it looked. They had support from the Medical School and it seemed to us that Dean Witgers was willing to consider substantial changes in order to make the program viable.

Yet this was all on the paper as proposed changes and we as I mentioned thought we would be best to give them a substantial amount of advice in writing regarding the kinds of things I just mentioned, to carry on another site visit this year, and then to decide on triennium application form at this time.

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1 As a result we gave them essentially level fundin
2 last year, a small increase so that they could undertake so
3 new activities and reorganization and then when more money
4 came available this past year RMPS gave them a little more
5 money to implement some of the projects that they had in mind.
6 All right. So in front of us then we have an appli-
7 cation that resulted from that -- those deliberations and this
8 year's application then asks for money to fund new projects
9 essentially. 23 projects. Seven of those projects were imple-
10 mented with funds RMPS gave them in the middle part of the
11 year as excesses occurred and the rest of them are new projects.
12 They phased out all their old projects, the ones we
13 were concerned about. They are asking for developmental com-
14 ponents $90,000 a year and asking for staff support of nearly
15 $800,000, per year. And so asking for about 2.3 per year
16 support for the triennium. So this is the application then that
17 is in front of us.
18 Well, we carried out the site visit this past summer
19 then, and some of the site teams members were the same people
20 who were there the year before so we had an opportunity to
21 look at their progress and see how they were doing. Now when
22 we read their application it seemed to us that they had made
23 substantial progress.
24 Yet we were skeptical for a couple of reasons.
25 One, we were really wondering how much they could turn an

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#16 1 organization around in that length of time, and number two,
2 you know, whether now that the same site team members were
3 coming back, whether they knew the right words to use and could
4 therefore give us a little better presentation.
5 In part I think that probably did occur. On the other
6 hand, we were fairly pleased, quite pleased as a matter of
7 fact, with the progress that they had made. All right. Our
8 finding, on an I might mention we did not as far as the
9 recommendations, recommend that we go back next year. I was
10 quite pleased to find that because on the trip in 1971 coming
11 out of Chicago we lost an engine and the trip this past summer
12 we were coming out of Philadelphia and we lost an engine; So
13 I am not about to try a third one under any circumstances.
14 All right. Well, their findings then, number 1,
15 they have tried to restructure their corporation. They have
16 taken a look at their relationships with the university and
17 tired to develop a different corporate structure that would
18 give them more autonomy and would strengthen the RAG.
19 They have expanded the RAG to include different
20 members on it and give different orientation away from univer-
21 sity control. (Slide). This shows you the transformation that
22 has taken place. From the domination, fair amount of people
23 on the RAG from the Medical School, you can see going from the
24 blue to the red, 1970 to 1972, that they have decreased, the
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25 providers have decreased, consumers have increased, and you can

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1 see they have decreased the members of RAG that came from
2 the Albany area and increased it from the outlying areas. So
3 they have really done a remarkable job in being able to re-
4 structure their regional advisory group.

5 Part of their ability to do this resulted from the
6 fact that they expanded it from 27 to 37 members. That gave the
7 running room and gave them a chance to add some different
8 people. In terms of minority representation they are still
9 light.

10 They have a couple of members from minority groups.
11 They recognize that they have not been as successful as they
12 hoped, in that area, but they really, in terms of the projects
13 they hope now to carry out, we feel that they need to make some
14 more progress in terms of minority representation on their
15 regional advisory group.

16 Secondly, after revising the group, itself, they,
17 Dean Wiggers from the Medical School stepped down as Chairman
18 and they then recruited a new chairman for the group, a man
19 formerly who was administrator, also an MD, a very capable
20 guy, he devotes one full day a week to the program and comes
21 in and works on their bylaws and things such as that.

22 He is devoting a lot of effort and it is largely
23 because of his efforts they have been able to restructure the
24 program as much as they have during the past year. They have
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25 restructured their executive committee and working executive

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1 committee. They are meeting monthly. Their regional advisory
2 group, they are trying to get together as much as nine times
3 a year.
4 I don't think they will ever really put it off, but
5 they think they need that much input. They are breaking them
6 into working subcommittees so when they come together they
7 work as subgroups on different problem areas and it is really
8 an active, involved group and we are really impressed with it.
9 The executive committee knows what is going on, they
10 look at themselves as policy makers in terms of the program and
11 they are obviously enjoying the role. Medical school as far as
12 we can determine are quite pleased to see all this happen.
13 They don't appear to be feeling at least that they have
14 lost anything over the whole shift and it seems to be working
15 out fairly well. They have been able as I mentioned to get
16 more community involvement through regional advisory groups and
17 of course that has helped them restructure their program again.
18 As a result then of reorganizing the RAG, they have
19 been able to reorganize their bylaws and then reorganize
20 their goals and objectives so again we have seen restructuring
21 in both of those areas. We feel the bylaws are still a little
22 weak in that they do not explicitly state who has the hiring
23 and firing power for the coordinator and they leave some areas
24 silent in terms of relationship with the university.

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25 And we feel they should spell out some working document

#16

with the university that deals with some of these fringe iss[illegible]
and they are now attempting to do that. As they went through
the reorganization of the corporation, the regional advisory
group et cetera, they then added a deputy director to their
core staff, a man by the name of Dr. Kraft. He has a great
deal of experience in group practice. And he is well versed
in organizational matters and we feel he is really a strong
guy.

He added a great deal to the program in terms of
the administrative ability and he started reorganizing their
staff, he started phasing out some of the regional coordinates,
the drug detail men they had on their staff. He phased out
two of them and now is reconsidering you know, whether he should
keep the other two or reallocate their talents in some other
way.

He has also streamlined many of the other relationships
in their corporation internally, because they had at one time
as high as ten or twelve people reporting to one person. He
is now you know restructuring that so they can handle the different staff members, he has been a real strength to their
staff.

As a result of that, of course, the staff has built
into a unit and are now pursuing tasks the program wants them
to pursue rather than what interest them that comes across
their desk and we believe their administrative hierarchy still

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has a way to go, and while we believe they probably need to outline some of their directives a little more in terms of operating policies, we nonetheless feel that they have gone a long way in the last year and that that staff is really capable now of handling a mature program.

They have, still, many vacancies on their staff and they are attempting to recruit for those although they are not anxious to fill them until they decide exactly what they want to do in terms of reorganizing the talent they have on board now.

That seems like an honest approach to us and one that made a lot of sense. We did note, however, that since they were embarking on a number of new programs it would be well for them perhaps to add some new staff members, particularly tose with monitoring talents, and with fiscal talents, and to be able to monitor those projects as they develop. Otherwise they will get out of hand.

As a result of these changes I have mentioned they have been able to turn the program around, they have phased out their projects and to their credit they have been able to find other agencies to come up with the funds to carry almost all of those projects so they have not terminated.

New projects, they have submitted to us, they were able to obtain nearly 1-3rd of the money for those projects so the money from RMP is essentially the two-thirds of it.

#16 1 They have been able to take it out of university
2 domination and spread it more judiciously throughout the region.
3 We have a slide here that represents the results of those
4 attempts, (Slide), and you can see the first diagram to the left
5 essentially is our visit in 1971 and the one to the right is
6 our visit this past summer.
7 You can see how the projects have changed to a broader
8 representative group in terms of sponsoring agencies. In other
9 words, reorganization of RAG, bringing in more community
10 representation they have really been able to reach out and to
11 bring that large number of sponsoring agencies to put in project
12 proposals.
13 Through this process they glean some 45 new projects
14 and then through their review mechanisms they brought these
15 down to 23. We feel that review mechanism still needs refinement
16 and there is an assessment to be carried out later, it was going
17 to be carried out after our review but after we got through with
18 our review they were ready for a rest, and had decided to delay
19 it a bit.
20 But that will be carried out a bit later. We feel
21 however, that they have the basic mechanism pretty well outlined.
22 They have the mechanisms to review projects in terms of their
23 priority. They have the technical review process outlined and
24 we feel they are capable of handling projects, and to realign
25 them into the program as they go along. We have one more slide

