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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

REGIONAL MEDICAL PROGRAMS SERVICE

REVIEW COMMITTEE

Rockville, Maryland
Wednesday, 17 January 1973

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Review Committee

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Conference Room GH
Parklawn Building
Rockville, Maryland
Wednesday, January 17, 1973

The meeting convened at 8:40 o'clock a.m., Dr. Alexander Schmidt, Chairman, presiding.

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PROCEEDINGS

DR. SCHMIDT: I have been waiting for some juice to get through the PA system here, and we are still having a little technologic difficulty. But I think that we can get through, at least my part of the meeting, without the benefit of the PA system. Years of lecturing in large lecture halls which also have problems with PA systems have led me to develop a penetrating voice that I hope carries to the back of the room.

So I will call the meeting to order and welcome everyone here, this first meeting welcoming the members of the committee and staff and also at this meeting any public members who might be here. This meeting as you all probably know, is the first one that is being conducted in accordance with the Federal Advisory Committee Act, P.L. 92-463.

And all committee members have with your agenda materials the rules for conduct of RMPS public advisory group meetings. And there is no particular need to look at this now, but it is kind of interesting and gives some ground rules for the conduct of these meetings and the participation of the public guests who may choose to join us during the open portion of the meeting.

I would direct your attention to at least one guest that I know of. Dr. Al Florin is here representing Dr. Ingles and the steering committee of the coordinators. Later on today,

Dr. Phil White will join us, an old committee member, to cover one of the applications.

We have found it necessary because of a conflict with another meeting that is scheduled to look at change of date for the May meeting. And we need to pick days during the week of May 7 to 11. Those of you who bring your calendars may want to check that out and pick days of the week for this. Wednesday and Thursday would be the 9th and 10th. As I recall previous discussions, the committee is kind of settled on Wednesday and Thursday as being good days which would make it the 9th and 10th.

Are there objections to those days?

(No response.)

If not, then we will settle on those.

The other days are September 12 and 13 in 1973, January 16 and 17 in 1974, and May 15 and 16 in 1974. We hope that is not anticipating anything too much.

I have a letter to the Regional Medical Programs Review Committee that was given to me a minute ago by Dr. Margulies from Vern Wilson. And I would like to read that letter to the committee. It says:

"Ladies and gentlemen:

"By the time this reaches you, I will have already left the position of Administrator of the Health Services and Mental Health Administration to return to the University of

Missouri. I feel I would be remiss if I did not express my sincere sense of gratitude for the considerable advice and counsel you have provided to me and to HSMHA during my incumbency.

"Please accept my thanks and most sincere wishes for the successful pursuit of your personal goals. I hope we will meet many times in the future in our joint efforts to improve health care for the people of our country.

"Best personal regards, Vernon Wilson."

Some people have asked me what Vern was going to do in Missouri and particularly was he returning to his academic vice presidency. And the answer to that is he is going back as a tenured professor and will be teaching and in activities having to do with community medicine and perhaps his discipline. I am sure that the opportunities for Vern will be many, and he will be able to select among many excellent opportunities to do what he wishes. But he won't be going back as the academic vice president.

There is a reorganization of the Medical Administration in Missouri as many of you know. And they will be choosing some vice provosts and so on. And how that will settle out no one knows.

But it is appropriate, then, to lead from a note from Vern Wilson to Dr. Margulies and the third agenda item, the report from Dr. Margulies and the Regional Medical Programs

Service. So I will turn the microphone over to Harold.

DR. MARGULIES: Thank you, Mac.

The Review Committee may feel a little more prestigious than usual for the moment. If you have read what has been happening since the election, there is virtually nobody left between you and the President of the United States in HEW. So you are very close to the seat of power.

We tried to arrange the meeting to be at Camp David but the roads were bad and the helicopters weren't flying.

I have a few announcements to make to you which have to do with specific situations within the REgional Medical Programs and would like to go through a number of other information items before we get to the reviews themselves. Some of them have to do with changes in leadership in Regional Medical Programs which are very key events as you all know from having reviewed RMPs.

There are three Regional Medical Programs which you knew were seeking new coordinators and which have in fact selected and officially appointed new coordinators. One of them is Albany where Frank Woolsey has resigned and has been replaced by Dr. Girard Craft who has been with that program for some time and is fully familiar with the activities and purposes of it. Frank resigned with a very positive feeling that he had been able to do a good many things that he would like to get done and with the strong feeling that it was time

for him to take it a little easier and have a different kind of leadership. And it looked very positive.

As you may recall, in Iowa, there was also a search for a new coordinator because the one who had been there had left so that he could move with his family to Florida. The new coordinator there is Charles Caldwell who again is an individual who has proved his value as a member of the staff and is a very capable individual. He was acting from the time that Dr. Weinberger left and has become coordinator since October.

And in Oklahoma where Dale Groom retired around September of 1972 of the past year, a new coordinator has been selected. That is Al Donnell, D-o-n-n-e-l-l. He is a lifetime Oklahoman as I recall and has been very active in the general hospital field and is keenly interested in the whole concept of regionalization, has worked with the RMP and appears to be a very attractive choice.

There have also been some resignations since we were last here. And I will just go through those quickly.

Dr. Wentz from Metro D.C. has resigned, and there is a search for a new coordinator.

Dr. Jay Brightman in New York Metro RMP has resigned, and Dr. Aronson is acting. And there is a search for a new coordinator.

Dr. John Lowe in South Dakota left in October. And

Donald Brekkee is acting there. And they are searching for a new coordinator.

And we just received that Dr. Henry Clark is resigning as of May 1 from the Connecticut RMP. I talked yesterday with Mr. Rogers who for a good many years was chairman of the Regional Advisory Group in Connecticut. He described the way in which they are setting up a search committee. We were especially interested there because there has been a kind of uneasiness in the Connecticut RMP between themselves and the State Medical Society or at least some members of the Executive Committee of the State Society.

They appear to have good accord in the method of search for a new coordinator. And the president of the State Medical Society is on the search committee.

There are some regions which have not yet made a final selection of new coordinators where there is an acting arrangement. Indiana is one where Dr. Beering is acting. He is Associate Dean, as I recall.

In Intermountain, Richard Haglund who for years has been on the staff has been acting coordinator for quite some time since Dr. Sadavik resigned. And they are still trying to find a new coordinator. I will get back to that in a moment because there are some issues there.

In Western Pennsylvania, Dr. Reed had agreed to stay on for one year. That year will be ending in the near

future. There is a search committee for a replacement for him. In the case of western Pennsylvania, you will recall that the coordinator had resigned to seek another academic position so that that one has been open for a period of time.

One other change which is of some interest is in Texas where a new grantee has been arranged for. This was done with mutual understanding on the part of the university, the State Medical Society, the Regional Advisory Group. It appeared that the involvement of the medical school could remain very full with a grantee which was a nonprofit organizational structure and was actually done under the aegis of the university and with their strong support. That began on January 1 and appears to be a satisfactory activity. And there will probably be something similar which will evolve from the Metro New York RMP although that is not yet official.

You may also recall that we did distribute during the past several months a very explicit policy statement regarding the relationships between the grantee, the Regional Advisory Group, and coordinator and his staff. This is something which had long been asked for. There had been uncertainty in many instances about what that relationship should be.

We have had discussions here. We had extensive discussions with the Council. It finally did receive endorsemen and was distributed. With one exception, it has been greeted either with enthusiasm or with accord which requires some

adjustment in the organization of Regional Medical Programs. Most people felt that it was overdue, that the statement was clear cut and did not represent an unsatisfactory way of conducting the business of a Regional Medical Program.

The exception most notoriously is in the Intermountain Regional Medical Program where the administration of the university feels considerable discomfort with the idea of a Regional Advisory Group making decisions which they feel should be made exclusively by the grantee. That issue remains unresolve And as I hinted a moment ago, it is probably one of the reasons why there has been some delay in the final selection of a new coordinator. I really don't know what decision they are going to make in Intermountain about adjusting to that policy or selecting a new grantee, whatever may be the situation.

But aside from that and some restlessness at least in Tennessee mid-South, we have had no real difficulties with that statement. And for the most part, the response has been a very positive one.

I think that it would be fair to say in Dr. Florin's name that New Jersey is making some changes in its organizational structure to accommodate it, but it doesn't appear to be too much of a problem. In that case, as was rarely the situation, the Regional Advisory Group and the grantee were essentially the same. And this requires some new organizational structure to continue doing business, but to be consistent with

HEW policy.

Now, let me get on the subject of the budget for a moment because there may be some casual interest in the subject. We continue to be operating under a continuing resolution which for those who have not fully enjoyed that kind of an arrangement, I will provide an explanation.

When there has not been an Appropriation Act passed Congress may pass a continuing resolution which allows the program affected -- in this case, those in HEW for which appropriations have not been made available -- to continue to operate on the basis of one of two alternatives -- either the level of budgetary allowance of the preceding fiscal year or the budget which was proposed by the President to Congress for the current year, whichever is lower.

Now, there was no gross difference between 1972 and the proposed budget for 1973. So we have been operating at essentially the same level of activity during that period of two years. There were two Appropriation Acts passed by Congress, and they were both vetoed. Congress is now in session and, of course, can pass another Appropriation Act, can continue under the continuing resolution, and can do the latter for an indefinite period of time. And we don't know what they are going to do.

During the period of time when we are on a continuing resolution, we continue to act according to those kinds of

rules. However, when it is as late in the year as it is at the present time, it requires a certain amount of fiscal prudence on our part and on the part of OMB. And so the one accommodation we have made until the budget for this fiscal year which is now more than half over has been determined is to limit the duration of grant support for programs which began January 1 -- not the amount, not the level, but the duration of support.

We could not for programs which had their beginning date of January 1 provide funds for the full 12 months. So what we were allowed to do was release grant funds at the level anticipated for the full year, but only for the first 6 months until there is an appropriation and a final decision on fiscal 1973 and some action on fiscal 1974.

Now, I suspect that what will happen, and it is really more than a suspicion -- it is based upon what information I have received -- is that when the President does present his budget message which is scheduled for January 29, it will include some recommendations for fiscal 1973. These will not necessarily be the same as those that were proposed by the Administration at the beginning of the fiscal year, but will be adjusted to the fact that we are well into this fiscal year and will reflect whatever kinds of recommendations are made for the subsequent fiscal year. I think it is fairly obvious that the pattern from one fiscal year to the next has

to remain reasonably consistent.

Congress will, of course, receive that information and act according to the way in which Congress feels that it should. It has the choice of passing an Appropriation Act at any time, of course. It could do so today if it wished to do so or wait for the budget message or act on the same day. And there is no way of predicting what will actually be done.

So we are really no clearer in our understanding of what our level of support will be now than we have been in the past. That means, although I am getting into the issue of review now which is a closed part of the meeting -- I may as well comment on it -- that we will continue, I hope, to do what we have in past years. And that is carry out a review process in which we look at what has been proposed by a Regional Medical Program, examine the application and draw a judgment based upon the merits of that application and not try to figure out what the budget is going to be when we don't know what it is going to be. That is an issue which is separate from the review of programs based upon their individual merit. And this Review Committee has been able to do that quite effectively in the past, and I am sure they can in the future.

Are there any questions about that illuminating statement?

(No response.)

I would like to mention to you that the steering committee of the REgional Medical Programs will be meeting in January, and there will also be a general meeting of all of the coordinators. And I would like to take a moment if I may to refer to the activities of the coordinator steering committee so that you can appreciate what kind of an assistance they have been.

During the past several years, the coordinators have felt that they can establish a more effective working relationship with the Regional Medical Program Service if they have selected representatives who meet together as a steering committee to bring to us information which they feel is not readily available to us and which represents a consensus of coordinators' concerns and to receive from us information which can be distributed rapidly to the coordinators.

Now, the coordinator groups within themselves are organized on a sectional basis. And so they meet Northeast, Southeast, West, Mid-continent, and so forth. They meet at regular intervals around the meetings of the steering committees and around their own kind of business. When the steering committee meets in January, it will take advantage of the fact that there is to be a conference on quality assurance. It will also be an opportunity for all of the coordinators to meet to elect new officers and to consider any business they want to consider.

That particular meeting is not one which is called by the Regional Medical Programs Service. That is, the meeting of the coordinators is not. They call that to conduct their own business, to examine their own affairs, and do what they think they need to do. If they want to invite us to be present, we are present. If they have some other business to conduct, then we are not present. And it seems to be a very effective kind of arrangement.

The meeting which then follows for the next two days on the examination of the professional issues involved and quality assessment and assurance is an invitational meeting and is an official part of Regional Medical Programs Service activities. That meeting which is to be held in St. Louis looks awfully good. We have been working on it modestly beginning a little over a year ago and with an increased tempo during the past several months. We made several decisions about it early on which we have stuck with and which have appeared to be a pretty good idea.

The basic one is that the meeting is to provide an opportunity for Regional Medical Program coordinators and for others who are interested to examine in a professional way the major issues which are involved with quality assessment and assurance. There is no effort involved in this activity. The quality assurance conference is not designed to examine new legislation. We are not there to consider PSRO or some

special kinds of activities. And it is very scrupulous in its approach. It is entirely designed around our understanding that there has been a whale of a lot of work going on for the last several years to look at all of the aspects of quality assessment and assurance.

There are some very competent people who we would like to hear from. And that is exactly the way it is designed. But in order to make sure that what appears to be unusually good input will be rapidly available, we have done two things.

One of them is to limit attendance and make the meeting pretty much theater kind of performance with the rapid presentation of cogent papers grouped together under general subjects, very, very limited time for discussion, with a clear-cut understanding that there will be rapid distribution of printed copies of the papers which are presented.

Now, there will be approximately 28 people who will have something to say in a formal way. We have plans to bind and distribute the papers within no longer than about 30 days after the meeting. We have already received something like 20 completed papers which is remarkable in itself. And I think that we will probably get, if not all, virtually all, of the papers completed, ready for binding and for distribution by the time the meeting occurs. That means that we can achieve our major purposes which is to have a discussion of a presentation and have the widest possible distribution.

Because of the quality of the conference, we are going to print an extraordinarily large number of volumes of the quality conference material and give them very wide distribution. This allows us to feel more comfortable with the limited attendance. If we had opened the attendance even by word of mouth, the number of people we would have to accommodate is staggering. We learned that within a few days. And since there was no way to compromise on that, we decided to make it a Regional Medical Program activity and restrict it accordingly.

We do know that some members of this committee are planning to attend. At the present time, we understand that this will include Ancrum, Anderson, Ellis, Kerr, James, and Thurman.

There is an agenda which is in your book which is Attachment B.

Now, one final thing that I would like to mention to you -- well, there are two or three things which we should mention in passing -- just to make sure that you do get all the news about what has been happening within our structure. I think you all know that Dr. DuVal has resigned as Assistant Secretary for Health. You do know that Dr. Wilson has left as the Administrator of HSMHA, that Dr. Marston has left as the Director of the National Institutes of Health -- has not left, but has resigned as the Director of the National Institutes of Health. At the present time, the Acting

Administrator -- and it is clearly on an interim basis -- for Health Services and Mental Health Administration is Dr. David Sencer who is the head of the Center for Disease Control in Atlanta. That is a program director within HSMHA. This is an arrangement until a new Administrator has been selected.

Dr. Stone who is acting as Deputy has also taken over the role of Acting in the position which Jerry Riso was serving as the Deputy Administrator for the development group. And that also is obviously an interim arrangement until the new positions have been filled.

I think that there is just one other thing which I would like to comment on and then perhaps, Herb, you might want to pick up on any other items that we need to present for information purposes.

As a reminder, the REgional Medical Program legislation has to be extended in whatever form it will be extended within the current fiscal year. It is one of several programs, one of an extraordinarily large number of programs, which will terminate June 30 without new legislation. There have been a number of activities around the country in preparation for new legislation. What the form of that legislation will be, whether it will modify the directions of RMP, whether it will address other programs in conjunction with RMP, is a matter of speculation. It appears likely, however, that there will be a

good many suggestions, and I know some testimony to Congress, proposing more specific kind of language to describe the mission of Regional Medical Programs and probably increased attention, whether it is in the form of Congressional language or in legislation, to the relationship between Regional Medical Programs and other Federal health activities, most specifically Comprehensive Health Planning. The relationship between the two, the definition of the two, has continued to disturb people since the legislation was first passed. And despite some strenuous efforts to reach some clarification, it continues to be confusing.