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#16

1 here that Burt will put on that describes a little more their
2 regionalization of the projects (Slide).
3 DR. SCHMIDT: While he is doing that let me inter-
4 ject here that this is one of the kinds of test presentations
5 to the committee. And we will ask specifically your opinion
6 of these visuals, this method of principles presentation by
7 the review committee member. The other two presentations were
8 a combination of staff and review committee, also with light
9 and sound.
10 But I will ask specifically about the visual so I would
11 like you to be thinking about how helpful they are or not help-
12 ful, because they are work that we don't want to put people
13 to unless they are helpful.
14 DR. KRALEWSKI: I am afraid -- okay, fine. This
15 represents, A, the little triangles there, the main, some of the
16 main projects they are submitting for funds, this represents
17 where they would be based and represents the fact that they
18 will be you know, out, some of them at least out of the Albany
19 area based in some of these other areas.
20 Burt, maybe you would like to explain that.
21 MR. KLINE: Yes, possibly, these are the headquarters
22 sites for activities which are city-wide in nature. The next
23 overlay will show the activities which are county-wide in nature
24 and the triangles represent the geographical locations of the
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25 project site headquart ers. The next overlay shows the multi-
county activities of -- and the triangles again represent

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1 again the project site headquarters. The fourth (slide)
2 is the region-wide activities and the project site headquart...
3 Mentally adding the triangles you get the feel, I hope, at
4 least for the regionalization or the outreach of the Albany
5 regional medical program during the past year.
6 DR. KRALEWSKI: Not only the outreach but the fact th...
7 they have been able to bring logical groups together in the
8 counties for regionalized kinds of efforts which we thought
9 were quite useful, helping put together grant applications for
10 HMO, feasibility studies. They have been working very hard
11 to initiate health programs, working with hospitals, working
12 with universities, working with -- well, there are no doctors
13 in towns in the rural areas, trying to develop programs for
14 them.
15 And develop projects that would train nurses for
16 these roles after they get the program set. This is essentially
17 what we found. We believe this. We think we have seen a program
18 here really turn around in the past year and we feel we should
19 give them support.
20 They are asking for a lot of money. We felt we
21 could not give them quite as much as they are asking. We
22 felt, however, we should give them some additional advice in terms
23 of the strength and weaknesses of their program.
24 We note that everyone of the pieces of advice we
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25 had furnished to them last year they have accomplished. They had

#16 1 addressed the question. They brought in an outside consultant
14 2 from another regional program and asked him to study their
3 organization and give them recommendations of how they should
4 reorganize their relationship with the university.

5 They addressed everyone of the suggestions we gave
6 them last year and have made progress in correcting every one
7 of the deficits. At our feedback session this year they asked
8 us to comment on several of the areas where they were strong
9 or weak and we did and we have a letter from them already
10 indicating the progress they have made on some of the areas
11 we thought they were weak in.

12 So it is really a heads up organization that is
13 attempting to strengthen the things they are doing and that
14 impressed us. In some though we feel they -- they get these
15 projects together rapidly and as a result there are a group
16 of projects but they don't probably represent a programjust yet,
17 also some projects in there that don't fall within the RMP
18 guidlines and we had to recommend those projects be deleted.

19 We noted perhaps as mentioned before then that the
20 core staff needed some strengthening in terms of being able
21 to handle these many projects and therefore we would recommend
22 they add some additional talents and fiscal management. The
23 letter they wrote us said they already had been able to attract
24 a man of that caliber and so they are taking that position to
25 strengthen core staff.

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#16 15

1 To continue to refine their core staff and to
2 reallocate some of the talents and we feel Dr. Kraft will do
3 just that because he is a good guy. He has some real adminis-
4 trative ability. No question about that and I think he has
5 the willingness to make the hard decision we have to make.
6 In terms of hiring and firing to be able to re-
7 allocate those talents, so we feel he will do it and has done
8 some of it already. We feel that they have to clarify a few
9 more issues with the university. Many of their staff members
10 have faculty appointments and there really is some question
11 about how much time they should spend teaching or how much time
12 at the university, et cetera.
13 We feel they should outline that in a working document
14 with the university so they spell out those factors, let their
15 faculty know about it so they can operate within those guidelines.
16 We feel they should go back to these projects and put them in and
17 take a package and put it into a program and we feel they have
18 the mechanisms to do that and we feel the regional advisory
19 group will be anxious to assume that responsibility to do it.
20 They should also bring their staff together, as I
21 mentioned, they were housed in different spots. Again all we
22 have from Dr. Woolsey indicated they have already done that.
23 We recommend to them also the university provide space instead
24 of it being in our budget because they are charging 52 percent
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25 overhead, the university has responded to that by giving

#16 ha 16

them space so the university is picking up the space tab for them since our visit and they have furnished enough space to bring their staff together since our visit.

These are indications to us of how responsive they are. In view of that review I have some suggestions for fundi... but I will I will offer those after our secondary reviewer perhaps.

...nd # 16

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1 MR. TOOMEY: Not having had the opportunity to
2 visit the Albany program, but knowing some of the people who
3 were involved in it, I frankly was more interested in the
4 people, the organizational structure and their achievements
5 over the past year rather than in specifically looking at
6 their projects.
7 I am impressed with the fact that they have a
8 practically new leadership both in their organization and in
9 their RAG. I knew Dr. Woolsey from years past, and his
10 interest in continuing education, and frankly I am not
11 surprised that this two-way radio system was their primary
12 thrust for the first period of years with the organization.
13 I also know that he is a very, very smart, very
14 capable and very fine person, very dedicated to this whole
15 idea of dissemination of knowledge for the benefit of the
16 people who will receive that knowledge and use it for the
17 benefit of patients.
18 I am a little bit surprised that there is so much
19 emphasis on his deputy or assistant coordinator because I
20 would have felt that once Dr. Woolsey was off on his
21 particular kick that he would have been able to accomplish
22 this pretty much with his own capabilities.
23 I am also impressed that you were able to get
24 Dr. Bordley, and I am not at all surprised, I know him most
25 by reputation and what he's done with the Mary Imogene Baptist

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ar2

1 Hospital in Krugerstown which is perhaps a model for hospitals
2 in this country in terms of the relationships with general
3 practitioners, the relationship of private practicing
4 physicians and yet with a full-time staff in a hospital
5 and a great educational program in that institution.

6 So that I was, in reading the material, quite
7 impressed with these changes because from these changes,
8 of course, can flow all of the other good things that have
9 happened to the Albany program. I think that Dr. Bordley's
10 leadership in the meeting times and turn around in the RAG,
11 the numbers of times that they met, the use of task forces,
12 the preparation of proposals, seemed to me was a -- I was
13 quite impressed with it.

14 I think perhaps unlike you, Dr. Kralewski, I
15 felt that their establishment of goals and objectives was
16 quite adequate, quite appropriate.

17 I similarly felt that the establishment of
18 priorities in terms of the projects that they were to under-
19 take were quite sensible.

20 For instance, they had seven projects that they
21 rated as very high priority and using almost 50 percent of
22 the funds for the allocation to those very high priority
23 projects. Another 35 percent of the funds allocated to those
24 that there listed as high priority. And this represents some-
25 where in the neighborhood of 80 percent of their money going

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1 into projects for which they themselves in terms of their
2 goals and objectives had established the highest kind of
3 priority.
4 I think that they also should be commended for
5 the regionalization. It was -- it was, and as far as
6 RMPS history is concerned, understandable that an organiza-
7 tion in RMP would be captured, if you will, by the university
8 in the initial categorical kind of structure of the regional
9 medical program.
10 And I think it is a tribute to the leadership in
11 Albany, including the Albany medical college, that when the
12 thrust of the regional medical program changed, that they
13 were capable, once it was called to their attention, that it
14 actually was something that seriously needed change, that
15 they were able to make the turn around in as short a time as
16 they did. And with the same, I think, effectiveness.
17 All in all, I was quite impressed with what they
18 had done. And I know Dr. Kralewski is going to recommend
19 the financing for this, and I will turn it back to him.
20 DR. SCHMIDT: I think I would agree with most of
21 the comments, but just add that once Frank Woolsey's attention
22 was captured, some things happened rather quickly, so on.
23 But it took a long time to get his attention.
24 John?
25 DR. KRALWESKI: It is somewhere to it, couldn't

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ar4

1 quite get the mule to work and promised if he bought the
2 mule from him, he would always be kind to him, so he called
3 the original owner over. He said, "What should I be doing?"
4 He said, "You hit him over the head with a two
5 by four."
6 He said, "I thought you said be kind."
7 He said, "Yes, but you have to get his attention."
8 I have outlined some of the funding of the program
9 since I started. We are going up here, doing pretty well,
10 and we cut them in here, and during this period, and then this
11 got to be a 15-month figure, so really it came down to 900,000
12 total.
13 Part of this 900,000 was money that was given by
14 RMPs to the program in the midpart of the year after they had
15 shown they really were turning the place around. So we came
16 into last year with them for funding, was like $700,000.
17 They were really going straight down and they were very
18 concerned over it, then, of course, they really decided they
19 should do something.
20 All right, so totally, then, during this last year
21 they had, after the RMPS supplementary funding, $900,000
22 broken out as 631,000 for staff, 269,000 for projects, and
23 no developmental funds.
24 What they are requesting now is this, triennium,
25 but for the next budget year, they're requesting 768,000 for

ar5

1 staff, million five for projects, 90,000 for developmental,
2 tune of 2.4.
3 Overall for the triennium their request would be
4 $8 million. That is what they would like to have. After
5 reviewing this whole thing along the lines I just mentioned,
6 and breaking this down to some categories to see if we have
7 come to grips with what we think they could handle, we are
8 recommending they go in with a staff of 638,000 which gives
9 them a 5 percent salary increase from last year. They have
10 got staff vacancies in there, so they can add one or two people
11 within that figure and that will force them, we believe, to
12 reshuffle some of their talent which they have really got to
13 do, and fire a couple people. Craft knows that, and he is
14 willing to do it. And that will give him a couple openings
15 to hire some people.
16 So coming in at 680,000 -- we are recommending
17 this million five they are asking for projects be reduced
18 to 950,000 dollars.
19 We think that first of all, there was about three
20 projects in there that did not fall within RMP guidelines,
21 so we told them about that, and the projects got thrown out
22 and reduced the budget.
23 Then we went through the rest of the projects to see
24 exactly what they were doing and where we might cut money,
25 and came up with this kind of figure for them. We believe

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1 they are capable of handling a triennium application and
2 capable of handling developmental funds, but we think
3 $90,000 would be hefty, so we are recommending $30,000 for
4 the first year in developmental.
5 The remaining years we are recommending the staff
6 goes up by one position is all, then the remainder is
7 increases for cost of living. We recommend these projects
8 essentially increase by the percentage proportion that they
9 had originally asked for based on our base.
10 So they would go up to the third year to a million
11 one. We recommend that the developmental funding from the
12 30,000 we are recommending for the first year, to 45 for the
13 next year, 60,000 for the final year for their developmental
14 component.
15 So totally, then, we are recommending a $5 million
16 budget for them for three years as opposed to their $8 million
17 request, developed along the lines right here of those three
18 figures added up to make up that 5 million with this figure
19 right in here (indicating) being the figure we are recommending
20 for the first year of the million six as opposed to their
21 2.4 that they were asking for.
22 DR. SCHMIDT: We will accept this, then, as a
23 motion on the floor and seconded by Mr. Toomey. So the floor
24 is now open for discussion.
25 Mrs. Clark Flood?

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1 MRS. FLOOD: Do you really feel in light of
2 their new thrust in regionalization with the operational
3 base of these projects being shifted from a strong university
4 center with all the skills and management, that reducing the
5 potential for hiring the skills they need in their personnel
6 is fair to them, to ask them then to adjust to a regional
7 concept with small institutions, small educational institu-
8 tions, health delivery people, assuming the responsibilities
9 for project information without being able to buy the in-house
10 skills for supervision, project management, evaluation?
11 DR. KRALEWSKI: That is a good question. First,
12 their shift from the university does not mean they lose any
13 of the university support services. They maintain all of
14 those. They need no additional people.
15 What they have really done is gotten it taken out
16 of the picture in terms of running RAG and a new guide in
17 and new corporate structure. The university is still the
18 grantee organization. Still furnishes them financial back-up,
19 does their auditing.
20 In terms of monitoring the projects, you are right,
21 they need the staff to do that, but we believe that they
22 should just take a hard look at that staff and reorganize
23 it and they will have spots. Plus the fact they did have two
24 vacancies, two, was it, Burt? I believe two vacancies, so
25 they have those two positions they can fill, and we think

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1 they can do it within that context.

2 Plus, of course, as I mentioned, the second year

3 we are giving them then an additional man.

4 DR. SCHMIDT: Burt, do you have any comments?

5 MR. KLINE: Only if I understand your question,

6 Mrs. Flood. They have a monstrous task, I think, facing

7 them in terms of surveillance and fiscal management. In

8 light of this, what they have done as reported in this recent

9 letter is they have hired a fiscal man which they did not have

10 before because they are very aware of this problem.

11 Secondly, I believe if I am not mistaken, and I

12 could stand corrected on this, but they had two 50 percent

13 men from the medical college assigned to work with the

14 financial aspects of the Albany regional medical program.

15 What they have done is they have traded those two 50 percent

16 men in and gotten one 100 percent. This gives them a firmer

17 grip on financial aspects as they relate to the college system.

18 DR. SCHMIDT: Other comments or questions?

19 DR. THURMAN: Burt said they had 21 professional

20 people on their staff and this represents even for a large

21 region, I think, a sufficient number of people. I think they

22 are worried about it. This is the picture I got, is that

23 they are worried about the fact they have so much area to

24 cover, but they also, I think, are willing to do with it.

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25 With 21 professional people, I think they have a pretty good

1 chance.

2 DR. LUGINBUHL: On the yellow sheet it lists

3 $75,000 in the current year for operational projects. And

4 your recommendation is increasing that to 950,000 dollars.

5 That is not in accord with the figures up there. There is

6 some discrepancy, and on your figures, the projects are

7 269,000 in the current year, going to $950,000 next year,

8 which is a threefold increase, but nevertheless not of the

9 magnitude suggested by the yellow sheet.

10 DR. KRALEWSKI: Right. The $75,000 represents

11 the old projects that they had and they have phased them all

12 out. The difference between the 75 and 269 is the additional

13 money that RMPS gave them in the middle of the year, and

14 they started seven new projects with it. Projects with it.

15 So that is what they are going into this year with.

16 Since they did restructure your whole program and

17 you are exactly right, that is a big jump in projects, but

18 since they really phased out essentially everything they had

19 and started those seven, we felt that, you know, that they

20 had now an opportunity to add the ones around that made

21 sense and that they could handle, you know, that amount of

22 money to do it.

23 DR. LUGINBUHL: I also get the impression there's

24 been a reshaping of the core staff which will give them the

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25 capability for handling increased project commitments,

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1 management projects, evaluations.

2 DR. KRALEWSKI: Right. A beginning, at least.

3 And we feel that it will continue.

4 DR. SCHMIDT: All right, are there any other

5 questions?

6 If not, then we will vote on the motion for approval

7 of the amounts on the board.

8 All in favor, please say aye.

9 Opposed, no.

10 I hear no dissent.

11 We have done five. There are eight together.

12 We could move on, or work hard tomorrow. I will ask you if

13 there is any strong sentiment.

14 Do you want to take one more?

15 DR. LUGINBUHL: One more, at least.

16 DR. SCHMIDT: Okay, let's move on to -- we -- we

17 thought we would go on to Hawaii next. So, Leonard, you are

18 on.