So that we may see anything from language of clarification to some modification to some restriction or some new direction, I am not sure what. But I think you will all be interested in following the progress. And in this particular case, I think that if you want to take the time, and it is easier to do it as it goes on, some of the congressional discussion may be of more value in some ways than the final form of the legislation because it is extremely difficult to write legislation which is as explicit as congressional understanding would have it be. This begins to bind the legislation so that it is not maneuverable. And I believe you will be interested in following that kind of an activity.

I do not know what the schedule is for congressional hearings either in the Senate or the House for new legislation.

Are there any questions on these issues?

(No response.)

Let me just get on two other subjects which are more specific and have to do with professional activities with which we are concerned. Both of these, we have discussed in the past and they have to do with the development of stronger working relationships and a more effective programmatic link for both cancer and heart disease.

As you know, during the past year, there was an increased amount of emphasis put on cancer in the National Cancer Institute, heart disease in the National Heart and Lung Institute, with some reorganization, with the proposal for greater support, greater financial support, for both of these areas of activity. We have had, therefore, during the past year a number of activities which have looked toward an identification of the ways in which those Institutes and the Regional Medical Programs can work effectively together.

As I have said to you in the past, what we would like to see is a definition which is evolving of the roles of the Institutes and of the Regional Medical Programs which I think from our point of view are fairly evident. It is clear that the NIH is a source of research, biological research, as RMP is not. It is also clear that the National Institutes are in a good position to identify major disease activities, major kinds of approaches to disease control, which they are

interested in seeing developed or which they think are ready for development and for which they can turn to the Regional Medical Programs for rapid expansion and for extension into the health care delivery system. This, in fact, is totally consisten with the original concept of Regional Medical Programs which was to do exactly that kind of thing.

Now that the RMPs are nationwide and are dealing in a kind of a network of activities within their regions and across the country, the possibilities of doing this have been increased. One of the better examples of what has already been selected as a major target, I am sure you know, is the secretarially sponsored program to establish a national hypertension control activity. During the last two days, on Monday and Tuesday of this week, there was another national meeting to address this problem.

It is the general understanding of the people who have been involved that hypertension is a disease of great prominence, that it is probably afflicting some 23 million people in the United States. Of that total number, a relatively small number, perhaps not more than one in eight, is diagnosed and under effective treatment.

It is also believed by those who have been working most fully in the field that the methods of management by drug therapy are at a point of great enough effectiveness so that a nationally designed -- nationally in the sense that it

covers the nation but is regional and local in effect -- program is perfectly possible developed around the concept of screening, of referral, of drug therapy, and of maintenance, understanding that this will require networks which will utilize physicians not exclusively, but rather for general guidance, and a good many other people for screening, maintenance, and for control.

The energy behind this is very great. In the meeting in the last two days, there were assembled people from many, many sources -- from medical societies, from voluntary health agencies, from industry, from labor, the pharmaceutical industry. The persons who were presented represented the views of the Secretary himself, speaking for himself, the current Secretary, Mr. Richardson -- and he gave us assurance that Mr. Weinberger had already accepted the importance of this as something he would continue -- the Commissioner of the FDA, NIH, HSMHA, all were fully committed to this activity. And we anticipate that it will be a major part of RMP activities in the future as well.

In fact, it was sort of heartwarming to me, excepting for one minor problem that they never mentioned, that a good bit of what was represented as examples of how to control hypertension was RMP supported. I was sitting in the front row listening to one example after another of the way it had been done. And I never heard the words "Regional Medical

Program" come out of it. Well, we are sort of used to that anonymity, but it happened to be a season in which I could have selected a little different way of describing our work.

Jerry Stamler presented a magnificent summary of current knowledge on the subject of hypertension, diagnosis and treatment. And I would say that 8 out of 10 of the examples that he chose of ways in which the disease could be managed were based on something which had been sponsored by Regional Medical Programs.

So it will not be a new undertaking, but it will certainly represent a channeling of energy which I think would be very exciting. It is one of those kinds of things which can be achieved in a relatively short period of time which I am sure you will hear a great deal more about.

Now, in the field of cancer, it will require further definition than we have had at the present time. But we are looking to those Institutes -- NHLI and the National Cancer Institute -- to give us a definition of those directions in which they would wish to go. We will need to work out more clearly the arrangements for staffing activities, for funding activities, and so on. But I think that we are now in a position to serve the public interest and to take advantage of a momentum which has been regenerated rather than newly generated.

Do you have anything?

DR. PAHL: Just one thing, perhaps. We have been talking somewhat seriously, and I would like to just share a personal observation with you and then make one point of information.

In recent days, it has become very important to me to go back to President Truman's observation as to when the presidency fell into his hands. And I just want to share with you that Dr. Margulies didn't take full vacation time last summer and so some time back decided that over the holidays, he would take a few days leave. And it was my good fortune perhaps to have on the very first day that he was not in charge of our program and therefore I was completely in charge the Washington Post indicate just how important it is to have our Director here full time. And I believe that from now on, I would prefer if you didn't take leave, at least, and notify everybody.

The only point of information I would want to share with you is that in a continuing effort to improve the management of our program, we have indicated to you that over many, many months a policy manual has been under development so there will be a single reference point for both our own staff and all of the staffs of the regions when it comes to what our policies are relative to the governing of the program. And that policy manual through the cooperative efforts of many, many of our staff has now been developed. And we have

even managed to clear it through all the official channels so that we are in a position probably immediately after the St. Louis meeting to mail it to the regions where we will be asking the staffs to comment on the content and then following a consideration of those comments, we will revise it and send it out in completed form. So I believe that we are trying to pursue what we believe to be improved management practices. And this, I think, is a very major step forward and is, I believe, so recognized by the regions.

And I want to take this somewhat public opportunity to again thank our own staff for really the many months of effort and intensive effort in recent weeks to get it to this particular point.

DR. SCHMIDT: All right, thank you very much.

Dr. Ellis.

DR. ELLIS: May I ask a question of Dr. Margulies, please, Mr. Chairman?

Dr. Margulies, we are hearing quite a bit about specialized revenue sharing for health. And I was just wondering that in the event that a decision is made to make bloc grants to the States for health, do you see that this in any way would affect the way the Regional Medical Programs would operate or the legislation? I ask this because it is necessary to know in talking to so many people exactly how to comment on this to the best advantage.

DR. MARGULIES: As I said the last time that question came up, that is a very good question. However, I will be a little more helpful this time. That is all I said last time.

I think there is no question about the interest in the Administration in promoting the concept of State revenue sharing. That has been the President's position. It was initiated during the last session of Congress.

There also has been an interest in what is probably incorrectly called revenue sharing in health. It really is a matter of grant consolidation with State management of the way in which the funds are being used, with greater latitude on the part of the State than they have under present categorical circumstances.

I think there is no question also that that kind of arrangement is one which could be proposed only by the Administration, but which would either be accepted or rejected by Congress. And I think there is some likelihood that an increased effort in that direction will be mounted by the Administration. But I think it would be rather useless speculation to try to answer the question beyond saying that there will really be two issues.

One of them is whether that kind of an approach to the support of health activities is acceptable to Congress. And that would be debated, I am sure, very vigorously by

Congress.

And, secondly, whether if that did pass, it would include Regional Medical Programs.

Now, if one were to include RMP in a kind of bloc grant arrangement with the determination of support to be made at the State level, it would obviously mean a different Regional Medical Program. About that, there is no question. But at the present time, I have seen oo legislation introduced which describes that kind of an activity.

I am not in any doubt that it probably will be. But until something of that kind does get introduced, until there is debate, until there is decision about it, there isn't any reason for us to consider it as anything other than an idea which is going to have to be somehow deliberated between the Administration and Congress.

The nature of Regional Medical Programs, as you understand better than anyone else in the Review Committee, requires a different kind of an approach as we have currently understood it to be. And so if there should be that kind of a basic change, it would really change all the rules of play. And then we would have to go at it in a totally different manner. But at present, there is no proposal of that kind which has been presented to Congress and which is under general consideration.

DR. ELLIS: Thank you.

DR. SCHMIDT: I won't ask if that answers your question. I will ask if that satisfies you.

DR. ELLIS: Yes, it helps greatly.

DR. SCHMIDT: I don't think there is an answer to the question. Basically, of course, the problem is there isn't enough money to go around to do things everybody recognizes as good. So in this instance, somebody has to decide where the money is going to be. And my own personal interpretation of things is that Congress is unable to make these decisions right now. It isn't equipped to do it.

There is some question about whether or not they have the authority to do it. If you looked at the Washington Post this morning, I think it was Congress is talking about some kind of their own super budget agency, Congress' own Office of Budget and Management, that would vie with the executive OMB. This sort of a thing could share in the decision-making of where limited numbers of dollars are going to go. But I don't see that in the next four years myself.

And what I do see is an increasing number of dollars placed at the State level with the decision-making being put at the State level. And in Illinois, since you are familiar with Illinois, I now see the amusing business going on of everybody trying to divorce themselves from the health centers, for example. The Mile Square, which is very well known, is having its funding pulled back by the Federal Government. And

Presbyterian St. Luke's Hospital is trying to pretend like they have never heard of Mile Square. martin Luther King is being peddled to Cook County Hospital of the University of Illinois because their funding which is now about $2.5 million a year -- I think they see a couple hundred patients a year, something like that, for that money -- everybody is pretending like it doesn't exist.

And what is going to happen is that I think that President Nixon will say to the State of Illinois, "I have given you this money, you now have these programs, and you decide what the State will support." And the State will be deciding what to phase out, what to keep, what to put together, and I suppose might even be deciding what of RMP should be supported in another few years.

Whether this will last when Congress really does find out that the money that is accrued by its taxation authority is being spent by States in the next Administration, I would rather doubt. These things are kind of fun to think about and to predict the future with. But I don't think people really know.

DR. MARGULIES: I think you should realize that the idea of Congress having a sort of super OMB of its own kind was generated in the period of depression following the Super Bowl and they felt they needed to reconstruct the conflict at a higher level. I don't know whether they worked out the

television rights, but it should be an interesting show if they bring it around.

DR. SCHMIDT: I don't think the Super Bowl was all that interesting myself.

Well, we do have a number of progress reports, or a few progress reports on various activities that have been supported through supplemental funding. And the first of these relates to health services and educational activities. And Veronica Conley will give us a report.

Veronica.

DR. CONLEY: Thank you.

Dr. Schmidt, Dr. Margulies, as was reported to the committee at its last meeting, 57 health service education activities which are located within 25 RMPs were funds in June 1972. Since that time all conditions for funding which were imposed during the review process have been satisfied.

At this point in time, all but a few projects have full-time directors and are moving ahead very satisfactorily. They are in all stages of development, varying from the fully operational San Fernando Valley Consortium, LAHEC in Erie, Pennsylvania, and TAHEC in Tuskegee, to the Batesville, Arkansas, HSEA whose director just reported last week.

The directors appear to be predominantly from the field of education, some of whom have had little experience with the health services delivery system. Many of the directors

have expressed the need for more orientation to the RMPS concepts for HSEAs and to RMPS policies.

Communications between the projects and the RMP staff is complicated by the great geographical distance between the RMP office and the project sites in many regions. They can be 150, 200 miles from the office.

Over the last few months, the need for more orientation became so acute that two of the Directors of HCs planned a national meeting of HC directors. This was cleared with Dr. Margulies. This meeting was held Monday and Tuesday of this week in St. Louis. One hundred fourteen persons were in attendance representing 36 RMPs. On the basis of attendance at that meeting and as a result of many contacts which we had in the past with the developing HCs, we have made some observations which we would like to pass on to you.

The directors have reported a general lack of manpower planning data in the communities where they are establishing HCs, even in some cases in the presence of a CHP agency. Invariably, under the circumstances, the director sees as his first task to conduct a manpower survey. All directors need encouragement to look at health services needs as a data base in addition to the more traditional types of surveys.

In the area of consortium formation, two problems have arisen -- one the issue of whether to incorporate or not, and the issue of consumer involvement.

On the positive side, through these consortia, the RMPs have on a broader scale than ever before been able to involve educational institutions -- the technical schools, the community colleges, and the senior colleges -- none of whom are necessarily in medical centers, but all of whom are participating in the education of our health workers.

In six RMPs, there are AHECs which overlap with the HC projects. And we have two very fine examples of coordination -- one between Northlands RMP and the University of Minnesota, and the New Mexico RMP and the University of New Mexico AHEC. The area of overlap in Minnesota is in St. Cloud where there is an HC which has developed and is the farthest in development of the Northlands projects. This is also the outreach community under the AHEC contract.

Through coordinated efforts, the RMP supported St. Cloud consortium will serve as the community arm of the AHEC. All relationships between the university AHEC and St. Cloud will be conducted through the consortium and not through individual agencies, institutions or hospitals.

In New Mexico, the AHEC contract is directed exclusively to the Navajo nation. The non-Indian population in the geographical area covered by the AHEC approached the New Mexico RMP because they wished to have the same services as the Indian population. And the New Mexico RMP is developing a section to take care of the non-Indian population in the area.

Areas of activity which may illustrate the potentially broad scope of activities of HCs include, for example, the Rhode Island State Medical Association which has requested that RISEC which is our HC in Rhode Island under Tri-State RMP requested that RISEC participate in PSRO planning particularly to provide advice on continuing education.

In Arkansas the School of Nursing has asked the HC to establish some affiliations with rural hospitals so that its persons trained at the university will have rural hospital experience and, therefore, would be encouraged to serve in rural hospitals.

There is also a growing surplus of nurses in Little Rock which has brought this about.

And another HC has been asked to represent the health community to work with architects in the planning of a hospital.

And, of course, several have been approached by State medical societies and local medical societies as they move towards mandatory continuing education for relicensure or for continued membership in the State association.

And, finally, in the meeting in the last two days, although they originally called the meeting to talk about program development, the issue which became an overriding one was what the directors call their survivability. They quite realize it will take many months and perhaps a year or more

before they can become self-supporting. And they are, of course, very concerned about RMP support and the possibility of its discontinuing. They explored many possibilities at length for obtaining funds, one of which was revenue sharing. And they were encouraged to immediately begin to set up relationships which would be important in any revenue-sharing activity.

And before they left yesterday, they appointed one of the directors to publish a regular newsletter so that they would be informed on the activities going on throughout the country in HCs and also about what is going on in RMPS.

And their last action was to appoint a steering committee. And its first charge was to explore ways and means how the directors both individually and collectively can assist the RMPs in the months ahead and in particular in regard to the upcoming legislation. And the chairman of that steering committee will be in touch with the chairman of the steering committee of the coordinators.

Thank you.

DR. SCHMIDT: I thank you.

Are there questions?

Bill.

MR. HILTON: Just a couple of small points. The PSRO is what?

DR. CONLEY: Professional Standards Review Organization.

DR. SCHMIDT: That is a nomenclature for peer review group.

MR. HILTON: Another thing, in your comment for the developing needs of the AHEC director, you mentioned the lack of manpower planning data and a couple of other comments you made which suggested that the system that is being developed among these project directors may be forced to replicate some of the things some RMPs -- I have visited and talked with people -- think they should be doing. Are the coordinators of RMPs familiar with these needs and is it your feeling they are responding to those things they can best do or CHPs, for that matter.

DR. CONLEY: Well, there is a continuing need for us to work with our regions in reorienting their thinking about how one arrives at what kinds of manpower we need and how that manpower should be trained. It is usually to conduct surveys and send questionnaires to find out how many vacancies there are, how many people are being trained. But it is our feeling that one must first look at the health services needs. And this is a new concept and one that is not easy for people to understand.

MISS KERR: I would like to ask a question if there is any distinction between "needs" and "demands." As you do surveys, we find so many indicate needs, but the employment opportunities are not there.

DR. CONLEY: That did come out at the last meeting and was stressed as a responsibility of the developing HCs to be sure that people trained would have positions to go to.

DR. ELLIS: Doctor, do any of these programs extend to education of people in the communities?

DR. CONLEY: They are moving into this.

DR. ELLIS: And how do they relate to the professional health educators as we understood it in years gone by?

DR. CONLEY: In the consortium representation, you would have representatives of the various health provider groups. And there are consumer representatives on the consortium as well. And as they move into the operational phase, they will move into consumer education, although each of these will probably develop quite differently from the other.