:16-a

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#17

1 MR. RUSSELL: First of all, I would like to call
2 to your attention at the request of the staff and representatives
3 that we are reviewing the Regional Medical Program of Hawaii,
4 American Samoa, Guam, and the Trust Territory of the Pacific
5 Islands.
6 In doing this, we will look at the two programs,
7 the State of Hawaii and that of the Pacific Basin separately.
8 They are closely related but they are in a way separate
9 programs.
10 This is what we refer to as a Pacific Basin,
11 however, American Samoa is not shown on this map. These numbers
12 in the circles are not pertinent to this presentation.
13 The Basin covers a geographical area of over 3
14 million square miles. It is populated by 220,000 people who
15 live on 105 islands. Ten different languages are spoken.
16 And the islands, here is Guam with about a hundred thousand
17 population, American Samoa somewhere off of the screen,
18 around 28,000, which gives us approximately a hundred thousand
19 people spread out over 103 islands.
20 The Regional Medical Program in Hawaii has moved
21 into the Trust Territory, into the Basin. They have two pro-
22 jects based in Guam. They have another one based down here
23 in the Palau Truk and another one in the Truk district, Guam;
24 American Samoa and Guam are different. More than 50 percent
25 of the population have no ready access to health care. So to

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1 give you an idea of where this is located, Saipan, which
2 sits here, is 3900 miles from Honolulu. So that is really
3 regionalization when you reach out that far.
4 Then if we could have the next slide.
5 (Slide.)
6 Now we are looking at the map of the State of
7 Hawaii. The total population here is around 750,000. By
8 counties you can see the County of Honolulu has the largest
9 population of 623,000. The next largest is Hawaii County,
10 62,000 population. Then we move to Maui County with
11 approximately 38,000. Then Kauai with approximately 28,000.
12 By air, Honolulu is approximately 5000 miles from
13 Washington, D. C. It is 2400 miles from the Mainland.
14 The chain of islands, if you draw a straight line from this
15 island on down to the other side of Hawaii Island, would be
16 approximately 400 miles. From Maui to Hawaii, here, is
17 approximately -- I am sorry, Maui to Hawaii is about 40 miles
18 I believe. Hawaii to Oahu is 170 miles. Oahu to this island
19 is 80 miles. And then Oahu to Molokai is approximately 30 miles.
20 Of course the main means of transportation here is
21 by air.
22 The headquarters is located here in Honolulu.
23 This, of course, is a large blowup of the main island Oahu,
24 not to be confused with the largest island in the state, the
25 Island of Hawaii.

1 There are no CHP "B" agencies. However, the
2 CHP "A" agency does have committees on all but two of these
3 islands. The location of RMPH activity, as reflected in the
4 review you will be doing, covers most of the state. There
5 are 18 projects in the application. Four of those we have
6 already mentioned are in the Pacific Basin. Fourteen of the
7 projects are within the State of Hawaii. There is one here on
8 the Island of Hawaii, the bedside nursing care project. There
9 is one on the Island of Molokai, which is a home health service.
10 There are eight projects which are statewide in
11 nature, cancer, chemotherapy, physiological data monitoring,
12 manpower utilization and hospital cost, medical care
13 utilization project, renal program, continuing education for
14 nurse practitioners. Medical library and continuing education
15 project for nurse practitioners also reaches out into the
16 Pacific Basin. So there are actually six projects which do
17 have an impact on the Basin.
18 In addition to what you have in your application
19 there, there is an emergency medical service project which
20 has already been funded and does also cover the entire state.
21 There are four projects that have the operational base in Oahu.
22 There is a patient origin study. There is a dietary counseling
23 project which serves a rural area of Koolauloa which is on this
24 side of the island. Also there is a health screen for the
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25 elderly project which covers two urban areas and the Honolulu

1 area. And then two rural areas. One of them is in -- I
2 can't pronounce it but it is over here and the other is --
3 Frank, could we have the Waianae overlay? This is
4 known as the Waianae Coast, up the coast from Pearl
5 Harbor, about two-hour trip by bus to Honolulu. This
6 community here has the lowest health profile within the State
7 of Hawaii and this is a particular matter of interest because
8 this is where the Regional Medical Program of Hawaii is putting
9 one of their proper priorities and has had an impact.
10 With that as a background, I will turn it over to
11 Dr. Schleris now.
12 DR. SCHLERIS: Are there any questions on the
13 geography of the area? I think it might be of interest to
14 know that the Territory, Samoa, Guam, so on, many of the
15 people find it more convenient if they are going to one of those
16 islands to another to fly back to Honolulu and then go back
down. So the transportation problems are immense.
18 We went to Hawaii. The visiting participants, I
19 want to list some of these because it really was a group
20 with which all of us enjoyed working. Mr. Hiroto, a member
21 of the National Advisory Council. Kenneth Barrows, Banker
22 Life Company. Dr. Holcomb, Eugene, Oregon. Mr. Russell, Mr.
23 Sullivan, Mr. Currie, and Dr. Hinman.
24 It was a valuable visit. I had opportunity to travel
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25 over with Dick Russell. On that flight we had opportunity to

review every document that has ever passed between Hawaii and RMPs.

We met informally the evening we got there, trying to outline what we viewed as areas we particularly wanted to explore. And I think this is a particularly useful device, to try to underline what areas appear to be most important.

Several things I learned in Hawaii. You don't tell people in Honolulu what it is like in the United States. You can tell them what it is like in the Mainland, but not in the United States because you will quickly get reminded that they are also part of the Union.

Secondly, the background of many of the people on Hawaii are totally different from that of the Mainland and these sensitivies have to be part, I think, of the reaction of the group.

We had been particularly forewarned as far as Hasegawa was concerned and documents related to him as far as the coordinator of the Hawaii Regional Medical Program. So we were alerted to some potentially important areas.

First of all, as far as the history of the area goes, their grant was divided very nicely into three different approaches; where they had been, where they are now, where they would like to go, which is a very logical approach. And they had originally started back in 1966 with the organization being University of Hawaii.

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1 At the present time the University of Hawaii is a
2 two-year school but its present freshman class went through
3 four years, so they have made that decision in the legislature.
4 Actively as far as getting faculty and gearing up for this,
5 and I would think that both the RMPs and medical school
6 benefit from this. Although I didn't see anything of Hawaii
7 on this trip, I had had the opportunity to be there a year
8 ago, had gotten to five major islands and had been to most of
9 the major island hospitals at that time. So I had some
10 background to apply.
11 After they had planned for about 26 months, they
12 put into -- requested three operational grants received in
13 1968. And part of the original problem of Hawaii stems from
14 the fact that they do include American Samoa, Guam and the
15 Trust Territory.
16 This is not exactly a homogeneous type of request
17 from one small geographical area. Albany thinks it has problems
18 in geography. It only has to think of coordinating the varied
19 activities in this area with its varied wings. To cover first
20 1971 they received a one year grant which they used to go from
21 their transition from what had been a purely categorical
22 approach to assist the improvement of health care delivery
23 system. They have nicely summarized in their brochure exactly
24 what they presented the public at the present time as being
25 what they have accomplished in their transition.

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1 I will come back to that in a moment.

2 This one year grant was extended to December 31,
3 1972 and at the present time they are applying for a second
4 triennual, beginning January 1, 1973, with the request also
5 for developmental component. I think the site visit group
6 I shared made a rather than usual recommendation as far as
7 when to start developmental component, roughly one year after
8 we left the island but I think you will see why we did that.
9 They define Regional Medical Program of Hawaii as folllows
10 which is the present statement, as a consortium of providers
11 in linkage with consumers which assists in the advancement
12 of health care delivery system of Hawaii by improving
13 equity and access, maintaining quality and influencing
14 moderation in the cost of health care.

15 They have a Regional Advisory Group chaired by one
16 of the -- I was going to say better. I would have to say one
17 of the best chairmen whom I have had the opportunity of
18 meeting. He is Mr. Bryan, serves as chairman of their group.
19 He devotes a good deal of his time to the effort. He has some
20 physical disability which not only doesn't immobilize him but
21 I think is part of his contribution to the program. He is a
22 strong individual. He is well aware of the program, of the
23 area, of the directions it has had in the past, where it is
24 going.

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25 I think he is one of the strongest people as far as

1 the program is concerned. Members of his RAG when we met
2 are capable people very much involved with the programs. And I
3 refer, will, a little later, to various documents of the past to
4 Hawaii indicating specific problems in their area and how they
5 think they have met each one of these, because they have
6 really tried specifically to meet each and every one of the
7 problems.

8 Functions are described, RAG functions, in the usual
9 way, additional functions on various committees. They have an
10 Executive Committee. They have a committee which they call
11 PIE which is for planning, implementation, and evaluation.
12 This committee poses some problems if you attempt to look at
13 the structure of the group because in reality so many things
14 pass through PIE that it gets to be a group which in many
15 ways presents overlapping and conflicting routes as far as
16 administration is concerned.

17 They have some categorical committees but actually
18 these are now, the advisory committee, continuing education,
19 allied health committee, Pacific Basin Council. So this is
20 show they define the categorical committees. Not in terms of
21 heart disease, cancer or stroke but in terms of their actual
22 delivering quality of health care.

23 I mentioned they include the Basin. The program
24 staff has been added to in the past few years. Many of the
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25 people who have been at it are indeed very strong. Perhaps I

1 could spend a moment discussing Dr. Hasegawa, a great deal
2 our evaluation in that area is dependent upon views of Dr.
3 Hasegawa, his potential strengths and weaknesses. He is still
4 a partially practicing pediatrician in Honolulu, and sometimes
5 I guess a little later for meetings. He was about 10 or 15
6 minutes late for our meeting.
7 As chairman, stimulated by members of the group,
8 I decided to start without him which I think he could
9 pardon. Having come so far we thought it might be nice if he
10 had been there at the scheduled time. We waited 10 or 15
11 minutes, then decided to proceed. I don't think we phased him.
12 He indicated he was busy with some other problems at the time
13 and this was an impression which my sensitivity is such that it
14 took a little time for it to wear off. But I think the rest
15 of the group took it in stride.
16 And as time went on I gather that Dr. Hasegawa --
17 he posed problems to me in evaluation and it is a problem
18 that as I read in one of Mrs. Silsbee's letters in 1970, it
19 went on page after page. Also presented problems in your group
20 of evaluating, both in performance, personality and so on. It
21 became apparent as the days went on, he operates very much
22 in the total community. He belongs I think to every committee
23 of any importance on Oahu.
24 He is respected by all of the organized groups in the

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25 island. He has been a tremendous impetus to the acceptance of

1 RMP at every level we can discern as far as consumers, prov...
2 And maybe it is his many faceted personality that permits ...
3 And I would say that in terms of what he has done for the
4 group, recognizing the fact that he has been reluctant to give
5 up many of the powers of director that he has now managed to
6 get the deputy director, Mr. Omar Tunks, who is functioning
7 very effectively with one problem, that is that the
8 controller would prefer to communicate everything to Dr.
9 Hasegawa, would rather not discuss much of the economic
10 aspects of the group with Mr. Tunks, but that too seems to hope-
11 fully be on the road to being modified somewhat.
12 But Dr. Hasegawa functions very effectively I
13 guess as Mr. Outside, and spends a good deal of his time as I
14 have indicated getting RMP accepted. It is one of the more
15 important committees of the local medical society and
16 acceptance of RMP into the medical society, Dr. Hasegawa is being
17 accepted by the medical society.
18 So I would say however a complex individual he is, and
19 complexity is only minimally hit by my discussion, apparently
20 has been part of what has been viewed as being good leadership.
21 And this is something that we will try to get out in many ways,
22 whereever we looked at it this became apparent.
23 After being essentially categorical for a period of
24 three years and its categorical emphasis was on rehabilitation,
25 catastrophic diseases, education to nurses, home care program,

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1 some of the hospitals and so on. Then entered a period of
2 transition. The program osmosis I was familiar with was
3 the CPR program, what impressed me was how all the islands
4 related beautifully with RMP, Honolulu, that program. That
5 has been phased out, is being partially supported and apparently
6 at a fairly adequate level by the Heart Association. This was
7 good to see that it was ongoing. They then entered a period of
8 transition where they stated the goal was to improve the total
9 health care delivery system to the region while not restricting
10 with the categorical disease field.
11 In reality they did restrict that. They entered into
12 priorities I gave, better health services, trying to develop
13 health manpower, better utilization of health facilities and so
14 on. One of the first things they became involved with was
15 attacked as a catalyst is where the Waianae Coast Comprehensive
16 Health Center which is in an area of real need. And we
17 met staff who had been involved with this from the point of
18 view more of time than funds and this had proved to be a very
19 important contribution. We met people who had been involved
20 with this from that area. They spoke of the contribution
21 RMPH made of this venture.
22 What they are requesting is a much greater movement
23 toward their goals as they see it now in terms of projects
24 so they are interested in a greater contribution. They are
25 interested in taking over and modifying somewhat EMCRO

1 which is the Hawaii Experimental Mental Care Review
2 Organization under Dr. Anderson. This is now being supported
3 through the Hawaii Medical Association but apparently through
4 side developmental funds, and through Dr. Anderson's
5 involvement with this they are looking with care at peer
6 system review and other methods for evaluation, delivery
7 health services.

8 Dick, you correct me if I am wrong. I think some
9 54 percent of all the physicians in Honolulu are involved
10 with this, isn't this true, as far as their EMCRO is
11 concerned at this time?

12 MR. RUSSELL: I don't remember the exact figure but
13 a substantial number are.

14 DR. SCHLERIS: Yes, and their feeling is thatthey
15 would like to support this through the Hawaii Regional
16 Medical Program for many reasons, first of all it gets them
17 into quality health care services, also into physician practices
18 in the area and there is wide support for this. And they have
19 listed certain strategies for improving health care and have
20 indicated how they will approach it.

21 First strategy is to improve your system of care.

22 MR. RUSSELL: Just since we have been back I
23 talked to Omar Tunks, the deputy. And I said, "Did the
24 Hawaii Medical Association get the message?" And he said,
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25 "Dick, I don't think they heard a word that was said." So

1 they are still working that problem out.

2 DR. SCHLERIS: I guess they got the message but

3 don't know how to interpret it.

4 The second major priority is designing system

5 measure providing health care services. This is part of what

6 referred to under the heading of EMCRO with Dr. Anderson.

7 The third priority is better health manpower develop-

8 ment. This involves upgrading and trianing of many of the

9 nurses on the Island of Hawaii. Better utilization of health

10 facilities and again this involves training in the allied

11 health field. Emergency medical services I have referred to.

12 Let me discuss some of the unique problems presented

13 by the Basin area. As you can imagine there are very few

14 physicians there. We met the individual of their staff who

15 was assigned to that area and he was one of the more

16 impressive individuals of their staff. He spends a good third

17 of his time out of the main island on the coast of Guam and Samoa

18 and the other areas.

19 Projects for which he has asked for support, and

20 I will refer to thosein a little more detail later on, really

21 referred to the need for something like physician's assistance

22 or health assistance. They aren't talking about the very

23 sophisticated training that is being given in many areas of the

24 Mainland. They are talking in many instances of taking

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25 natives who now function at the minimum level, upgrading

1 their training by using very basic audio-visual techniques so
2 that they can either treat some of the more simple illnesses
3 they found or be able to communicate by radio with physicians
4 on some of the islands. They have very basic problems there
5 in terms of needs. Youngsters have hearing loss, they want
6 to screen these for help. There are problems as far as
7 some of the more basic health needs in that area and some of
8 the funds requested for specific basin are specifically earmarked
9 for a specific basin.
10 That means in terms of our figures we will be
11 specifically suggesting that "X" funds be specifically for
12 core or for specific programs in a certain basin area. I know
13 this has been done somewhat previously and we feel this
14 should be done at the present time as well.
15 With reference to the specific site visit report,
16 you all have that. Perhaps you have been scanning it as I
17 have been presenting the report. Perhaps I can mention
18 some of our concerns and then some of the assets of the program.
19 We were concerned about some of the key projects.
20 This was related to the feedback sessions with Dr. Hasegawa.
21 Emergency medical systems troubles us because it should be a
22 trouble system which it doesn't appear to be. I mentioned
23 to Dr. Sloane since they do not refer very much to corenary
24 needs or other emergency problems I asked Dr. Hasegawa whether
25 they had utilized the ICHD reports in arriving at any of their

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1 recommendations for the emergency medical system and there was
2 pause which ran for 30 seconds while I deliberately waited to
3 see if there was a response and I had still been waiting
4 because I have a feeling that ICHD is not known to the RMP
5 group in Hawaii. In fact afterwards it was apparent they
6 had not utilized these reports, not only haven't utlized them
7 but haven't been aware of them. To this extent, many of their
8 staff. And I would suggest that some effort be made to make
9 sure that various RMP programs indicate at least an
10 inaudible.
11 Dr. Anderson's position in core is not yet fully
12 understood either by us or by him. Very often questions were
13 asked which could have been answered by him. They more often
14 were answered by Dr. Hasegawa and he is aware of this as well.
15 Waianae has a great deal of promise but yet there is also a
16 considerable area of risk. If they promise certain services
17 and they don't work out in that area I would be concerned about
18 potential reaction.
19 Pacific Basin area, this is a group of individuals
20 who obviously have chauvinism, possibly to their own island,
21 their own area. As far as it was away we have three or four
22 individuals who were there and were extremely interested and
23 involved and know what is going on in Samoa and Guam and the
24 Trust Territory. This is an area that bears watching, I know
25 there are little pressures which are of extreme importance in