DR. ELLIS: Because one of the really great needs in health education is broad, across the entire population of consumers from childhood on through adult life. And I was just wondering if this wouldn't be a very important thing to build into some of those training programs. It really could be done without altering the pattern too much.

I think it would make a tremendous difference in the overall contribution of the program to the needs of people.

DR. CONLEY: This is one of the elements in our concept, Dr. Ellis, which we are trying to promote.

DR. SCHMIDT: Thank you very much, Veronica. That

was a very good report.

Emergency Medical Services. Dr. Rose will give us a briefing.

I believe he has a handout.

DR. ROSE: A rather large amount, about half of what I am passing out there, most of you have seen previously. It is a reminder and updating as to where the supplemental RMP awards of last spring went and in a general sense for what purposes they were to be spent.

As you will also see, there are some lists of applications, both those that went through November Council and those which are coming up now, which are offered more as an indication of how much interest has been stimulated in the RMPs to work in problems of emergency care. And I am not suggesting that is a complete list. We are still a little way from a real definition as to when a coronary care training program is heart disease and when it is EMS.

There is also a list of the regions that we have visited over the last few months and those that we hope to contact within the next few months. Again, a list of visits is not set in any fashion. It is largely a matter of where we feel the priorities for visits may appear and where the regions feel a need for these trips.

In the visits, we have been talking with a variety of people in the RMPs -- those specifically interested in one

particular area of emergency care, members of the RAG, executive committees, coordinators, evaluators, various kinds of people within each of the RMPs.

A few words about the status of Emergency Medical Services within some of the other programs around the building: CHP, the Comprehensive Health Planning Program, has expanded its interest somewhat over the last few months. They have done a series of planning sessions around the country for members of B agency staff. They have had three such meetings. The fourth one is coming up next month in New Jersey. They are designed to acquaint members of the CHP staff with the concept ofplanning for emergency care and the value of this care.

I have attended two of these meetings. I hope to attend the one in New Jersey. And I found them very interesting, although I am not sure that the audience has seen in these kinds of sessions what they would like to see.

As is usually the case, there is a lot of concern about how much money are we going to get and how are we going to get it and that kind of a simple question.

The Comprehensive Health Planning Service has also printed -- it is in the final stages now, should be out next week -- a general statement of their approach to emergency care which will be distributed to the CHP A and B agencies. And we will send it out to the RMP as well. It is an overall policy statement, not much different than the sort we

put out last spring.

What used to be called the Special Project Office for Emergency Medical Services -- I mentioned this to you last time -- this is the office which set up and monitors the contracts for model emergency medical services in five places around the country -- is likely to become, probably already has become as of this week, the Emergency Medical Systems Service. And it will include personnel from the Division of Emergency Health Services as part of their organization. A large part of their activities will continue to be the monitoring of the five model programs plus a sixth which was activated in December in Maryland and a likelihood of the seventh one which is in an innocuous phase now, being carried forth within the next few weeks or months.

As far as Emergency Medical Services legislation is concerned, which at the moment it appears will not affect RMP, hearings are scheduled or planned to be held on legislation very much like the Rogers bill of last year. The hearings are tentatively set for next month. It is likely that this year there will be the same bill introduced in both houses.

You may remember last year there was a Senate bill and a House bill. And they never came to conference. That bill relates to rather categorical EMS activities -- ambulances with people to ride on ambulances, very straightforward almost highway safety oriented type approach.

One final statement, if I may, about some of the concerns we have been having in talking with the regions. I think the overall concern that I mentioned last time still exists. A number of the regions are still treating emergency medical services as a separate sort of health activity apart from the rest of the thing that the RMP is interested in or perh should be interested in. And a large part of our conversations have been trying to encourage the idea of emergency care as just a requirement of the total health system rather than as a separate project.

In some places there has been concern about the responsibilities for contractors who have received money from these supplemental earmarked funds versus the responsibility, the management responsibility, of the RMP itself. And this has generated a fair amount of concern on our part and I think is a fairly significant problem in some of the RMPs which we hope to be talking with over the next few months.

Who is responsible for designing and evaluating the project? Is it the contractor or is it the RMP? The hardware orientation is still there. Where can I get money to buy radios is a common question. And we try to get away from that.

I think the key issue which is coming along now both in the RMP activities and in the model systems is the matter of how one valuates the effectiveness of the system both in

terms of the project goals and in terms of its effect on the rest of the health problem. We have been working rather hard in this area with our Office of Planning and Evaluation here.

The National Center for Health Services R&D has stimulated a fairl amount of interest in their staff in this area. And, of course, there is a major requirement for evaluation techniques of this sort in the model systems.

DR. SCHMIDT: Are there any questions or comments in this area?

DR. SCHERLIS: Are future requests for Emergency Medical Service funds as they come from the individual regions being looked at by your group or are they being looked at as part of the general review mechanism without input from your group? How are these to be considered?

DR. ROSE: There are some in the present cycle. We are trying to pick them out for our own interest, but they are being thought of at least by us as another activity of the RMP in no way separate or distinct from their other activities.

DR. SCHERLIS: In short, are you including in any of the data which we have specific evaluation by yourself as far as the EMS proposals as they come in from individual regions at the present time?

DR. ROSE: No. There may be staff input just as there might be for any other kind of activity, but there is no specific EMS-related input which is included because it is

EMS. There is no such.

DR. SCHERLIS: There are no earmarked funds, I assume, then at this particular time. This is just that one go-around, is that correct?

DR. ROSE: Yes.

DR. SCHERLIS: They come in as part of the total overall requests.

DR. MARGULIES: Correct.

MR. HILTON: Len's question raises a point that is precisely what I wanted to ask with regard to the EMS. Is that floated in exactly the same way?

DR. HINMAN: Yes, it is.

DR. SCHMIDT: Are there other questions or comments?

DR. SLOAN: Would you like to mention the conference with the American Heart Association on emergency care of cardiac patients?

DR. ROSE: No more than I guess just to say I am not as up on that as I should be. There is interest in a conference. There is to be a conference which I believe is May.

DR. SCHMIDT: Dr. Sloan, would you care to comment?

DR. SLOAN: Well, the American Heart Association asked us to cooperate with them in development of a conference on the emergency handling of cardiac patients in relation to our interest, the RMP interest, in general emergency medical services. And I think it is just worthwhile to note that we are

trying to cooperate with them and that such a conference will be held, the proceedings of which will be made available to all Regional Medical Programs.

DR. SCHMIDT: We have learned in Illinois through a disastrous train wreck, two airplane crashes and Florida recently learned that the real trick in this whole area is to have the emergency occur where you can handle it. And if that doesn't work, you are out of business.

Len wanted to say something.

DR. SCHERLIS: I was going to ask in reference to Dr. Sloan's statement if the interest to RMP extends, I would hope, to participating in the financial support of this conference or is it as one of the many agencies, and there are many, which are listed as cooperating in this conference? It is an important one. It is for emergency cardiac care. It is being held at the National Research Council much like the earlier one was several years ago when CPR was stressed. This is for total early care.

Have you been asked for financial support?

DR. MARGULIES: I don't know that we have been asked, Len. I am not sure.

I understand we have not.

DR. SLOAN: The AHA has a sufficient appropriation.

DR. MARGULIES: We have, as you know, a continuing and to be renewed major contract activity with American Heart

Association. So if they need funds, they know the channels. And if we haven't heard from them, I assume they can do for the moment without us.

I would also assume from that they have something else in mind later.

DR. SCHMIDT: Well, Bill Hilton mentioned PSROs, and this stimulated our thought that there is something going on in this area. And Dr. Margulies perhaps could comment on the H.R. 1 type of activities with PSROs and even perhaps the kidney problem.

DR. MARGULIES: Let me take those in reverse order for the moment. I suppose that we will forever refer to what really has another title as H.R. 1. As I recall, it is 92-607 or something of that kind. But H.R. 1 is a catchy title.

That, as you know, is the very, very large and complex series of amendments to the Social Security Act. And it includes some striking new activities, the full extent of which is still to be realized. One of them had to do with a new method of reimbursement for the services required for individuals requiring dialysis and transplant. This is designed in such a way that the source of funding for the payment of those critical services will be relatively ample compared with the way it has been up to the present time.

As I recall, that becomes effective, is it, April 1, Ed?

DR. HINMAN: July 1.

DR. MARGULIES: And it is at the present time being worked out by the Social Security Administration.

What we are hoping for, and we have had good cooperation up to the present time from the National Kidney Foundation, from the people in NIH, from Social Security, from CHP and others, is the recognition by those who must reimburse for payments of the need to identify those settings for dialysis and transplant of patients where the quality of care can be well attested to.

There is always a risk when something can be paid for that there will be people available to provide the service because it could be paid for rather than because they are expert at it. That is not a pejorative statement aimed at the profession; that is a sort of general human reaction.

In this particular case, it is urgently important that the institutional setting -- and by that, I mean broad institutional setting -- in which patients are to receive dialysis leading to transplant or without transplant, be well identified, well qualified, and that reimbursement be limited to those situations where the patient will get the best possible care without interfering, of course, with his access to care.

It fits in extremely well with our own plans for developing dialysis in transplant centers through a national

kidney network which has been making good progress. We have been meeting regularly with the people in SSA. And at the present time, I feel quite encouraged that through a combination of the various Federal agencies and the professional bodies which are involved, we will come out with something which represents both access to patients and protection of patients with assurance that they will get good quality care. But the final definitions have not been reached.

On the subject of PSRO, let me just spend a few minutes on that one because it is an extremely important subject and one which the whole health community is interested in and so also are patients or certainly organized consumer groups.

It is essentially a proposal which was known usually as the Bennett Amendment which states that there must be a mechanism associated with Social Security-SRS reimbursement mechanisms to give assurance that the quality of care which is being provided meets acceptable standards. And for that purpose, it was agreed that there should be established what has already been described as a Professional Standards Review Organization which has been very, very broadly described in the legislation.

The main elements of it which are clear at the present time are that the initial phases of this kind of quality assessment and assurance will be confined to institutional settings which means hospitals, intermediate care

facilities, and nursing homes; that there will be a total dependence upon a peer review mechanism, but with full access to this peer review mechanism on the part of all major providers of medical care.

The circumstances in which a PSRO organization will be established need to be described so that there is a long series of regulations which must be written. They will, as presently planned, consist of opportunities within States and within portions of States for professional groups to establish peer review organizations which will then set some kind of criteria, measure performance against those criteria, and use these as a basis for giving assurance to the public that the quality of care they receive is what it should be with, of course, the controlling element being reimbursement for the services being provided.

The present state of development of that consists approximately of the following: The Office of the Assistant Secretary for Health -- Incidentally, that is a new name for the position which Dr. DuVal was occupying. It was Health and Scientific Affairs. It is now Assistant Secretary for Health. There has been a new description of the position in the Federal Register with a fuller understanding of what their function is. The basic responsibility for the development of the PSRO lies in that office.

There is under way, and I have been out of touch for

a couple of days so I don't know if it is completed -- I think I would have heard if it had been -- the search for a director for the PSRO activity who will be located within that office. It will then from the Federal point of view be necessary for a number of activities to be carried out which range all the way from the establishment of a National Council for PSRO to the definition of what the PSRO is to do, to the establishment of regulations, to the creation of reimbursement mechanism through the Social Security Administration, to the establishment of a range of technical and professional advisory functions which will have to be carried out within and outside of government.

From the HSMHA point of view, there has been established within the agency a group of people to work on PSRO as a general activity for us to understand more fully and to allow programs to be as prepared as they can be for whatever responsibilities they are given.

There has been no explicit assignment of responsibilities excepting for preparation for whatever support the Department is going to need when it does make its assignments. Within HSMHA it is organized as follows:

One individual who is one of the Deputy Administrators, Emery Johnson, is the key person involved in the PSRO activities. There is, then, an agency-wide coordinating body which represents a number of programs, including RMP, National Center

for Health Services R&D, which has basic quality R&D responsibilities, Community Health Services, National Institute of Mental Health, and so on, which are all on this PSRO coordinating committee.

It also has an executive committee on which I sit as the Director of RMPS which includes some of the same groups I just mentioned -- NIMH, the Office of Planning and Evaluation, National Center for Health Services R&D, Community Health Services. They have associated with them a working task force.

Now, this executive group and the coordinating committee and the task force are working very closely both with the Department and the Social Security Administration as we begin to develop an understanding of what a PSRO prototype would be, what the elements would be, how criteria are to be established, what kind of continuing education will be required.

We have also primarily on the urging of RMPS, R&D and CHS, been asking groups outside of government to come in and share with us their own interests and their own activities. And we are going to set up a series of such meetings so that we can make sure that the interests of the American Hospital Association, the American Medical Association, the foundation groups, etc., are involved. And we see -- and this is really a judgmental statement rather than a bureacratic one -- a great responsibility on the part of the Government to assist

the health activities, the organized health activities, outside of government to act together to coordinate their activities rather than to go about it separately even when they are not in conflict. Because if there is dysjuncture between groups like AMA, American Hospital Association, foundation groups, associations of medical cinics, and so forth, it will be to everybody's disadvantage and certainly will not help to develop an effective PSRO structure.

So far we have been deeply encouraged by the great willingness of groups to not only come in and share their interests with us, but to join their organizational peers in meeting together.

At the same time, I rather suspect that some of those same groups are going to have to help us from the outside coordinate our activities.

Generally speaking, as a kind of a basic principle which Peters has not approached so far as I know, bureaucracies can be organized better from pressures from outside than they can by energies from inside. You may quote me on that. So we will look to those outside us to bring us together, and we will look at ourselves to bring them together. And I think that the prospects are very good. It is hard to predict what the actual impact of PSRO activities will be.

Two or three things are clear. There will have to be developed data and information systems which serve not only

existing utilization review, but also PSRO activities and as well the kinds of basic informational demands for health services which Veronica Conley was referring to when she was talking about the health educational activities.

We must have a common, well-defined, consistent source of data which can serve planners, which can serve PSRO, utilization review, and do it in such a way that we know what we are talking about or at least we are all looking at the same set of data rather than at a whole range of incompatible data which mean whatever you think they mean at the moment.

There is real movement in that direction. And I think that SSA is going to help a great deal as will be the rapidly expanding Federal-State-local health data system which is emanating from HSMHA.

Secondly, it is clear that there has to be a continuum and a linkage between utilization review as it is presently carried out in institutions and the PSRO activities which have to do with the quality of services which are being provided.

And, third, there is limited, very limited, recognition of the need to be prepared to do something about what it is you are discovering when you carry out this kind of a review activity. There is an almost reflex tendency on the part of the inexperienced dealing with PSRO to speak in terms of sanctions against those institutions or individuals who don't come up to the mark as though the only solution if someone

does poorly is to cut them out of the system. This is clearly not our intent. And it won't work in any case.

The real problem will be not only to develop effective information systems which certainly have to include a revolution in medical records and standards of reference and comparisons between performance and those standards, but some techniques for remedying what is found wrong. And the responsibility for doing that will certainly include Regional Medical Programs, not only in the kinds of educational activities with which we have some familiarity, but some organizational improvements, some manpower extension activities, some improvements which overcome the problems of deficiencies in services due to shortages or maldistribution of health manpower. And of all of the activities in PSRO, it seems to many of us that the remedial aspects of this have been least attended. They will be addressed not in the PSRO structure, but as broad issues which are important in any setting at the St. Louis conference, but I have the feeling that we will do less well on that subject than on a good many others that we are going to be considering.

I think there is little doubt, for example, that there will have to be rapidly heightened, even above the present pace, attention to sensible, logical, recordable, transferrable, medical record systems which can be used for audit purposes. And this in itself is an undertaking of no mean proportions.

So what is happening is a rapidly growing response

on the part of Government to legislation which was passed very late in the last session of Congress, but which must become effective by January 1. So that the time involved is very, very brief.

DR. HESS: I wonder if you could comment a little bit more on what is going on in the area of medical records because this is of extremely critical importance in this area.

DR. MARGULIES: Well, in RMPS, but certainly outside of it, there is a crescendo of interest even above what it was a year ago in the problem of oriented medical records. Recently a conference that Willis Hurst held down in Atlanta had a huge attendance on the part of people who realized that this may very well be the best available kind of record system. We see growing evidence around the country of hospitals, of groups of people, beginning to recognize the fact that there must be a rapid change in medical record systems. I don't believe that this agency or SSA has recognized a need to put official pressure behind the development of that kind of a medical record system, but it would not surprise me if that kind of thing should occur.