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1 that area. And I think a word should go to Dr. Izutsu,
2 who is the associate director for American Samoa, Guam and
3 Trust Territory on behalf of the Hawaii staff. He is
4 excellent and I think one of the strongest people they have. I
5 think if he were to leave that whole project would fail
6 abysmally but he is obviously married to it in many ways.
7 Mentioned problem providing continuity by early planning for
8 other sources of funding rather than at the last minute looking
9 for alternate fundings. We are very concerned about their
10 evaluation system. They do have PIE. But when we try to get a
11 clear understanding or evaluation the man in charge of the
12 evaluation gave it one way, Dr. Hasegawa tried to give it
13 another way. I think he used the term that heads will fall
14 because there was confusion on this point.
15 Request had been made about RMPs, can't give
16 developmental component without bylaws and at the moment it
17 requires revision. One can't have developmental component
18 without having more formal bylaws than they do now although again
19 as I said they are giving this a very, very high priority.
20 We were concerned about the relationship of PIE to the
21 Executive Committee, to RAG, seemed to be a duplication of the
22 way documents would move. They never really stop anything once
23 it enters the system. They do invite the person who submitted
24 the project to be available and to come to each one of the

25 review mechanisms so you can be a categorical one then a RAG

ty 17

1 then executive then PIE and it can go on and on so this was
2 discussed and they didn't think duplication was the problem
3 but obviously PIE is somewhat in concept with them.
4 We thought communication within the organization should
5 be improved because again as I have said Mr. Tunks should
6 have great access to the comptroller and funding. It is
7 hard to run a show without knowing where the money is.
8 We were concerned they should have more allied health
9 representation. This was conveyed to them. We were favorably
10 impressed with the leadership as far as the head of RAG. I
11 told you the complexity of Dr. Hasegawa and it is apparent
12 that now that he has appointed Mr. Tunks as deputy director
13 that there are changes and the changes are real.
14 Mr. Tunks at the site visit took a very, very active
15 role and obviously knows what is going on and those like
16 Russell who knows the problems of Hawaii this is a very refresh-
17 ing change. He has a good staff, a lot of bright young people
18 aboard and they are interested, they are dedicated, and I think
19 a good group to move with.
20 There are little problems that take place. The
21 head of CHP agency, use to be the secretary to Dr. Hasegawa.
22 So this gets to be a little difficult in terms of having
23 your former secretary head of another large agency but apparently
24 this hopefully will work out. A lot of the projects are very
25 innovative. Had to be impressed with the tremendous change in

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1 direction. We are impressed with the Pacific Basin Council.
2 They have set up a separate council to help review the problems
3 of that area and the other thing was we asked them suppose they
4 only got half the money they asked for, what would they do in
5 terms of which projects they would support and they had a list
6 there already of priorities for each and every one of their
7 items which demonstrates a certain level of responsibility.
8 The university has a research corporation which
9 serves as a fiscal agent and very fank discussions, this has
10 worked out extremely well. They have had no problems with this.
11 It has been a good source of support, fiscal-wise to RMP.
12 It should also be mentioned that the funds of Hawaii RMP
13 represent the greatest source of funds for that research
14 corporation, so the university is obviously very interested
15 in this, dean of the medical school was there and gave very,
16 very strong support of RMP. He obviously knows what they are
17 doing but like Hasegawa, really runs a separate show.
18 I will go thorugh the details as far as the rest
19 of our meeting was concerned. We obviously had questions in
20 terms of their bylaws, in terms of evaluation. It is thorough
21 but confusing. This is really what it amounts to. And what
22 I would like to do at this poin t is to have the secondary
23 reviewer comment. Then give our recommended levels for funding.
24 MR. HILTON: I promise to be very quick, not only
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25 out of altruism to fellow committee members but at this point

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1 the call of nature is very emphatic on my part. I appreciate
2 the comments with regard to Pacific Basin. Some concern and
3 some questions about that.
4 I do need some direction here with regard to the
5 yellow sheet. I see the figure of about -- is that currently
6 available for a two-year period? That threw me off a little
7 bit, maybe we ought to discuss that when we talk about
8 projects but I didn't quite know what that meant. You find
9 it on the -- on the very bottom, No. 2.
10 MR. RUSSELL: The money there that is shown there,
11 the $1.4 million, has has been awarded for the emergency
12 medical services project. Actually that is two years' worth
13 of money. However, it has been awarded for fiscal purposes
14 in a one year period. They will be able to use it for two
15 years.
16 MR. HILTON: I was concerned about the Hawaii
17 Community Clinic. Am I under the impression that the state
18 and model cities will pick that up or is the -- apparently
19 they are going to phase it out and a number of other projects
20 as well at the end of next year I believe.
21 Are these things being picked up for continued
22 support or what is happening to them?
23 DR. SCHLERIS: Well, they are very actively involved
24 in Waianae groups in getting all the support they can.
25 So far the Hawaii RMP. Has acted as really one of the

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1 best friends they have had towards being accepted in respectable
2 society as a group that could come in for funding and their
3 acceptance now by the medical society, even though it is whole-
4 hearted, enthusiastic one, whatever has been achieved has
5 been through RMP.

6 They are looking at all other sources of support and
7 right now most of their support is from outside RMP. Remember
8 I mentioned that some of the strengths are potential weaknesses.
9 If Waianae doesn't get support after RMP this could really
10 react unfavorably for RMP. They appeared to be very aware of
11 this and are doing everything they can to assure support.

12 Do you want to comment further on that?

13 MR. RUSSELL: Just to point out that Mr. David
14 Pollick, the gentleman we heard from at the site visit, is a key
15 man. Mr. Pollick is really one of the leaders in the minorities
16 of Hawaii. The minorities there being the Hawaiians,
17 Puerto Ricans, Portuguese who were brought over as -- in the
18 plantation days. Mr. Pollick is extremely active politically
19 and if there is anyone in Hawaii who can shake loose state
20 dollars which he has been effectively doing I think we can
21 have a ring of confidence that there will be social support
22 coming as long as IPH is there to guide Hawaiian representatives.

23 MR. HILTON: I am concerned with that. I am glad to
24 hear there is another possibility of support. Actually, well,
25 maybe -- will your recommendation include some kind of

1 contingency?

2 DR. SCHLERIS: Yes.

3 MR. HILTON: Also, you are recommending a figure

4 that is a hundred thousand dollars higher than they are

5 requesting and I was interested in that. You are recommending

6 1.8 and they are requesting 1.7.

7 DR. SCHLERIS: I will come to that.

8 MR. HILTON: Well, that concludes mine.

9 DR. SCHLERIS: Mr. Chairman, do you want me to

10 comment and make our recommendations at this point?

11 Each of you has been given a comparison and these

12 are listed at the top part of the page in terms of Pacific

13 Basin, I am sorry, the top part combines them both and the

14 bottom is the Pacific Basin. Perhaps I can go to the Pacific

15 Basin area first which is the last series of blocks on the

16 page.

17 The Pacific Basin only, the program staff now is

18 $50,000. They requested $107,000 and we, column four, are

19 recommending they be granted that amount.

20 The reason is the staff now is very limited. The area

21 to be covered is large and in terms of what we think are

22 programs that will go, they appear to have projects in those

23 programs which are indeed viable. They now have $142,000 for

24 projects in the Pacific Basin. They requested $192,000. We

25 have recommended this amount be granted and what we would

1 like to have in our final recommendation would be that these
2 be specifically stated as being for the Pacific Basin.
3 I have no doubt these funds will be utilized. As
4 I mentioned, Dr. Izutsu operates alone in this entire area and
5 the cost of transportation alone as you can appreciate is
6 tremendous just going back and forth between these areas.
7 This is one reason why many of the members of these islands
8 don't come too often to RAG or as I said they were there
9 for the RAG, as I said they were there at the time. This is
10 one recommendation as far as the staff of Hawaii only -- if
11 these names are confusing while we were there the suggestion
12 was made by one of their legislators and I forwarded this note
13 to RMPs, that a name be changed because now it is RMP Hawaii,
14 American Samoa, Guam, Trust Territory of Pacific. It comes
15 out as Hawaii RMP.
16 They suggested we just call it Regional Medical
17 Program, period. But it was pointed out this conflicted with
18 all the other regional rpogram in the United States. They are
19 currently being funded at $467,000 and had requested $584,000.
20 And we didn't specifically make a recommendation as far as
21 staff is concerned. But in terms of their total projects they
22 have requested, they now have 395,000, had requested 1.092
23 million.
24 Now if you refer to the upper blocks across in
25 terms of combining these, program staff and projects, currently

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1 $1,079,000. Requested $2,254,000, which for them would be
2 an increase of 109 percent. We recommended $1,820,000,
3 which in terms of what they are getting now is a 68 percent
4 increase which reflects a high degree of confidence in their
5 change in direction and in the leadership and staff of core,
6 and in the specific projects that we reviewed.

7 It is obvious that we are cutting out several. We
8 are not recommending developmental. We think they could handle
9 it if they only had bylaws which were accepted and if they
10 only had, I think, a few days work going over the evaluation
11 procedures. But what we suggested instead was that they be
12 considered for developmental components the second year of the
13 triennium, and that there be not a formal site visit but almost
14 can be a staff site visit to assure us that they indeed have
15 evaluation procedure and bylaws.

16 I think they can handle it. I think that the
17 combination of Dr. Hasegawa and Mr. Bryan, the deputy director,
18 the staff that he has, and their ability to get involved with
19 programs that are starting, to me, is a good indication that
20 they are all moving in the right direction, and are mature
21 enough to handle it.

22 They try to answer every specific, oh -- in the past
23 they have had many letters back and forth indicating weaknesses.
24 They have tried to answer every one of these and they have
25 very effectively accepted the ones I have outlined.

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1 I recommend what we have here.

2 DR. JAMES: I am not sure I understood the reference
3 in your material relating to the inability of some members to
4 get information "from the comptroller."

5 Could you speak to that point?

6 DR. SCHLERIS: Dr. Hasegawa has always run the
7 Hawaii Regional Medical Program very tightly. He has been
8 the source of all information and I guess one way of doing
9 this is to have the comptroller respond only to him.

10 One very strong recommendation was made that the
11 deputy director, who now has, who has taken over a great deal
12 of the internal control but as far as the comptroller is
13 concerned that has concerned us, anything that goes out, you, if
14 you have a deputy director he should know what is going on.

15 Do you want to comment on that?

16 MR. RUSSELL: Yes. I would like to point out that
17 inthe past Dr. Hasegawa has been very reluctant to confide
18 in any of his staff members except the comptroller. In
19 fact for a long time it was very difficult to tell what was
20 actually the deputy. As a result of site visit recommendations
21 in the past, about a year ago I believe it was, Dr. Hasegawa
22 did appoint Mr. Tunks deputy. However, up until this past
23 site visit, after a few traumatics to Hawaii, only -- was
24 Mr. Tunks allowed in fact to operate as a deputy. He is, as
25 we saw it, tremendous change was being looked to as deputy

1 but all of the staff except the comptroller.

2 Now, I know for a fact there is a personality clash

3 between the comptroller and the dputy. This may not, however,

4 be the primary problem.

5 We know the withholding of fiscal information

6 policies of the RMPH not only to the comptroller but to the

7 association. They had a great deal of difficulty --

8 (inaudible) -- this may well be and this is condoned by Dr.

9 Hasegawa. This may well be Dr. Hasegawa's way of controlling

10 which information he wants to go to whom and when.

11 However, we do plan as a result of the review process to

12 hit very hard to this issue of making the deputy a real

13 deputy.

14 And we think that when the word goes back to the

15 RAG, which now is definitely taking over control which in

16 the past belonged to the coordinator and to the Executive

17 Committee, I feel confident that the RAG will be given more

18 direction to Dr. Hasegawa and as a result, we will see some

19 changes.

20 Does this help?

21 DR. JAMES: Yes, the way that it was written in the

22 report here, gave me some concern. If in fact no one else

23 was sharing fiscal except the director and the comptroller, then

24 how could the RAG or others be apprised or know what was going

25 on in the development of the program? Just seemed kind of odd

1 or strange that those -- that was a tremendous amount of
2 responsibility for one or two people. I don't know.
3 I didn't understand in the narrative as to who was
4 the, monitoring the fiscal --
5 MR. RUSSELL: It indeed has been strange in the past
6 I think it is on the way out. I think a year from now we may
7 well have a case history as we did on Rochester. We are now
8 getting down to, if you will pardon, the real gut issue which
9 have been ferreted out and now we can deal with them from the
10 advice of this Committee.
11 DR. SCHMIDT: As far as fiscal sresponsibilities
12 go there is no question about the handling of the money or
13 anything like that. It is more a personality and power issue
14 than it is anything having to do with counting.
15 MR. RUSSELL: Last night I received a call from
16 Hawaii and they wanted me to be sure and report to the
17 Committee that their bylaws they say are finalized. They have
18 gone through five drafts since we have been there.
19 I asked them if they had incorporated the recent
20 REMPS policy on the grantee-RAG relationships and they said
21 "Oh, yes, we have modified it substantially."
22 So I said, "We will have to see that. Right away."
23 So to go on with what Dr. Schleris has been saying,
24 they have not had an opportunity to test the review process and
25 their bylaws. The review process by the way they tell me has

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1 been rewritten since we have been there and it is complete
2 but here again hasn't been tested.
3 DR. KRALEWSKI: Two questions: One, did they call
4 collect? The second one, as I recall the last time we reviewed
5 this program we attempted to earmark some money for the Pacific
6 Basin project. Did that work out? Did they use the money for
7 that?
8 And so your similar recommendation here you feel
9 will be --
10 DR. SCHMIDT: I think it is safe to say that the
11 coordinateor feels very greatly the responsibility, this vast
12 territory. And I think he used to be certainly anxious to
13 put money into it.
14 DR. SCHLERIS: There is no question I think as far
15 as RAG is concerned. They have a great deal of sensitivity
16 about that area and are willing and anxious to do everything
17 they can. They support the Pacific Basin Council. They support
18 Dr. Izutsu. I am sure they will accept this recommendation.
19 If any of you appear confounded by our statements
20 about Dr. Hasegawa and his relationship to the comptroller
21 and deputy you share that, we were there for a few days and I
22 am sure that RMPS has shared that for many years; is that a
23 fair statement?
24 MR. CHAMBLISS: Doctor, I don't intend to respond
25 to your question. I wanted to add additional information if

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1 I may.

2 It was out of the concerns of this Committee that

3 the earmarking was done for the Trust Territory. Just last

4 week the HSMHA raised questions as to the kinds of commitments

5 that RMP was making into the Trust Territory and it is

6 out of your actions that we were able to make what we considered

7 to be a very substantive response to show that there is

8 definite commitment from RMPS, and that things are happening

9 with our dollars in that area.

10 I thought you would like to know.

11 MR. RUSSELL: In answer to Dr. Kralewski's question,

12 yes, that earmarking was extremely effective. As the people

13 on the Basin said we are damn tired of planning.

14 Now RMPS is one of the first organization that has

15 come in and funded operation in the projects and they are

16 very, very successful.

17 DR. SCHMIDT: Never forget the first time I met the

18 coordinator he came in my office and I had a lot of stuff on

19 my desk and he was trying to make a point of how big the

20 Territory was and in describing he swept everything off my

21 desk.

22 Now we have a motion on the floor but no second.

23 DR. KRALEWSKI: I will second it.

24 DR. SCHMIDT: Are there further comments or questions

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25 directed to the reviewers? Or just to me?

1 If not, is the motion understood?

2 DR. JAMES: I would like to make a comment. If I

3 do understand, that this is a fairly new area for the RMPS

4 to engage in and because obviously it is primarily an area

5 that will be considered minority I would certainly want to say

6 that it is tremendous and if the man wants to keep his mouth

7 shut about his money I don't blame him because it may be

8 part of growing pains and it may be a good thing that the comp-

9 troller and director share such information for any new program

10 as valuable as this.

11 I am sure there must be some distrust somewhere

12 lurking, either in the Mainland or on the Islands.

13 DR. SCHLERIS: I will make a comment but after the

14 vote if I may in response to that statement.

Time is XX 6 p.m. when this portion was taken.