I know that Representative Rogers has been strongly tempted to introduce legislation requiring that kind of a medical record system which I think would be most unfortunate. I would prefer to see the profession reach in that direction.

We have not, however, and this concerns me, been

able to reach a conclusion in this agency that we should take a position and promote a kind of medical record system at this time. I am impatient with the tendency to continue to research and wonder and study on something which at least is well enough established so that it would be a vast improvement over the kind of patchwork we have at the present time. I would like to see us come to the conclusion saying this or that.

I don't know if anyone is going to have courage enough to require under PSRO at the central level a medical record system of a specific kind, but I rather suspect that a good many of the early developments in PSROs where the progress has already been great are going to come to that conclusion right at the beginning this will be the only medical record system acceptable. But the action is general and not coordinated.

MISS ANDERSON: Dr. Margulies, I know it is hard to mention all the names of people involved in this planning, but are allied health groups or nursing groups involved in this initial planning phase?

DR. MARGULIES: You mean within the Department?

MISS ANDERSON: Well, planning for this national council. You talk about the AMA and Hospital Association and so forth. I was wondering about the nursing association or the allied health group.

DR. MARGULIES: Well, the question is how extensive

has been our involvement in bringing in groups to work with us. We have only just begun. This particular PSRO activity is not more than 6 or 8 weeks old. And so we have actually been responding initially to those who have come to us with some interests of their own.

For example, the QAP of the American Hospital Association was of immediate and early interest as has been the Social Security Administration. And we had already been working with the National Kidney Foundation. But we will certainly find it necessary to work with those other kinds of professional groups like nursing associations, allied health, where there has been developed an approach and some understanding or where there is a need for it in establishing the PSRO.

Even though it is keyed very clearly in the legislation around the physician peer review mechanism, it should be self-apparent that PSRO as it is going to develop will require an effective review for those who provide medical care which means a small minority of physicians and a great majority of others.

And I should mention one other thing that although the legislation require-s PSRO in the institutional setting, it does allow room for some experimentation and some early entries into the ambulatory care delivery system with the implication that as PSRO develops in the institutional setting,

it will be expanded out of that and into the ambulatory delivery environment.

Now, that was a decision made for practical reasons. It is tough enough to do it in the institutional setting. And the feeling was we really aren't ready to try to take on the ambulatory PSRO type of thing. And in fact, if you reflect on it for a moment, the institutional setting sounds tough when you think of hospitals and agonizing when you think about nursing homes.

We have somehow or other never gotten ourselves to really talk seriously about PSRO in nursing homes. I think everyone is well aware of the fact that that is a very, very difficult field.

DR. ANCRUM: Dr. Margulies, for the institutional settings, isn't that only if they are involved with reimbursement for Title XVIII and XIX? I am thinking about an institutio may not want to come in. Do they have that choice?

DR. MARGULIES: This is based around the Social Security amendments. That's right. What usually happens, however, and it doesn't take very long, is that all third party carriers fall into the pattern of what has been establishe through SSA. So that it would seem to me highly unlikely that other methods of reimbursement would remain isolated from the PSRO activity if it appears to be a method of giving warranty of good quality care to the public which is being served.

But it is a requirement only under what used to be known as H.R. 1.

DR. SCHMIDT: All right. Thank you.

Are there other questions or comments?

Yes, Dr. Brindley.

DR. BRINDLEY: Not specifically related to that. This may not be appropriate, but where do we stand on HMOs as far as RMPS is concerned?

DR. MARGULIES: The question is on HMOs.

This is a great morning. How do you think those things up?

Well, as you recall, the legislation for Health Maintenance Organizations did not pass during the last session of Congress. As a consequence, there is nothing officially known as HMO. The RMP funds which were used during the last fiscal year went to some 29 HMOs which were in developmental phase. There is no more RMP money identified for that purpose. There will be no funds used for operational support of HMOs.

There is a hope, of course -- and again Mr. Rogers has indicated his interest in it -- that the Health Maintenance Organization legislation will pass very rapidly. There then will be appropriations. And in those circumstances, it will be existing as a separate, self-sustaining activity in which the RMP interest will be only as it is appropriate to the RMP mission.

I think that the kinds of conduits which were used in the past for this will either no longer be necessary because the HMO activity fails or no longer necessary because it succeeds and has its own independent appropriation.

DR. SCHMIDT: Other comments?

MR. TOOMEY: Dr. Margulies, what has been considered in terms of the composition of the membership of the PSRO?

DR. MARGULIES: At the State, you mean, at the local level?

MR. TOOMEY: State or local.

DR. MARGULIES: Well, that is described again rather loosely in the legislation. It must include -- and I don't know the exact terms, perhaps someone else here does -- physician representation which is not limited to M.D.s. We are talking about M.D.s, osteopathic physicians and other health care providers. It cannot be designed, for example, around a county medical society because that is a selected group. If you have to be in a county medical society to be in the PSRO, then that is not an acceptable PSRO arrangement.

On the other hand, members of county medical societies can make up PSROs as a separate activity.

The intention, as the language was developed and as it was understood in the Department at that time, was to give the PSRO governance a very broad base which would mean that it would represent quite frankly the best description of a fairl

characteristic PSRO base as Dr. DuVal was understood at the time it was passed was a good regional advisory group of an RMP, a good many health care providers, people representing institutions, allied health, and some consumers. But it is not really a consumer-oriented thing. It is a provider-oriented. And in the final analysis, it is the physician peer review mechanism which dominates in the legislation and in the management of it.

And as I recall, the National Council is an all-physician group. Is that right, Bob?

MR. MORALES: There is a requirement to include other providers such as nurses and that type of officials.

DR. MARGULIES: It was designed in such a way that it would not become the private fiefdom of physicians.

MR. TOOMEY: Will foundations be able to move in as a PSRO without changing the composition and foundation and board itself?

DR. MARGULIES: I would say yes to the first part that the foundations will very likely not only be able to move in, but they are likely to be early beginnings in PSROs.

I suspect that a good many of them will have to change their structure in some way because they tend to be restricted to physicians and will have to embrance a larger group of individuals involved in health care provision. But thatis the kind of thing which regulations will have to be

written to to identify. And I could be wrong on that.

DR. SCHERLIS: In its broad phase, can this get involved initially with categorization of facilities as it sets up professional standards or is it looking at individual rather than group service?

DR. MARGULIES: The question is could this get involved in categorization of institutions. I think the answer to that is probably yes, depending upon, again, interpretation and regulations. But one of the aspects of the PSRO is institutional quality review which is again almost self-evident. One can hardly expect a group of health care providers to meet a standard of performance in an institution which does not. And certainly, if a hospital is to be utilized, there must be evidence that it meets some kind of quality criteria for its own diagnostic and care facilities.

When we began to think about our own Section 907 activities which I will remind you of in a moment, we realized that these needed to be moved into the PSRO environment for our own group to look at. And we are going to be doing that.

Now, the Section 907 activity is one which has grown out of the original legislation through which RMP was established. You may recall that it is a section which says that at that time, the Surgeon General, now the Secretary, will publish a list of hospitals which have the most advanced facilities for health disease, cancer, and stroke, and then later kidney

disease was added. We are currently in the late phases of a very vigorous contract carried out with the Joint Commission for the Accreditation of Hospitals to establish some kinds of criteria which conform to the current intent of that section.

What has been done is the distribution of a very complete questionnaire to hospitals all over the country with a remarkably good response which will allow us to identify hospitals in accordance with their capacity to deal with heart disease, cancer, stroke, and kidney disease.

It will also allow us to establish a kind of tier of quality which could roughly, depending upon how it finally evolves, identify institutions which are able to do the most sophisticated referral type of activity, a good example being transplant of kidneys or chemotherapy which can be done only under very specialized circumstances for patients with cancer and so forth, the so-called tertiary institutions. We should be able to identify the criteria and perhaps the institutions meeting those criteria for tertiary care, for secondary care -- that is, institutions which are able to accept referral patients, not necessarily for the most advanced, but for something which requires referral -- and other hospitals which are adequate for primary purposes.

Now, if the PSRO is designed around the medical care system of a region, of part of a State or all of a State, then the identification of institutions which are competent to

do some kinds of things and apparently not to do others would be of real value in trying to set up criteria for performance and in trying to identify where therapy, where diagnosis and treatment should be carried out and what the resources are for better teaching and for systematic regionalization of health care delivery systems. This, of course, would mean that they would be linked in closely with planning agencies. And we propose to utilize this list of criteria in hospitals so that planning agencies will be able to take advantage of them as well.

I rather suspect that PSROs could if they wished to, Len, use this kind of thing and decide whether they want to enter into that kind of definition of where a particular service should be provided and where it should not. You can easily appreciate the hazards which are involved in that decision, but in some cases the hazards would certainly not be great.

It would not be difficult for a PSRO to say that this institution is not prepared to take on open heart surgery and this one is. The gross distinctions would be relatively simple. It may get a little tougher if you try to make decisions about where you can manage a patient with an initial infarction who is already in congestive failure or something of that kind. It is a little bit more doubtful. But you have no difficulty in distinguishing between a small primary hospital and a secondary referral hospital in that case.

I would suspect they would want to take advantage of it if they are imaginative and aggressive. But the decision will be theirs.

MR. TOOMEY: I believe the legislation also said that if you have an adequately functioning utilization review committee within the institution, that this can act as a PSRO. Has your group given any consideration to this particular situation? And what is an adequately functioning utilization review committee?

DR. MARGULIES: The question, if you couldn't hear it, is related to the fact that the legislation indicates the acceptability in hospitals of existing utilization review activities.

When the Administration was preparing its own position on H.R. 1, it expressed its skepticism regarding existing utilization review activities throughout the country. There will be no objection to the use of existing UR activities, but there will be considerable doubt about whether they could do the PSRO kind of activity if their performance with the utilization review is a criterion of what would happen under PSRO.

I think as a matter of convenience, what they are saying in this is there will be increased attention and demand to both utilization review and PSRO. And since they will be dealing with the same patients and same kind of information

systems, it is reasonable that that be an element in the PSRO. But I rather suspect regulations will require something more than what has been established for utilization review up to the present time.

And there is concern with those who are working on it that the use of the utilization review mechanism might tend to restrict what happens to utilization review rather than really get into issues of quality which are not the same issues. I think that, however, you have touched on something which is as likely to be a difficult issue as any in the whole process.

MR. TOOMEY: Because there is a tremendous opportunity for conflict within the medical profession itself. Of course, the American Hospital Association is pushing its QAP, Quality Assurance Program, to be melded into the utilization review simply to allow for the physicians who are using the institution to continue not only to evaluate the quality of care, but also the utilization of the institution or vice versa.

DR. MARGULIES: I think it would be unwise where there isan effective utilization review activity to set up another and parallel activity. That should be the core of it. But it should not be restricted to that core. That is the problem.

MR. TOOMEY: That is why they are going into the QAP.

DR. MARGULIES: I think the QAP makes very good sense.

MR. CHAMBLISS: Does this not, Dr. Margulies, require the expansion of the review utilization committee? It has been pretty well a hospital-related function.

DR. MARGULIES: I think so.

DR. JAMES: May I make a comment along that line? When you mentioned earlier regarding standards for hypertension in terms of perhaps the nation has come to the point now where it could set up standards for the adequate treatment of patients, I think that is the way I understand it. It seems to me like while we are talking about utilization and quality control, where are the standards for good medical care as you would see them related to the total program?

DR. MARGULIES: One of the responsibilities of the Department will be to guide the way toward the development of what will be effective standards. There will be two issues.

One of them is the creation of acceptable standards which represent a professional output like those that we have done, say, through the Inter-Society Commission on Heart Disease Resources or through the National Kidney activities, the things we are doing with stroke and so forth. And there aren't enough of them. We need more of them. And we are developing some contracts in RMPS and also in HSMHA to move in that direction.

But the other and thorny part will be to see what the relationship is between those kinds of general standards

and local concepts of practice. The PSRO, I suspect, will be asked to develop its criteria, but it is going to be looked at very carefully to see how it goes about that.

Those who are being critical of the profession are afraid that a development based upon local standard setting will be established at a point of kind of mutual self-protection instead of aiming toward high quality. I think people who say that are being a little foolish. Our experience has been that those who step aside from their practice to work toward the establishment of criteria which they think they should meet tend to set them too high -- actually higher than they can achieve. Because when they get away from day-to-day practice and say, "What should I be doing for the identification of a patient for a tonsillectomy or eye surgery or whatever," they tend to become a little textbookish rather than practice oriented.

But the real question, and I think the profession is going to have to play a very, very alert part in this, is the translation from national standards to local practice or local circumstances. And I would like to just say on this subject in general that if ever there was a time for the health professions to meet a responsibility which is probably the most important individual responsibility they can possibly meet, it is in this one subject.

Last month I was asked to attend a conference in

England to compare the health delivery systems of the United Kingdom, Canada, and the United States. And one of the issues we dealt with was quality assessment. And it was apparent that when other countries, including Sweden and some of the eastern countries, began to look at the United States in this subject, they agreed at that conference, the people from the other countries, that we do far more at the present time without PSRO, without utilization review and so forth, to measure the quality of medical care than do any of the others. They don't have tissue review committees, they don't have record review committees, they do relatively little both in Canada and the United Kingdom, and that includes Sweden as well. We are well ahead of them.

But now they are looking to see what we are going to do, what the profession is going to do -- and this is really a professional issue -- to prove its basically conservative professional character which is to protect and promote the quality of medical care.

Now, there has never been within the profession any dissention over whether this is an acceptable and basic purpose in what we do. In fact, the whole issue, everything we talk about in the Federal Government and outside of it, comes down to the question of whether medical care is of good quality, whether you are talking about the how many people or what is done with the individual. And this is the time when we could

not only evaluate practice here and make a difference in the whole professional environment, but set a pattern for the whole world. Because if what we can achieve can be done effectively, it will influence the practices in Canada, in Western Europe, in Eastern Europe and, of course, throughout the rest of the country. It is being looked at with great, great interest. And as it develops to a higher level, it is going to set the pace for generations to come.

If it fumbles, if it is not done effectively, somebody is going to come along with some kind of further regulation which is not as good. I think it is an exciting time, but I think very few people realize the full involvement, the full difficulty, which it presents.

DR. SCHMIDT: I think you have given us a logical break point. The next activity will be to synchronize watches.

It is approximately 25 minutes to 11. And we will now break and reconvene not later than 10 minutes to 11.

(Whereupon, a recess was taken.)

DR. SCHMIDT: We still have a couple of items to cover. We have talked a little bit about revenue sharing and the subject of sharing of authority and responsibility is something very much being discussed in a number of areas. We mentioned the sharing of decision-making and priority-setting and so on that will be going on as part of future developments. And the next agenda item really kind of can be umbrellaed by

that general topic.

We all have been told from time to time and have been briefed on the activities having to do with the individual RMP review process and what have been called verification visits to regions, looking at specifically their review and decision-making processes. And Mr. Chambliss is going to tell us a little on how that has been going.

MR. CHAMBLISS: About a year ago, RMPS developed a document in response to recommendations from the FAST Task Force, entitled "RMP Review Process Requirements and Standards." And this document set forth the requirements for the decentralization of project review and the decentralization of funding authority to the RMPs.

A handbook was produced setting forth certain definitions and certain requirements in this area. And the key issue was to have the regions abide by certain standards that would make for overfunding decisions and having to do with the technical adequacy of proposed operational projects and also those activities which were funded within the approved amount of the grant award.

There were minimum standards set forth on review criteria and program priorities, on staff assistance, on CHP reviewing comment, technical review, project arranging and funding, feedback, and appeal procedure.

Now, during the past year, the Division of Operations

and development staff has set a goal of visiting to certify or to review the verification processes of all of the 56 RMPs. During the year, then, 51 of the 56 RMPs have in fact been visited. Five regions were not visited, and those five regions are California, Arizona, Northeast Ohio, South Dakota and Delaware. There were specific reasons why these regions could not be visited within the specified time.

In the case of California, there were tremendous logistical problems that you could well imagine there. The staff is now planning to make that visit soon. As you can appreciate, there will probably be a period of two weeks that the staff will have to be in California looking at the 9 areas of that RMP.

There were other technical problems having to do with Arizona, Northeast Ohio. And in the case of South Dakota and Delaware, those two regions are still in their planning stages.

Now, of the 51 Regional Medical Programs visited -- and I might say it has taken a yeoman effort on the part of staff to get these visits in within the prescribed time -- there has been unusual staff cooperation between the components of RMPS and I should say here and now before the committee, before the staff and the public, that the support given the Division of Operations and Development by Planning and Evaluation and by the Division of Professional and Technical Development has been very noteworthy. Of the 51 regions visited, and I might

say that these regions are, as you know, organized along the desk structure, the Eastern Operations Branch having 20 regions, the South Central Branch having 16, the Mid-Continent Operations Branch 14 regions, and the Western Operations Branch 6 regions, including California -- that of the 51 visited, 36 regions have been fully approved or certified to date. There are 15 regions which have been provisionally certified or which have been disapproved due to substantive shortcomings in applying the standards. And as a consequence, staff is working with those regions very closely in seeing that whatever the deficiencies or whatever the bases for disapproval are cleared up.

You would like to know that most of these visits have been made in the last six months, and the nearest being, of course, Metro Washington and the furthest away being Hawaii. And I think you would like to know that one of the visits was made at 27° below 0°. So you can get a vision of the zeal and enthusiasm that our staff has had in carrying these out.

But in some, we would say that we proposed to finish up the remaining visits within the next two months and will give you a report on that activity later.

DR. SCHMIDT: I am sure that some of the visits must have generated some heat.

MR. CHAMBLISS: They did indeed.

DR. SCHMIDT: The general topic, though, is kind of

an interesting one. And I was musing in the last few days as to whether or not this report would generate any discussion. So now I am going to find out.

Is there any discusion?

MR. TOOMEY: What were the shortcomings you found?

MR. CHAMBLISS: The shortcomings? We have undertaken a study of this, but many times the application may not meet the criteria set forth in the standards or maybe there was improper or incomplete review and comment by CHP agencies. Many times, the priority ranking system was not adequate to ensure that the proper funding decisions could be made in keeping with the criteria. Occasionally, we found there was inadequate feedback to the applicant who had not been successful in having his proposal funded. So there were a number of reasons why they did not meet the review criteria.

MR. TOOMEY: When you disapprove them, what happens?

MR.CHAMBLISS: Generally, the region is told what the basis for the disapproval is. It is itemized. And then if it is a technical disapproval, we attempt to tive the region a time in which to meet that particular standard. And the staff usually works very closely with the region in trying to overcome that.

MR. TOOMEY: Have you had enough time to see how quickly they attack these shortcomings that you have pinpointed?

MR. CHAMBLISS: We have been most pleased with that.

Just this week, we had three responses from regions saying that the technical basis for the disapproval had been overcome. So they are closing those deficiencies as much as possible.

Now, there are some with more substantive bases for disapproval. And the staff is working with them much more in detail.

MR. TOOMEY: Do you find at all they will disagree with your judgment?

MR. CHAMBLISS: This has been a very interesting phenomenon. Many times the region has said to us, "We agree with the bases," because it has given them an opportunity to strengthen some of their internal procedures. Occasionally we have had a region somewhat disagree, but in the process of discussion and negotiation, those have been overcome.

DR. LUGINBUHL: Could you give us an example of one of their substantive problems?

MR. CHAMBLISS: One of the substantive problems had to do with CHP relationships and review and comment and especially in one of our regions under the Mid-Continent Operation Branch.

DR. SCHMIDT: First, Judy, did you have a comment?

MRS. SILSBEE: I was going to say in answer to Mr. Toomey's question, our goal is to get all of these regions in compliance because the stated next step would be to take away from them all decisions with regard to what the project

technical review and funding decisions are. And that is something that we don't want to take back into Rockville. And so the incentive on both our parts and regions is quite great to get these things straightened out.

MR. TOOMEY: What happens at the rank level when you point these things out? Are these people conversant enough with your operation to understand the deficiency you point out? Do they have problems?

MR. CHAMBLISS: Dick.

MR. RUSSELL: I would like to respond to that because we have had on a couple of occasions going in -- of course, we do meet with representatives of the Regional Advisory Groups. And as a result, when we have our feedback session, they seem greatly relieved in some cases that this has been pointed out to them. And in some cases, this gives the RAG the clout that they perhaps have exercised in the past. So they have been very receptive to the feedback.

MRS. SILSBEE: I don't think any of us mean to imply the millenium is here. These are minimum standards. And all of the visits have pointed up need for monitoring and kind of continued seeing how these are working out and whether they are following them.

DR. SCHMIDT: First, Mr. Hilton and then Dr. Thurman and Dr. James.

MR. HILTON: I just had two questions or maybe

comments.

The procedures manual that was referred to earlier, does that go into this area of technical review to provide guidance so that when it is released, we know it is documented somewhere?

MR. CHAMBLISS: Yes, it will contain these standards.

MR. HILTON: With regard to the CHP, was staff able to make any determination as to the degree to which the problem originated with CHPs understaffing contributing to that and the other kinds of problems where the RMP might have tried to make the proper communications with the accepted guidelines, but couldn't?

MR. CHAMBLISS: Mr. Peterson, would you care to comment there?

MR. PETERSON: I think we might say two things about the CHP review and comment procedure. I think there have been perhaps three levels or three different kinds of problems we have seen. Some of them are essentially technical, but sometimes they get beyond the technical problems leading to emotional stress and strain.

There are technical problems relating to a 30-day requirement and what you give a CHP and whether some things are being technically complied with. I think in a few of the regions, at least, that I am aware of, we have sensed that they really were symptoms of lack of adequate cooperation and

understanding, that they were simply the clubs that were being used in this battle.

I think a more substantive aspect of this which really one in part comes out through the verification visits -- and I personally only participated, I guess, in three or four and none within the last six months -- comes to light as a result of an analysis that my office has done, is in the process now of getting out, in the way of a program analysis memorandum on the scope and nature of CHP comments during the first year in which that was implemented.

We required as of the May cycle, 1971, that all RMP applications, the opportunity for CHP review, a comment be provided. So we had a year's experience as of this past summer. And we have been trying to analyze to the extent that there was written comment letters supplied with the applications, sort of the nature of those. And I think there are some striking things that can be said in that regard.

First and foremost, I think we find that much of the CHP comment is of a general nature. They comment on the application as a whole or the RMP. And it tends to be of the Good Housekeeping Seal of Approval. It doesn't say much, and I question it.

There is very little CHP comment to date in terms of specific activities being proposed -- this home care project or that EMS planning effort. There is some of that, but on the

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There is very little CHP comment to date in terms of specific activities being proposed -- this home care project or that EMS planning effort. There is some of that, but on the

whole, it is comparatively small. To the extent it exists at all, it tends to be favorable.

That may simply mean that there are other forms in writing in which they express themselves unfavorably. But certainly in discussing these findings with some of the CHP staff here, I think there is a general agreement that what this points up is that in most CHPs, whether they are talking about areawide or State, but principally areawide, there really aren't the kind of specific priorities or plans that have been developed yet that permit them to comment in terms of a particular kind of activity or a specific proposal. And I think that goes beyond the verification visit process, but I think it has some implications for CHP review and comment.

DR. SCHMIDT: Dr. Thurman.

DR. THURMAN: I am out.

DR. SCHMIDT: Dr. James.

DR. JAMES: I don't know quite how to ask this particular question related to what you are speaking of, but I think you mentioned that primarily what was involved had to do with the decentralization of the review process.

MRS. SILSBEE: The technical review, Dr. James, of projects.

DR. JAMES: At the local level. And I wanted a clarification on that so that I would be sure that I understand the focus here relative to the larger applications coming into

this review committee or is the focus relative to applicants at the local level in that the local RMP is following the guidelines? I wasn't quite sure where the focus was.

MRS. SILSBEE: Well, the background of this particular verification was when the FAST Task Force which was before your time, but it was an organization for streamlining grant operations and application procedures and so forth, when they looked at the Regional Medical Programs and saw what was developing out there -- and this was several years ago -- it seemed to them that the national review process was duplicating what was occurring on the local level with regard to looking at the individual projects, looking at the technical adequacy of them. They recommended, and Dr. Margulies implemented, the procedure that the national review process would no longer do that particular thing.

Before your time, this review committee used to take a project and the applications came in with the full material, all the background information on a project, and go through the project and look at it to see if they thought it was technically adequate and whether the project itself should be approved or disapproved. This was creating problems since the regions in many instances were doing this also and the national review did not have as much information as the people that were doing it at the regional level. So the FAST Task force recommended that this be stopped at the national level.

And this process that Mr. Chambliss has been describing was to verify that indeed each of these Regional Medical Programs did have a process by which the projects were looked at from a technical point and other standpoints.

The national review then looks to see what the effect of all of these activities is, what the composite effect is, rather than the individual projects as such.

DR.JAMES: Then, I can relate very well how you may pick up in your visits the relationship of the CHP agencies in that respect.

Now, when you get down to the area of what happens as far as local applicants are concerned in the appeal mechanism, how are you able to sift that information out?

MRS. SILSBEE: The process by which the team looks at this is to look at the documentation that has occurred in the local review, to look to see what the records are, to see at what stage a project proposal gets stopped in the process, what the feedback is to the procedure, whether the Regional Advisory Group -- what kind of information they have about these ideas that they haven't been asked to act upon. These are all steps in this review process to make sure that someone who has an idea gets it considered and knows, if it hasn't been considered and approved locally, why.

DR. MARGULIES: For example, there is an effort made to interview unsuccessful applicants to see how they perceive

the process, how they got involved, what occurred when they were turned down, if they had an adequate explanation of why it was rejected, whether they feel the process was fair and so on. So that they try to get verification of the true dynamics of the review process.

DR. SCHMIDT: In previous discussions of this in the review committee, we have gone back to something that we are all very familiar with. And that is the project grant type of review conducted in NIH where, indeed, the technical review of a research grant is carried out by the study section on a one-by-one basis. But within NIH, there are developing centers. The so-called centers of excellence approach, for example, is one in which NIH will fund a center and then the center locally can fund research grants. And they must have the ability to do technical reviews then of the research projects within the center locally. And then the study section and the Council really serve to accredit the center to do this job.

So then you can translate that to Regional Medical Programs wherein the function of a review committee at times we have said is to accredit the region to do this job that as Judy pointed out used to be done by the review committee, in many cases not as well. And, finally, the people who we do it with come from regions anyway.

And when you play with this a little bit, you see

that in the kidney reviews, for example, recommendations have been made to get experts from without the region. And all of these sorts of things get into this. The triennial review and this sort of thing becomes an important aspect of this also there.

First Leonard and then --

DR. SCHERLIS: I think your analogy as far as centers of excellence is an analogy, but not, I think, paralleled by RMP type of organization because in each region, you do have an RMP. And in each region, you do set up a verification system. You aren't saying that is a center of excellence which really has all of the necessary technical skills to decide about each individual project.

If you select the center of excellence, it is in competition with many other centers. And you are selecting from a large pool in determining which ones do have over and above a system of review the basic ability, talent, and necessary review officers in that area who can look at it technically.

What I am getting to really is that I still believe that within this committee, we have a right to decide the quality of a program submitted by a sampling mechanism. And I find it invaluable in reaching a conclusion about an area to look at a project or two in order to determine whether they are just forwarding up to us some what otherwise would be very low priority items. And we have the decision and I think, indeed,

the responsibility to determine by such a sampling mechanism whether or not the overall grant request is a valid one.

I would like to interpret the results of whatever this discussion will be that you are not removing from our responsibility and purview the right and indeed the responsibility if we chose to look at individual projects as a sampling mechanism to determine our overall reaction to the entire request. Will you comment on that, please?

MRS. SILSBEE: That seems like a very reasonable approach. And in order to answer some of the questions that are asked in the review criteria, you would have to do this. But it does differ in that you don't go through each one and say this one is approved and this one is disapproved.

DR. SCHMIDT: I agree. What you have done really is described how we have been operating in the last year or two. And when you get right down to it, the program is a kind of a nebulous thing that is something more than the projects. But what you have in hand to look at really are the projects . And as we all know, even now regions are not making some decisions they should, but booting them up here. And, of course, what this means is that there is something wrong with that process and we have to continue to work with the region.

Dr. Florin.

DR. FLORIN: I might report on a recent visit. We thought our review process was quite adequate. It was pointed

out in the Regional Advisory Group meeting some of our shortcomings. And it was accepted with understanding and with appreciation. And we have since modified some of our review mechanism to do it.

I think the major concern they had at our site review visit was that those applicants be informed of their right to appeal to the Regional Advisory Group at any time even though decisions have been made at a lower level before that time.

I think also to comment on another statement that was made by Dr. Scherlis, as funds become more competitive, the problem within the Regional Advisory Group was one of fairly good review in that they tried to cull through the projects so they didn't have poor projects. Hopefully, if the staff allowed them to come up that far, they would be eventually filtered out by the Regional Advisory Group. This isn't always possible, but I don't think the undue influence of people that early existed in that program is now evident certainly in our areas.

DR. SCHMIDT: There was a comment along this side of the table.

MISS ANDERSON: I think I was going to comment on the fact that the site review teams have an opportunity to see some of the proposals in depth and bring it to this review committee for discussion.

DR. SCHMIDT: The comment for those who may not have heard it was the site review teams certainly can and do look at projects and use this as an entry point into the survey of the local decision-making process.

One question I would have is what are the plans for some kind of -- well, let's say, are the forthcoming site visits then as part of the triennial review the mechanism for looking at compliance or does staff intend to go back in a year or what mechanism of seeing to this process have you considered?

MR. CHAMBLISS: This will probably be done in a variety of ways. The staff is making regular visits, technical assistance visits, to the regions. And they will be monitoring and checking through with the provisions of these the verification as they go to see how they are being maintained and what the status of the region is as it relates to this decentralizing process.

DR. SCHMIDT: Yes, Mr. Toomey.

MR. TOOMEY: One of the things that bothers me is the number of times that one of the Regional Medical Programs --

DR. SCHMIDT: I am sorry, let me interrupt and ask you to talk into a microphone because there are people in the back row.

MR. TOOMEY: One of the things that bothers me is the number of times that a region is visited and the number of

purposes for which it is visited and the number of reviews that a region has. I know the last time that I visited as a site visitor, I think that within the period of four months, there had been a management assessment report, there had been a field trip, a technical review. And it just seemed that there was almost an unconscionable amount of visiting to that particular region, although I am sure each trip was justified. And we did get a report on it.

But the thing that bothers me is the fact that when we take the rating sheet, the review sheet that you spoke of, Judy, it really doesn't reflect the number of visits, the kind of visits, the results of the visits. It doesn't give the site review team real specific knowledge about what was found, what wasn't found.

I am not saying it right because really this discussion has brought on something that bothered me. And I am kind of struggling for the words a little bit. But in any event, it seems that there should be a more specific kind of indication.

I know what I was going to say. We do get the problems Now, this is for sure. We get them at the RAG level, the program development level, the field level, the staff level. We get the problems. And then you use another sheet to provide a rating mechanism for what has gone on. And sometimes the two don't jibe actually.

And as a site visitor who attempts to prepare himself,

I look at the problems. And then as the review mechanism of what has gone on, you don't focus on the problems, you focus on process, performance, program, and some other things.

And this whole thing, the number of visits, the kind of visits, the purpose of the visits, the results of the visits and then the result of the site visit, don't seem to meld adequately.

DR. SCHMIDT: Let me ask for clarification.

MR. TOOMEY: I would ask, really, if anybody else has had this same kind of problem in bringing all this material together.

DR. SCHMIDT: Let me ask for clarification of one thing you said that I didn't understand. I recently made a site visit to a region that had been visited a number of times. And each group that went in pointed up the same deficiencies and the same problems. And we did, indeed, I thought, concentrate on their problems.

What did you mean when you said that you go in and really don't concentrate on the problems? I missed your point.

MR. TOOMEY: I think the point is that you do concentrate on the problems, but the problems that you find as a result of one are the problems as a result of three visits. And you actually have made a number of visits for a number of different purposes presumably, and they all come out the same

way.

And then my last point was that the assessment, the in-depth assessment, that starts with process and performance, these questions do not always relate to the problems that have been identified by previous visits except by indirection.