15 DR. SCHMIDT: Anyone else?

16 MR. RUSSELL: We have another kidney problem,

17 Mr. Hilton.

18 In terms of the project and the application, maybe

19 Dr. Miller, would you like to comment on that, please?

20 DR. MILLER: Actually there are probably two problems

21 related to the kidney proposal with Hawaii.

22 The first one, the main one is the fact that there

23 is a competing hospital on the main island and that is Kuwakini

24 Hospital. And the grant was originally set up so that St.

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25 Francis Hospital would be the primary tertiary center for the

1 Islands of Hawaii.

2 It is my understanding that there has been no
3 resolution of the problem of competition between these two
4 hospitals, and it would seem rather foolish to put one's
5 money in one bag and have competition in the same area. It
6 would defeat the purpose of the kidney idea of establishing
7 just one tertiary center in one area to serve the population.

8 DR. SCHMIDT: Dr. Hinman?

9 DR. HINMAN: I attended the site visit and discussed
10 this issue with the RAG chairman and staff there. Part of
11 the problem revolves around the issue that one of the
12 hospitals is predominantly oriented toward the Chinese
13 population so there are some ethnic background issues that
14 have to be addressed involving this problem.

15 RAG has taken the position -- according to the
16 verbal statement given to me -- that they will support St.
17 Francis Hospital activity and that will be the only place they
18 will put their money because this is where the primary
19 competency is.

20 It is anticipated that the Kuwakini Hospital will
21 either eventually begin to share with or work with the St.
22 Francis group or it may be difficult for lack of support.

23 DR. SCHMIDT: Leonard, you were going to make your
24 comment.

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25 DR. SCHLERIS: No, that was what I was going to say.

1 DR. SCHMIDT: I am not sure I should pursue this.
2 Is there any need to pursue this further?
3 DR. SCHLERIS: I don't believe so.
4 Dr. Hinman who attended our sit visit as you know
5 is charged with the responsiblity in this area and I am
6 sure that the funds would not be expended until such time as
7 there is a coordinated effort. It has been our assumption
8 and our goal that there only be one program and that dupli-
9 cation be avoided and I think Dr. Hinman will find duplication
10 in his own way in this or his group would.
11 DR. HINMAN: Of course the problem is that we
12 could never tell when we were to stop providing care of any
13 type. The only controls we have is to not fund their
14 activity or not support them. I believe the Comprehensive Health
15 Planning Agency is aware of some of the problems here.
16 There are several other things that lie somewhat
17 behind this in the number of different ethnic groups in Hawaii
18 that have to participate and work together. They have some
19 unresolved problems here. It is a very complex thing. I
20 think they are working toward what is the best possible
21 solution for the patients in the area.
22 DR. SCHMIDT: Thank you.
23 Any other comments or questions?
24 DR. MILLER: One other point I wanted to make.
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25 That was in the proposal there was an item of equipment called

1 a liquid scintillation spectrometer which deals with testing
2 compatible kidneys. You mostly really in retrospect and mostly
3 really dealing with related donor population. The proposal
4 does suggest that they purchase this machine which I assume
5 from reading this, they don't state it but it is about another
6 $15,000, in the actual monies, and according to the technical
7 reviewers of the project, two of the technical reviewers felt
8 that this item of equipment was not necessary.
9 The RAG, itself, did not address itself to this
10 problem and I think that something should be mentioned about
11 this. Again I am going to refer to Dr. Hinman on this who
12 represented the renal group as well as the staff.
13 Do you want to comment?
14 MR. RUSSELL: What we need here, I don't think the
15 lack of a Regional Advisory Group, not to consider this, I
16 don't think it was deliberate. I just don't think it was
17 clear to them that they were supposed to decide between the
18 two. I am serious. You have to have been out there to understand
19 it.
20 DR. SCHMIDT: Strikes me as being a rather technical
21 decision and I am not sure it is one the advisory group should
22 make.
23 MR. RUSSELL: Well, they have the recommendations
24 of what it boils down to, three people. Tow of them say no,
25 one of them say yes. I think what we at staff need is say

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1 will you make that decision for them since they failed to do
2 it or will you delegate this responsibility to Dr. Hinman's
3 staff?
4 DR. SCHMIDT: Once again concern is registered and
5 you are aware of this. I thank you.
6 Other comments or questions?
7 If not, we will call the question.
8 DR. KRALEWSKI: Just quickly, are we voting on
9 some money for that kidney project now then, or are we not?
10 DR. SCHMIDT: Yes, it includes the kidney project.
11 DR. SCHLERIS: I think it should be a matter of
12 record that Dr. Hinman's group will have the final word on
13 that. We have not looked to them in detail. We have always
14 looked to the renal group.
15 DR. HESS: Does it meet that criteria of the
16 region having developed a regional plan when there is another
17 hospital developing activities?
18 DR. HINMAN: The region has a plan and the plan is
19 to support the St. Francis Hospital activity.
20 DR. HESS: For that activity?
21 DR. HINMAN: Yes, sir.
22 DR. SCHMIDT: I don't think Dave can be faulted
23 because there may be a dissenting group that wants to go on
24 their own. That would be asking I think too much.
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25 DR. HINMAN: I think the same phone call last night

1 Mr. Russell received there was another approach that they
2 are trying to work out in that area which may involve that
3 actually some of the surgery is done at Kuwakini Hospital
4 by a team at St. Francis which is a possible solution which
5 would get aound some of the considerations so they are
6 actively working on the issue.

7 I think that it is complex enough looking at the
8 entire history of Hawaii and the socioeconomic conditions
9 that I think for us to recommend anything more stringent than
10 what we have already done would be a little unfair to the region.

11 DR. JAMES: Right, I agree.

12 Would that not constitute an internal affair of
13 the region which possibly would not be, well, could be
14 resolved at that level?

15 DR. HINMAN: That is what we have asked them to
16 do.

17 DR. SCHMIDT: Questions?

18 If no one wishes the floor, that is really not in
19 order. We can vote. We can't call the question. That is
20 really not a legal parliamentary procedure.

21 We will call the question then.

22 All in favor, please say aye.

23 Opposed, no?

24 Once again I hear no dissent.

25 Leonard?

1 DR. SCHLERIS: The comment I wanted to make was that
2 the whites on Hawaii are 39 percent, nonwhites are 61 percent.
3 And if you break up all the groups there all minorities, you
4 know, no one has the total majority there. So it is hard to
5 define minorities.
6 Dr. Hasegawa represents a different issue in a
7 way because he was one of the unfortunate Japanese who lived
8 in apparently California at the time of Pearl Harbor, was
9 one of those who was confined in a concentration camp at the
10 time. And a great deal I am sure of -- of his reactions and
11 operations are rightfully based on that experience and I
12 assume that part of the problems might relate to that experience.
13 Hadn't brought that up before but I think it is
14 pertinent in his being coordinated. He has not only been
15 accepted but has done an exemplary job as coordinator, despite
16 the tremendous limitations. He is a tremendous asset to the
17 regional organization of Hawaii.
18 DR. SCHMIDT: Before we break up, I would remind
19 the Committee of several things. First, now we have had the
20 Rochester presentation by Eileen this morning, then we had
21 the presentation by John with the aid of some visuals and in this
22 last presentation we had a short overview by Dick of the
23 region provider to the presentation by the Committee member.
24 Now these are all variations on the theme. There will
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25 be one more in the morning after which we will stop and discuss

1 for 15 or 20 minutes various forms of presentation and see
2 whether the visuals which are included in your review book
3 by the way are helpful in this sort of setting the region in
4 place, and is valuable enough to continue.
5 I would remind you the document is Chapter 4 that
6 we would like you to look over tonight. We will discuss it a
7 little more.
8 The function of the Review Committee, it is your
9 reading assignment and we will have an oral quiz on this at
10 8:30 in the morning when we start.
11 Your rating sheets you may keep but they should
12 be kept more or less confidential.
13 Do you want to pick these up today?
14 All right, keep them but put them away and continue
15 to use the same sheet then tomorrow.
16 With thanks to the group for their good work today,
17 we will adjourn and reconvene at 8:30 in the morning.
18 (Whereupon, at 6:10 p.m., the meeting was adjourned,
End #17 19 to reconvene at 8:30 a.m., Friday, 22 September 1972.)
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