DR. MARGULIES: I think that is a valid problem, but I think that it has little to do with a sort of an accident in timing, Mr. Toomey, although staff may want to add to this. We have had an excessive concentration of necessity on two kinds of visits -- management assessment and the review process verification. These were necessary because we had undergone a profound change in the way in which we ran our affairs. This has meant in some cases a deluge of visits which include not only the regular visits, but the specialized ones for management assessment which we had to have and for review verification process as well.

I think in the future, there will be less of this kind of specialized attention to programs and a better opportunity to integrate them. I am suggesting that this is an erratic phenomenon rather than a consistent one which moved us from where we were to where we need to be.

Mr. Chambliss commented a moment ago on what we would be doing in the future. What we would like to believe is that this intensive period which we could not possibly duplicate as we could not duplicate management assessment visits sets a

plateau from which we can operate with attention to what comes up as a variant from the norm, but which we will then have to re-examine at some point to see if anything more intensive has to be done.

In fact, the responsibility for the two kinds of processes rested in different parts of the Operations Division. And we had our own difficulties in bringing them together because they did put a great strain on RMPs and added an amount of information which was not necessarily a part of the regular review process, but was rather a buttress for it.

DR. SCHMIDT: Of course, the review criteria and that kind of a laundry list and form for site visitors and so on was clearly intended to be a guide and not all-inclusive. And I know that many site visit teams have gone far beyond that guide. That was not intended in any way to restrict site visitors or the review committee or anything else. Of that, I am sure.

Judy.

MRS. SILSBEE: I was just going to say to Mr. Toomey in terms of trying to plot out these visits where they could be combined, the verification visit and management survey were put together. And the strategy within staff was to try to do that enough in advance if there were going to be a triennial site visit so that the region would have the benefit of the observations and recommendations and an opportunity to try to

correct some of these things before their three-year funding request got considered by the national review process. This didn't always work out.

DR. SCHMIDT: O.K., any other comments, then, on this subject?

MR. HILTON: I just need to follow Mr. Toomey's comment for just a little clarification for me.

From what Judy was saying, as I understand it, these visits, management, technical review, etc., etc., are they deliberately then timed to precede a visit by the review committee, Council, that kind of mixture, so that we in effect follow up to assure that what has been discovered in the earlier visits has begun to show returns? Leave the verification for staff?

MRS. SILSBEE: The thought behind that, Mr. Hilton, was that in some instances, this would relieve the site visitors of having to go over that same old ground and be able to concentrate more on the program and the activities and the effectiveness of those activities so that they wouldn't have to focus on the organizational structure so much.

MR. HILTON: Is that to say, then, as this develops there would be no need for us as we did, for example, to ask them to go through projects, that we are sure that the processes is legal and that kind of thing, we won't have to be bothered with that?

MRS. SILSBEE: I don't think that is indicated I think at any point in terms of the perspective of the application that these things have to be checked out as Dr. Scherlis was saying.

DR. SCHMIDT: I would get alarmed if anybody thought in any way they shouldn't do anything that their brain and tummy told them ought to be done on a site visit. And you know, you smell something, you go right in and find out what smells.

I think the thing that bothers me about this is as will come out in our discussion of regions in the later part of the meeting, why is it that there can indeed be a series of visits all pointing up the same thing? And what is wrong that over a period of even two consecutive triennial -- do we have any two consecutive -- the same things are there? And there is a certain obstinancy sometimes that one needs to change.

Well, fine. Bill.

DR. THURMAN: In no attempt to match the wit and eloquence of our chairman, let me point out Mr. Nixon's statement was the carrot-and-stick procedure was designed for the jackass.

(Laughter.)

DR. SCHMIDT: I think we have to take a recess to figure that one out.

I did hear a marvelous line, though, the other day

that came from Congress. In talking about this congressional budget bureau and so on, one Congressman said that the Congress is fiscally irresponsible and if you added up the monies that Congress appropriates and spent that the country would obviously be broke. And one Congressman described Congress as a fiscal junkie which I thought was a great line.

I will use this for transition into the next subject. Those of you who read what I think, Dr. Margulies, was a very interesting and informative summary of the Council meeting -- I hope that Review Committee members read the Council highlights - you will recall there was reference to the developmental component including a little bit peculiar fact noted by the Review Committee often. And that is the developmental component was often most needed by the region that didn't merit it. And for this and other reasons, the developmental component has been under serious discussion by the Council.

And Judy will review this for us and get us up to date on the status of the developmental component.

MRS. SILSBEE: Well, we were talking a little earlier about the fact that this review committee used to be involved with project review and the developmental component was introduced as a tool to help regions about the same time that we were trying to get regions in the habit of submitting an application for funding once a year rather than every time a review cycle came up. And the developmental component was at

that point, which wasn't too long ago when you really get back and look back and see what actually happened -- it was in 1970 -- a revolutionary idea that the regions would request funds for projects and at the same time would request funds for activities that they didn't specify at the time except in terms of the areas in which they would want to develop programs. And at the time this committee and Council considered the developmental component, they decided that there had to be certain standards for those regions which were to be approved for the developmental component.

And in practice, this became a way of sifting out those regions which had Regional Advisory Groups which were able to make decisions, withstand the local pressures of some kind of technical review. There were a number of different qualifications.

And in terms of the way this review committee recommended the regions receiving developmental components, looking back over the past two years, it sifted out pretty well. If we look at the regions that are roughly in the A category and the B category and C category, in the A, most all -- and one region had not requested a developmental component -- of those were approved for developmental component. In the B area, I think of 26 -- and when you do these categories, it depends on what point in time you are doing it -- 20 of them have been approved. In the C area, only one or two. So in

terms of a way of sifting out regions, it has been effective.

But since the developmental component was introduced and has been utilized, the regions themselves, the ones that have decided to allocate their funds in this direction because we have never actually given additional money for that purpose, we have had a number of other things happen. We have decentralized the project review. The RMP review processes have been studied. This triennial system has been inaugurated. We have the RAG grantee policy which states very clearly what the Regional ADvisory Groups' role is in a more succinct fashion than ever before. And we have the policy for discretionary funding which provides the opportunity for a region to do everything that the developmental component allowed them to do if they are approved for triennial status. And then regio have the opportunity to shift funds to initiate activities within one application time to another.

And at this point in time, it seems that the developmental component as such, a request for it as such, has served its purpose, and it is no longer a necessary part of this evolution into decentralization.

In looking at the results, there are a number of regions that have requested developmental components two or three times and been disapproved each time. So as a mechanism for getting them to do the things that Mr. Toomey says he keeps seeing coming up in every report, it didn't seem to be effective.

And at the same time, there seemed to be for those regions that needed to initiate some new ideas or move in different directions, they were using their disapproval for developmental component as -- they interpreted that action as disapproval of the type of activities they were going into rather than some difficulty with their decision-making and local review.

So at this point in time, staff feels that the developmental component has been a very useful device. It has served its purpose. Regions have had ample opportunity to request it and that it might be better to eliminate that as a special thing -- not eliminate the developmental idea, but to eliminated the component as such which has created some problems internally.

DR. SCHMIDT: I think that is an excellent review. And, of course, the existence of discretionary funds really is to me what renders the developmental component a little bit unnecessary now because the developmental component was intended to provide, indeed, discretionary funds. It got to be sort of like the stamp on meat, unfortunately.

I forget what the current grading is now. But if you got the developmental component, you were stamped choice or whatever the top grade is which is sort of ridiculous.

MR. CHAMBLISS: Prime.

DR. MARGULIES: You have forgotten about it because it cost so much.

DR. SCHMIDT: I am on the verge of forgetting about meat because it costs so much.

Dr. Scherlis, you had a furrowed brow at several point

DR. SCHERLIS: That is a lack of good vision rather than any reaction to your comments.

(Laughter.)

DR. SCHMIDT: Then put on your glasses because we need your clarity of vision on this committee very much.

Joe.

DR. HESS: Just a question for further clarification. As I have understood the use of the developmental component, this has been some funds that they could use in a variety of ways. How will that be requested now in the future in applications?

MRS. SILSBEE: At the present time and through March, it will be requested just as it has been. But if there are some revised instructions, it would provide an opportunity to put that in the program staff budget as developmental activities which is where they have been putting some of these funds anyway. In looking at the situation right now, regions sometimes are requesting a developmental component, then under their program staff budget, they are requesting money for feasibility studies, they are requesting money for contracts and a number of things which have the same purpose. So we thought if we could get it, it would be tighter if we could get it all in one place.

DR. SCHMIDT: What will be interesting is when we arrive at the point this afternoon or tomorrow morning when a region has had a review verification visit and has had this project approved and the recommendations of the site visit team will be in that region that they do not merit a developmental component. And we will see how that comes out. I will predict we will have that situation.

Mr. Hilton.

MR. HILTON: Such terms as aside from developmental component, growth funds, rebudgeting or budgetary flexibility, discretionary funds, I am assuming there is no substantial difference between those terms; they all are really saying the same thing. I am surprised, however, to note that I have seen at least one application in which more than one term is used for one application. And so they are kind of doubling up on flexibility.

How many different ways do you provide incentive and how much of that do you tolerate? I guess I am seeking guidance.

MRS. SILSBEE: Mr. Hilton, this has been a concern and is part of the reason why staff looked at this whole area of developmental component.

In terms of the discretionary funding policy which came out about the same time as the RAG grantee policy, it again puts a burden both on our staff and this review committee

of looking at the results of a lot of flexibility after they have already initiated it rather than before. And in looking at the ways in which regions have used developmental funds, there have been very exciting things that have occurred. And there have also been some of the other kinds where they have put it all together and started a project.

So we have to monitor this very carefully. But if we could put it all in one spot, we think it will be more helpful.

MR. HILTON: So you are saying if we get an application like that and they are asking for four different kinds of flexible money, we could easily disallow three out of four or something if that seemed to be feasible.

MRS. SILSBEE: If it seemed like an undue proportion without any kind of justification. And this is certainly within the line --

MR. HILTON: This whole question of degrees of extra money like everything else.

DR. SCHMIDT: All right, let me seek out now any comments from anyone around the table, anyone who is here as representative of the public. Are there any general comments or questions not necessarily directed at the last topic from anyone in the room?

(No response.)

If there are none, then I think that we will declare that this section of the Review Committee meeting is closed.

We will reconvene at 1 o'clock in then the first of the closed sections that will be devoted to program review.

Leonard.

DR. SCHERLIS: I have no comment except an inquiry. Have you determined who would or would not be here tomorrow in terms of making sure that the review can be done today? Has this been taken care of?

DR. SCHMIDT: The information I have -- we can do this little bit of housekeeping right now -- is that Dr. White will be here this afternoon only; that we must do today Alaska, Connecticut, and North Dakota in part because of your schedule.

Is there anyone else who is involved in a conflict?

MR. HILTON: Yes, Mr. Chairman. Unfortunately, I, too, will only be able to be here this afternoon.

DR. SCHMIDT: All right, we have got Washington/Alaska scheduled also. So I intend to work the committee very hard this afternoon and do the most we can today with this so that we have the benefit of the members who may not be here tomorrow. So eat heartily and have a good strong cup of coffee and come back with loins girded.

(Whereupon, at 11:55 o'clock a.m., the meeting recessed, to reconvene at 1 p.m. the same day.)

AFTERNOON SESSION

(1:00 p.m.)

DR. SCHMIDT: I think I will call the meeting to order.

Let me first suggest an order, kind of doubling back to the last topic. And it would seem to me that -- let's see, Phil isn't here yet and will be coming about 1:30, I think. And giving him a little while to get here, it might be 2 o'clock. So I would suggest the following order: Washington/Alaska first, and then Louisiana, then Connecticut and North Dakota, then Metro D.C.

Now, those seem to me to be the musts this afternoon. And if we go on beyond that, it would be good.

Is that acceptable? Have I left out some imperative?

(No response.)

If not, then let's start with Washington/Alaska. The primary reviewer is Mr. Hilton and then Dr. Luginbuhl is the secondary reviewer.

Oh, yes, I forgot to bring to the attention of the review committee the conflict of interest statement and the confidentiality of meeting statement. You know that we cannot participate in situations in which we may have a conflict of interest. Committee members will absent themselves when regions in which they have an interest are discussed.

I don't have to read this, do I?

MRS. SILSBEE: No, since everyone has it in front of them.

DR. SCHMIDT: You all have a copy. This is a requirement of meetings.

Then, before we do start with Washington/Alaska, Mr. Chambliss will inform us as to the Council recommendation stemming from our last review meeting.

MR. CHAMBLISS: As a result of the September-October review cycle at which time 13 regions were reviewed by this committee, 9 of which had applications in for the triennium, 3 anniversaries prior to the triennium, and one anniversary within the triennium, we certainly thought the committee would like to know that all of the committee recommendations were accepted by the Council with the exception of one. And that was the case of New Mexico.

In the New Mexico application, there was a site visit recommendation of a funding level of $1.3 million. The committee recommended $1,150,000. And Council upped that level and recommended a level of $1,250,000 which was $100,000 above that recommended by this committee.

DR. SCHERLIS: Was there a reason given?

MR. CHAMBLISS: And I simply thought you would want to know of those proceedings.

Thank you.

DR. SCHMIDT: Let's take Leonard's question. What

was the reasoning behind this?

MR.CHAMBLISS: The question is the reasoning. And would you speak to that, Mr. Posta?

MR. POSTA: I might pass the ball over.

However, actually, Dr. Kamaroff was on the site visit to New Mexico and did differ with the committee's report and actually brought in a number of the improved activities which had taken place in New Mexico in a complete reorganization and felt perhaps they did deserve a little bit more what we used to call until this morning developmental component funds. And that was the primary reason for it to be increased in a slight amount.

Is there any other comment?

MR. ZIZLAVSKY: An additional comment, Dr. Kamaroff who chaired the site visit felt it was a little bit stringent and they should have a little bit more in funds and not in flexibility. The actual amount of funds awarded, however, was more in line with the committee's recommendation.

MISS KERR: I notice on the summary sheet requests, it is footnoted No. 3, Review Committee rating gave Connecticut 312 which would place it in the B category. And it was changed by Council to be an A region.

I wonder if you could give us the reason for that or why this was changed?

MR. CHAMBLISS: Let's see, Mr. Nash who is the Chief

of the Eastern Operations Branch -- Miss Kerr raises the questio
on the rating for Connecticut.

MISS KERR: The rating changes for Connecticut from B to A.

MR. NASH: That was raised by Council itself.

MRS. FAATZ: That was a year ago.

MR. NASH: It wasn't here.

MRS. FAATZ: We are reviewing Connecticut again.

MR. NASH: It was a site visit, by the way.

MISS KERR: Well, I notice it was on this sheet.

DR. SCHMIDT: We will be doing Connecticut so maybe we can hold that off, then.

Are there any other questions specifically directed toward the Council actions?

(No response.)

If not, then I think that does bring us to the program reviews. And for those of you who have just come in, the order will be Washington/Alaska, Louisiana, Connecticut, North Dakota, and Metro D.C., beginning with Washington/Alaska and Mr. Hilton.

(Dr. Ancrum absented herself from the room.)

MR. HILTON: Ted Moore from the staff will provide a few minutes of introductory information using the audio-visual and then we will go into our report.

DR. SCHMIDT: We will have audio-visual presentations

on Washington/Alaska, Louisiana, and Intermountain which we hope will be helpful. And once again, we will want your critical evaluation of these presentations.

MR. MOORE: We don't have a speaker, but of the 3.5 million people in the two States.

(Slide.)

As you can see, this is Washington State. And the 3.2 million people in the population areas of Bellingham, Seattle to Tacoma, 80 percent of the population resides in this area here surrounded by the Olympis Mountain Ranges and the Cascade Mountain Ranges. The rest of the State is flatland. And the other 20 percent of the population is in Spokane and Walla Walla and a few other small places in this area.

One large river, the Columbia River, stretches 1500 miles into Oregon and.

Next slide.

(Slide.)

Alaska has 310,000 population. Population bases are located here -- capital at Juneau, Anchorage the largest city, Fairbanks in the central part with a scattering population on the coastal regions.

You have the Brooks Mountain Ranges in the north and the Alaskan Ranges in the south with Mt. McKinley's 20,000 foot peak here.

Next slide.

(Slide.)

The region encompasses 700,000 square miles. As you can see, it is approximately one-fifth the land area of the United States.

Along with the size, the terrain density of population, weather and so forth, you can see where this would add problems to health care planning and health care services.

Next slide.

(Slide.)

These are air mile distances between the larger cities in the area of Seattle, Portland, Spokane, Fairbanks, and Anchorage. As you can see, it is quite a problem to travel to RAG meetings and other committee meetings. Three days are allowed for such meetings.

It is very hard to consider that the time that we leave National Airport in Washington, people are leaving Fairbanks to attend the same meeting in Seattle.

With the isolation that contributes to the goals of accessibility and availability of care, however, the people were able to see the Super Bowl via satellite communications.

Next slide.

(Slide.)

This is a view of Bethel, Alaska. It is Main Street Bethel, 1500 population, in southwest Alaska.

Next slide.

(Slide.)

This gives a population percentage breakdown within Washington and Alaska. In Alaska, of the 310,000 people there, you have around 9,000 blacks, you have 52,000 Indian-Eskimos, 2,000 other, and the remaining is 79 percent Caucasian.

In Washington, you have 3.5 million population. 71,000 blacks, 53,000 of Oriental extraction, Indian population 33,000, remainder Caucasian, or 95 percent.

In Alaska, there is around a 40 percent shortage of primary care physicians. They have a total of 320 physicians, half of whom are military or PHS physicians.

In Washington they have a little above the national average of health manpower in terms of physicians and nurses.

Next slide.

(Slide.)

These are the areawide planning agencies. There are 7 in the State of Washington. There is one in Alaska in Anchorage.

As you can see, the shaded portions are covered. The unshaded portions are not covered by any Federal or State planning health agency.

Next slide.

(Slide.)

This is a composition of the various committees, Washington/Alaska committees. Some are technical and others

are on the broader committee functions. As you can see, around the populated areas, you have representation in kidney, continuing education, Community Health Service, heart, cancer, and health care technology. So representation flows with the population bases centered around the university.

Next slide.

(Slide.)

As a result of some of the earlier planning -- this is the total RAB membership. There are 46 members in the State of Washington. This gives a geographical distribution of the membership. Advice given by the management assessment team in February of 70 indicated that they needed a larger geographical spread, professional spread, consumer and other groups on the RAB. And this shows the geographical spread.

Also, of the 46, 8 members are from Alaska. And there are around 9 consumers on the total Regional Advisory Board.

Next slide.

(Slide.)

This is the Alaskan Advisory Committee composed of 22 members. They assess the health needs in Alaska. And this is a communication device into the RAB. Eight of these 22 members are also RAB members.

Next slide.

(Slide.)

As a result of some of the earlier planning -- this is the Providence Hospital in Anchorage, Alaska -- prior to 1969, there was no super radiation therapy available to the Alaskans. Many cancer patients had to travel 3,000 miles to other States for their radiation therapy. RMP purchased the cobalt unit and the community provided the financing and built the facility you see here.

In its first year of operation, 135 patients completed therapy at the unit which was twice as much as had been expected. Today, 300 to 400 patients receive cobalt treatment at this center.

This is one of the first successful RMP projects which, of course, have been taken over with other resources.

Let's have the transparency.

Mr. Hilton, would you like to present the planning process for their triennial application?

MR. HILTON: I think probably, Ted, we can hold off on that planning process slide unless questions arise.

Is that the one you are about to show? We will hold up on that one.

Here is an additional audio-visual aid, and I also have a handout to share with you.

Basically, our approach to the Washington/Alaska region was what might be qualified as a --

DR. SCHMIDT: Could you kind of cozy up to that mike

a little bit?

MR. HILTON: O.K.

Our basic approach to the Washington/Alaska region was what might be described as somewhat negative in that we sought initially to identify what the problems were, what was wrong in the region, understanding from the literature that it apparently has a rather good history, that it is really very highly rated by staff. Still, there were problem areas. And really, I guess we can probably break them into two types -- what might be called minor league problems, problems, for example, revealed in the management verification visit, such things as not providing adequate feedback to applicants. And there was a question at one time about the number of vacancies on staff and the lack of an evaluation director and a number of other problems.

There were also major concerns, some of which were not entirely resolved as of our site visit. And we have some recommendation as to that these perhaps ought to be watched.

Among the major concerns as I have characterized them, there were really five. One question that arose was with regard to the future of the coordinator or director, Donal Sparkman, of the Alaska Regional Medical Program who has been apparently a very strong leader in the region since it became active. He is approaching retirement age. He has indicated to us that it is an option that he is not going to pick up and that

he will be able to continue to provide leadership.

Part of that whole package in terms of leadership, of course, depends on the appointment of a rather strong deputy director. And we have received assurances that this, too, would be done and that such a person is presently being sought.

There was a legal concern raised, legal in terms of RMPS policies and procedures, with regard to the memorandum of understandings which the RAB staff have been drawn up with the grantee organization, University of Washington Medical School, in that the memorandum of understanding includes a statement which in effect says that the RAB can override the grantee should the grantee decide to fire the coordinator.

And staff called that to the attention of the RAB, an it is one of the things that should be called attention to in the advice letter. And staff should look again at that at some point in the not too distant future to see that it has been corrected.

There were reports about a possible degree of competition between two health education type activities in the Washington/Alaska region. One of them, one that was established first, called the WAMI program -- that's W-A-M-I which stands for Washington/Alaska/Montana and Idaho -- is a cooperative program in which medical students can come to the University of Washington for part of their clinical training and

then go back home, and the whole idea being to sort of centralize this kind of activity on the medical student.

When the local RMP came up with another HSEA program a little later on and sought cooperation of the grantee, there was some difficulty there. There remains some uneasiness on this point, although we were confident after talking with Dean van Citters of the Medical School and the staff -- we had, I think, some very helpful open and frank discussions with him on these problems -- that it wasn't a problem that couldn't be resolved. There have apparently been very good relationships between the grantee and the RMP.

This seems to have been the only problem that can be really regarded as a significant problem that has evolved in the 6-year relationship between the two bodies. And it is not one that we necessarily see as jeopardizing the relationship at this point in time. But again that is something staff ought to be aware of and be mindful of.

There was a concern about the degree of planning input that was being received from the CHP agencies. And considerable discussion centered on this point. Representation from the Region 10 office was on hand.

Apparently the blame for the problem rests in both parties, both the RMP and CHP. The CHP has not been responding, making appropriate meaningful kinds of comments on materials as they come to them for review. And the RMP has not felt it

necessary, apparently, to give the CHP sufficient leadership or respect on their commentary at all. And there has been this kind of emotional friction between the two.

Again, our feeling was that an advice letter to the RMP or an item in the advice letter to the RMP, on this matter would help to resolve the problem.

It was also my feeling that some similar step should be taken on the other side of the confrontation to get CHP's cooperation a little better. And staff assures us this will happen to Region 10 staff. It is going to be resolved that way.

Another kind of major problem we got involved with the Washington/Alaska program centers was on the lack of any real comprehensible system of arranging operational requests, of establishing priorities.

Now, apparently prior to the visit, some serious thought had been given to this between the time of the application and our actual site visit. And some more thought had been given to this.

We did spend some time with staff in which period a system was described to us. And admittedly, it was a new system, somewhat complicated in some respects, but nevertheless a system. Whether or not it is workable, will be workable, is something to be proven in time. And again we are advised that this is something that staff might look at.

These were the major problems. The other problems I mentioned that evolved from the management review team, problems on feedback letters to applicants, problems on the structure of the review bodies, etc., were for the most part to the best we could determine -- and we sort of subcommitteed ourselves to deal with these issues -- were resolved by the time of our meeting.

We ranked this particular region -- and I say we -- the site visit team ranked this particular region. And most of the site visit members, by the way, had not had the opportunity to do this before and had not had any in-depth background information on the region. And even so, from our own independent observations and inquiries and conversations with staff and others who had been participating with the RMP, we ourselves came up with a pretty high rating. And in talking to some of the staff, I understand they rated themselves a little bit lower. But nevertheless, this has been a pretty good region as far as we could determine in our investigations.

They are requesting funding for a triennial period, 06, 07, 08 years. Their requests are recorded on some of the materials here. This document has a good brief statement on it.

For the 06 year, $3,173,000.

07, $4,480,000.

08, $4,421,000.

Our recommendations are that for the first year, 06 year, $2,500,000. $3,000,000 for each of the subsequent years. And we have not involved ourselves at all with the 910 application centering on the Fred Hutchinson Cancer Center there and have accepted their requests as they stand.

I can best proceed from here on the basis of questions which you might want to hold until after Dr. Luginbuhl has made his comments.

By the way, the handout I gave you tends to break those figures down and make it more easily assimilatable.

Did everyone get one of these now?

DR. LUGINBUHL: I followed the instructions laid down by our chairman, and I went out trying to smell out the problems in this program. And in looking over the material in the meetings prior to meeting with the group out there, I made a list of areas that I thought we should dig into. And they included program management, planning process, program evaluation and the budget. I will comment briefly on each of these and try to be quite brief because I think you did cover them, too.

As far as program management is concerned, Dr. Sparkman is due to retire. And he was allowed to stay on one year on the basis of a waiver by the university. And the head of the RAG and Dr. Sparkman seems to feel that he would be allowed to stay on indefinitely on an annual review basis.

I did have the opportunity to discuss this with the

dean of the medical school, and he told me that it was with some difficulty he got this clearance. And I think this is an unresolved question therefore and probably should be addressed.

There was also question of the continuity of leadership in the RAG in that the chairman appears to be a very strong individual and very capable, is up for reappointment. And I think they have a limitation on reappointment. He, however, felt that there were other people that would provide continuity. And, indeed, there is a waiver provision so that he might be reappointed.

My impression was that it had been a very strong group and there were a number of individuals who were very important to that group. But there does appear to be the potential for continuity.

The planning process, as Bill said, we did pursue in some depth. And I think none of us were completely convinced that the planning process is as well coupled to the program goals and priorities as we would wish. I for one got the impression that they have set up goals and priorities, but when it comes to approving projects, they do this and then sort of relate them back to the priorities after the fact.

I feel that is an area that does require continued attention.

As far as evaluation is concerned, they have put a lot of effort into evaluation. I don't think they have solved

the problem by any manner of means, but I was impressed they were making some real progress in this area.

Do you want me to talk about budget now in more detail?

MR. HILTON: Yes.

DR. LUGINBUHL: The budget for the three-year period as submitted was a total $12.1 million. And the first year was $3.1 million, the second and third year were each approximately $4.4 million. The budget in the current year is $1.8 million.

I for one and I think other members felt it was virtually impossible to adequately analyze a budget of this magnitude in the time allotted. But we did the best we could.

We really felt that we would have to almost delve into some of the individual projects and review some staffing and staff assignments to tell whether that is a logical budget or not. And we just simply couldn't do that as you all can well imagine.

We reviewed the proposed new positions and reached the conclusion these might be well reduced, especially considering the number of unfilled positions.

We also felt that funds could be cut from the proposed developmental aspects. This conclusion was reached in part by the realization that these developmental activities were designed to yield an increase in the second year of

$1.3 million in new project activity. And this could almost certainly not be funded even if developed.

And we did review their ranking of projects. And some of them had a low priority. And we felt that they could well be reduced. And therefore, we made a cut in that area as well in our thinking.

Using this approach, the budget for the first year of the triennium of $2.5 million was recommended and budgets of $3 million for the second and third year were recommended, recognizing these latter years would be subject to additional review.

The increase of approximately $700,000 between the current year and the coming year was thought to be a generous award and one that would tax the capacity of the program.

In summary, I thought it, from my limited experience, seemed to be a pretty good program and deserved encouragement. The strength had been because of the staff and the leadership of the board. There were deficiencies, and it was impossible to really deal with effectiveness of individual projects.

We did feel that they could handle additional funds, but certainly not the amount that they requested.

MR. HILTON: I guess we could hold staff comment and handle questions.

DR. SCHMIDT: Let's go ahead, then. Are you prepared to make a motion at this time to get something on the floor?

MR. HILTON: I would move then our recommendations of $2.5, $3 and $3 million for those three consecutive years.

DR. SCHMIDT: $2.5, $3 and $3. Now, this is exclusive of the 910 projects. That is not a part of it.

MR. HILTON: Actually, it includes the 910 projects.

MR. MOORE: No, no. It includes the developmental component and kidney projects, but not the 910.

DR. SCHMIDT: It does include the developmental?

DR. LUGINBUHL: And the renal.

DR. SCHMIDT: And renal, but not the 910.

MR. HILTON: Not the 910.

DR. SCHMIDT: Then, you are seconding the motion?

DR. LUGINBUHL: Yes, sir.

DR. SCHMIDT: So that we do have a motion on the floor.

I will do three things very quickly. I want to remind the committee of your rating sheets, these big long things.

The other one is to welcome Phil White.

Welcome, Phil. It is nice to see your face in the room.

The other one is just for the fun of it. I spent part of last week with Dave Rogers, a good friend of RMP. We had him out for visiting Professor of Medicine. Those of you who know what he is doing know why we had him out as visiting Professor of Medicine.

(Laughter.)

And we spent a fun evening drinking and talking. And a good part of the conversation revolved around what I think has become a kind of a legendary site visit -- the first one in Washington/Alaska where Dave went and Martha Phillips went, and I was there. And this was a magnificent visit. I still start shaking when I think about it.

But he spent a great amount of time talking about Washington/Alaska, that visit and RMP.

The floor, then, is open for comments or questions.

Joe.

DR. HESS: I would without knowing a great deal of detail about the program, but accepting your evaluation as a quite good one, concur that the recommended increase of $700,000 a year is a fairly generous one. And I am wondering about the further increment of another half-million dollars in the second and third years.

It seems to me that is a rather substantial escalation for a region who though it has problems probably is at least in the middle range as you look nationally of resources and geographic and other kinds of things which get in the way of delivering health services.

And I wonder if you might comment a little bit more on your rationale for that steep an escalation.

MR. HILTON: Well, Bill has done an excellent job,

I think, of recounting much of the thinking of the committee as we struggled with this item of budget in terms of some of the elements he mentioned -- reasonable projections as we saw them, really looking at what they wanted, really looking at their ranking systems, and in effect in terms of our, for example, projects budget, working with their recommendations and shaving that back somewhat.

You mentioned the cost element because of the resource I think it was very much impressed on many of us that this region does have some pretty excessive costs because of the broad expanse of land territory. And their emphases are upon not only accessibility which I guess would account for a greater -- in fact, which does account for the greatest portion of their budget, but they also have taken into account acceptabilit of health care which becomes very important in terms of the diverse kinds of populations they are trying to serve in Alaska and elsewhere.

And they do have some considerable extra costs. It takes them three days travel time to come to a RAB meeting, for example. They don't have as many RAB members from Alaska becaus of the transportation problem largely.

Those kinds of things in addition to as careful a study as we could make in time, although their projects and their staffing requirements really led to that kind of --

DR. HESS: My question is can you justify a half a

half a million dollars a year further escalation for those kinds of things?

DR. LUGINBUHL: Let me say at the outset I really don't feel that I could go through this budget either in the first of the three years or in either of the subsequent two years and justify it in the kind of detail that I wish I could give you. I simply don't think you can take a $12 million program and in two days break down a budget in the kinds of detail that I would like.

I think that we concentrated on the first year. And we did make a very concerted effort in the time allotted to build that budget up by looking at the staffing pattern, by looking at the kinds of projects that they had ranked, and those that we thought could be eliminated, what they might reasonably be able to expand, and so on.

They were very ambitious about expanding that program, and they felt that they would put a great deal of effort into the development of new projects in the first year and then ask for money to carry them out in the subsequent two years.

I would say that our $3 million figure, the half-milli dollar increase, is going along at this stage with their hope they can expand their activities. I would regard it as a very tentative recommendation. It is one that I certainly wouldn't want to have firmly set at this point in time.

And I can only make a recommendation for any number

with the understanding it is going to be reviewed. And I think when it is reviewed, particular attention has to be given to what kinds of new projects they develop that they then want to fund in the second and third years. I certainly don't feel that that should be a firm figure at this point in time.

DR. HESS: We ought to do something about it because that recommendation is a firm recommendation.

DR. SCHMIDT: John.

DR. KRALEWSKI: I am concerned over that budget also. And I was wondering if you might provide us with a couple other pieces of information that might help to evaluate it.

One, I would be interested in whether or not they have some unexpanded funds for this year that might be carried over.

Two, the question over their core staff, the vacancies they now have. Will they be able to fill those and will they be able in your estimation to then add the people that they are hoping to add to expand it to this budget?

And then, number three, their record of phasing out projects. Are we funding here projects over a long period of time or are they phasing out the projects or are these new ones? And are there a large amount of new ones and are they all solid projects?

MR. MOORE: Yes. In answer to the first question, we were told they would be zero balance. They would not be

carryover funds.

DR. KRALEWSKI: How can there be with all the vacancies they have?

DR. THURMAN: They rebudgeted. That is what Judy was talking about all morning.

DR. SCHERLIS: They knew you were going to ask that question.

MR. RUSSELL: Historically, this program has managed their finances extremely well and have because of discretionary funds the flexibility RMPs have who have very consciously and carefully budgeted their unexpended funds which because of their good management processes, they have been able to look down the road and see what was going to lapse when and where and plow that money back into the programs.

MR. HILTON: On the question of phasing out, they do have a pretty good history of gathering continuing support. We had one question about one project, No. 5, which apparently has been or will be by a set date in fact effectively phased out. We had some question as to some of the resources that might show up in another project further down the road.

But they have been pretty successful in getting continued support for projects.

You also asked a question about core staff. And as I recall our deliberations on that, I can only say that I would imagine the site visit team was confident in the ability

of the leadership there to fill the position. We didn't give them as many positions as they wanted. We were reasonably confident they could fill the ones we allowed them to have.

MR. RUSSELL: There are a number of candidates under consideration now for the deputy position. They have been actively recruiting.

DR. SCHMIDT: John.

DR. KRALEWSKI: Can I follow that with one question?

Under your plan here, then, how many positions would they have to fill this coming year?

MR. MOORE: We were told that within two months they would have the depty director, the director of professional education, and the director of medical services. So there would be three positions, top positions, filled within two months.

DR. KRALEWSKI: How many additional positions would be in this budget?

MR. MOORE: The additional positions below directors grade, I believe, are around 15. And most of those are in community health services, spread out in Spokane and Alaska, to be above those subregional offices.

DR. SCHMIDT: Bill.

DR. THURMAN: Could you give us just a little bit of a rundown on the relationship of the Fred Hutchinson Cancer Center? I think the only reason I ask it, and I think it is

pertinent, is that over a quarter of a million dollars and going up each year of this budget is for relationship to it. And probably more than that if we really knew.

MR. MOORE: The direct relationship to it is the 910 application which is $66,000 which would provide the Regional Cancer Council --

MR. HILTON: Are you asking about the background of the center?

DR. THURMAN: No, how this relates to it. Because I think if you look at several things down here requested for 06, 07, and 08 and add them up, they are half a million dollars which basically is going to go into the Fred Hutchinson. Do we understand how that is going to work or is that just down the pike?

DR. LUGINBUHL: Dick.

MR. RUSSELL: The 910 figure shown there represents the support of the Regional Cancer Council which will cover more than just the State of Washington. We advised the Washington/Alaska RMP that we did not think it would be appropriate for the Washington/Alaska RMP to support totally the Fred Hutchinson Cancer Research Center, that Regional Council.

Does this help any?

DR. THURMAN: It helps some, Dick, but there are other things like Project 52 that really basically are going

to be Fred Hutchinson Cancer care. And they are worth a quarter of a million dollars right there. Yet we don't have a building yet, do we?

MR. RUSSELL: No, not yet. The status of the building is that we funded the one phase of it which is worth $5 million. NCI has just recently approved, and their award is expected soon for the rest of the building.

So, no, it is not up yet by any means.

DR. LUGINBUHL: Could I ask a question?

DR. SCHMIDT: Are you asking what the relationship is of the RMP program funded projects in cancer?

DR. THURMAN: Related to the Fred Hutchinson.

DR. SCHMIDT: To that upcoming center. In other words, is a good part of the dollars going to the Washington/Alaska Regional Medical Program going in point of fact to be spent in that center?

DR. THURMAN: Right. And that is why I think it is pertinent. Because going back to Joe's initial question, they are asking, and we are projecting, a very large slug of money. And yet we really don't have any bricks and mortar on which to spend the money. That is a little bit nebulous.

DR. SCHMIDT: Those are new projects that you were adding up?

DR. THURMAN: Yes.

DR. LUGINBUHL: I don't think it is correct to say

we are projecting funds specifically for the Fred Hutchinson Cancer Center in that we simply gave an overall recommendation. And I would point out that we did cut $1.4 million out of the second year and the same amount approximately out of the third year. That was obviously not a categorical cut; it is a general cut.

I would like to ask a procedural question and that is if we approve tentatively a $3 million figure, what is the further review that will occur?

DR. SCHMIDT: I was going to make this point in a minute in regard to what Joe is saying. The dollar figure that we put on is in effect a ceiling. And unless Council would override our recommendation, the $3 million for the subsequent two years becomes a ceiling which they could not exceed.

DR. LUGINBUHL: It is a ceiling or a floor?

DR. SCHMIDT: It is a ceiling and not a floor. There is really no floor. The floor is set by the availability of funds which is the first one.

And then, secondly, when this comes up, there will be a staff anniversary review of the application. And staff will make a recommendation. And we have later on some recommendations coming before the committee.

And staff, of course, is guided by the instructions given from the site visits and review committee and is guided by the concerns expressed by the committee during this discussic

DR. HESS: Just as a matter of further emphasis, I don't think we ought to take that ceiling too lightly. Because what it says in effect is that if there is enough money to go around and do everything that they could be funded up to that level. And I think the question that we have to -- or one question that we have to -- be concerned with here as we are trying to look at the country nationally is not just do they have a good program and would these things be worthwhile doing, but in relationship to all other programs countrywide can we justify spending this much money for this program?

The site visit team goes in with a narrow view, and we should take the broad view when it comes here to this table. And it is from that base that I have some serious reservations.

DR. SCHMIDT: There is a real trap here, though, and that is that the committee must act consistently. And I will listen very carefully for the committee's actions over a two-day period because if the committee looks at one region and has that in mind and then tomorrow morning after a night's sleep and so on makes judgments without the total number of dollars available for the country in mind, then really there is an inconsistency in the committee actions.

And the business of reviewing and making judgments by merit kind of irrespective of availability of dollars is something that Dr. Margulies talked about a little bit this morning.

The decision as to the allocation of what funds are available, of course, is made at a level superior even to the Council. And there is some balancing here between regions, depending on availability of funds.

DR.HESS: I don't disagree with what you are saying. In most respects, Mac, we don't know. We won't know tomorrow what the availability of funds is. But I think there is a kind of a general feeling or balancing that we need to try to do here in terms of looking at both the quality of the RMP staff and the elements that go into the program, the needs of the region, the relative resources which they have, and so on.

And as a general practice in order to be consistent, I think we ought to be trying on a national basis to channel the most help to the regions which have the greatest number of problems. And it is that kind of balancing and consistency which I am arguing for. And I certainly agree that we ought to be consistent, but I think consistent with the broad picture in mind, what the overall goal is.

DR. SCHMIDT: Well, let's see -- Leonard.

DR. SCHERLIS: I was interested in one particular project -- the patient care appraisal and continuing education one. Because over a three-year period, that absorbs well over $1 million. And although I don't like to review small projects, I think in view of our discussion earlier today about peer review and quality control, I would be very interested in this.

It is sponsored, I think, by the medical society.

I was wondering what sort of a progarm it is. It is a million dollars, and I think it is worth spending a little time on.

MR. HILTON: I think we broke ourselves down into committees, and it seems to me we had some discussion on that patient care appraisal. And I am not certain now, Bill, in my memory, who handled that.

DR. SCHMIDT: Ceci.

MISS CONRATH: This is the implementation on the statewide basis on a program that has been going on for about three years. This is the plen ground approach, the tri-cycle approach of physicians within an institution determining what criteria they are going to use for quality of care, looking at records and determining deficits, implementing an educational program and evaluating results.

The State medical societies became very much interested in it and has undertaken this as their major activity.

About two years ago, they passed a resolution for assessing a portion of the annual dues -- namely, $10 per member per year -- to help underwrite the expenses of a continuing education program that has as its goal improvement of patient care. And this is their major program thrust.

This is probably the most extensive program in the country in terms of implementing on a statewide basis this

plen ground approach in community hospitals throughout the State.

Alaska is also interested in this and plans next year to implement it. They have a core of faculty; they have probably one of the most thorough community organization schemes in the country to really test out the principles of this approach.

DR. SCHMIDT: Leonard, do you want to push that a little more?

DR. SCHERLIS: Only if any other information is available. Perhaps you could comment in the view of our discussion earlier today how this fits in with H.R. 1.

DR. SCHMIDT: Let's see, do they have plans to extend that or relate that to what must come along in peer review or PSROs?

MISS CONRATH: This is the first cut of peer review. Itis a peer review apprcach. And it probably means that Washington would be able to move, depending on how PSRO evolves. They will have a cadre of people who are more sophisticated in terms of peer review and also in terms of criteria setting than is true in other places.

DR. THURMAN: Ceci, do they have an EMCRO in addition to that?

MISS CONRATH: I don't know. I don't think they do. This is the culmination of about three years of work

with the State Medical Society, the School of Medicine, and RMP. There is a film on it that has been used, I guess, in about 25 States -- on the patient care appraisal. We saw portions of it.

MISS ANDERSON: Does it include the other health professionals, Ceci?

MISS CONRATH: They are beginning to in the last six months through Larry Hulbert and the group. Both nursing and allied health are involved and some other projects -- namely, the laboratory projects -- have long-range plans to interface with the projects. At the moment, it is physician oriented, but the continuing education program in nursing is patterning its approach on this particular program.

DR. SCHMIDT: Mrs. Flood.

MRS. FLOOD: I have a question to ask in regard to that particular project, too, with respect to the $3 million within a three-year period. Have they developed a mechanism for the continuation of the program without RMP support?

MISS CONRATH: Namely through the Washington State Medical Association through the membership dues. How this is going to work out, I don't know, but it has already got about $35,000 a year going in through membership dues about the last year and a half. How it goes in from this point on, I don't know.

MRS. FLOOD: Up to $375,000.

DR. ELLIS: That is just about one-tenth of what they need to operate in the year.

MISS CONRATH: This is the beginning.

DR. SCHMIDT: Joe.

DR. HESS: I have a process type question. And that is how did they through their goals and priorities arrive at a project of this type funded at this level?

MR. HILTON: We took them through the process on a couple of projects, not this particular one.

Would it be of help maybe if we went through the process as they do it generally?

DR. HESS: No. I was just curious. This is a very expensive project for this kind of thing. I am not arguing. I believe it is a very excellent type of thing to be doing. I am just questioning the amount of money that is going into it. And I am wondering if this in relation to all their other problems and needs is the most effective way to use that much money.

I am trying to use this as an example of their decision-making process to see how they arrived at a recommendation of that nature because to me it seems a little out of balance with what I would expect. And I just wonder if they had good justification for it.

DR. LUGINBUHL: As I said, we really did not try to

review individual projects. We did go spend quite a long time with them on their ranking, their mechanism of ranking. And once again, as I said earlier, I for one was not convinced that they had a sound coupling of their projects in all cases to their priorities and goals.

What we did with the projects, as I recall, is look over the list. And our feeling was that there were a number of projects that were either of lower priority or were very large in the amount of funding requested. And rather than try to make recommendations on them individually, we made an overall cut. And the overall cut was about $1.5 million per year in the second and third year.

But once again, I really don't feel that I could build up a budget for $3 million any more logically than I could build one up for $3.1 or $2.9 million. I am sorry, but I honestly don't think I have the kind of confidence in this figure that I would like or that you would like.

And I don't know how you can do it given the nature ofthe review process.

MR. HILTON: I am a little confused at this point on one thing. And, again, in the area of process, we talk about an overall, and it was indeed as Bill says, an overall cut. It is true that we did look at some particulars, but generally it was a figure that we shaved out. And we think we built in enough flexibility for the leadership of the program, looking at

program primarily, to handle.

With regard to any single project that appears on the printouts, there is no specific guideline. We could have had we the time gone down project by project and shown what was cut out or what percentage was cut out. But as long as there was an overall cut and as a percentage of one million plus dollars are extracted, I don't know what the decision of the leadership would be in the face of that. They don't know yet what we are talking about.

But we can't really say that this project, in other words, is going to cost that much. We didn't say specifically and have not made it known to you or to them that we are saying only 50 percent of their patient appraisal. Maybe they will elect that the million or so we cut out is the patient appraisal.

DR. SCHMIDT: Leonard.

DR. SCHERLIS: One or two questions.

In your feedback session or during your actual review site visit, did you have occasion to ask their leadership if they had set up a priority rating so if they got $1 million instead of $10 million or whatever the sum might be, that they were able to delete certain projects?

MR. HILTON: Yes.

DR. SCHERLIS: Did you have presented to you that priority?

MR. HILTON: In fact, we raised that several times because if you look at the application, it is somewhat confusing there. Their explanation which involved a system of attaching if I recall correctly numbers, weights and values --

MR. MOORE: A, B, C, high, low.

MR. HILTON: A, B, C, high, low. They have a system which they explained to us, and we asked for a sample of what would happen. And I do recall in this particular area, there was some concern especially on the part of Dr. Ogden that we were suggesting what the budget might be. And we tried to point out we simply wanted to see them go through a dry run of the project.

DR. SCHERLIS: Can I ask one more specific question about a project? And that is Emergency Medical Services which looks like a good system except it seems to be sponsored by the Tacoma Community College. And it isn't just training. It talks about setting up a total system, grading emergency rooms and so on.

And I was just curious, having had experience looking at various sponsors of EMS, this was unique, having a community college being sponsor.

Do you have any details on that?

MR. HILTON: What project number is it?

DR. SCHERLIS: 64, 064.

DR. SCHMIDT: Miss Conrath?

DR. SCHERLIS: I don't want to belabor the point. I just asked as a question of curiosity.

MISS CONRATH: I don't have particulars on that. But the plan in Washington is different than in many other places -- namely, the community college is a recipient for many community programs which are not training in which the community college system in the State of Washington undertakes wide, broad-scale community activities way beyond the usual. And in this case, I think this is probably what is happening. They serve as the sponsoring agency.

It is a much stronger community force than is true in many other parts of the country.

DR. LUGINBUHL: I think the most serious question about this program is a question about continuity of leadership. And if indeed Dr. Sparkman does retire because of university regulations and if indeed they do not get a replacement or even now a qualified deputy for him and if there is a significant turnover in the leadership of the RAG, then I would be very concerned about the level of funding. I frankly feel that the level recommended would be too high.

If these problems are not solved as we were told they would be solved -- we identified the problems, we discussed them, we were given assurances that they were being addressed -- if in fact they are not addressed and these basic problems are not solved, then I would feel very strongly that the funding

should be scaled down in keeping with their capacity. Because I don't feel that without continuity of leadership, they would have the capacity to expend this amount of money.

But once again, I visualized it as a ceiling, but certainly not as a floor.

DR. SCHMIDT: Joe.

DR. HESS: Primarily with concern for consistency with what we have done at past meetings and what we are probably going to do in the future based on past experience, I would like to offer a substitute motion for funding for this region, something which I think is more in line with what we have done in the past with regions of similar capability and similar needs as best we understand them under these limited circumstances. And that is for the first year, the funding be $2.3, for the second $2.4, and for the third $2.5.

That gives them a half-million dollars increment over their current level of funding which I think is a fairly generous one and a pretty good vote of confidence in the program and also gives them a gradual increment of dollars $100,000 a year over the next three years to provide for some expansion. Within those funds, they still have the flexibility for reallocating monies as they see fit.

So I would just like to offer that as a substitute.

DR. SCHMIDT: The dean here has a great ploy. He just whipped out a slide rule.

I installed a computer terminal in my office. And whenever I really don't know what to say, I whirl around and start punching my computer terminal. And usually when I whirl back, the person I am talking to has turned absolutely white.

DR. LUGINBUHL: We can't afford that.

DR. SCHMIDT: The computer terminal isn't hooked up to anything, it is just a computer terminal.

(Laughter.)

We have a motion on the floor, then, which I will accept as a substitute motion. Is there a second?

MISS ANDERSON: I will second it.

DR. SCHMIDT: All right, there is a second so we are now discussing a substitute motion of $2.3, $2.4, and $2.5. And I do two things in this case.

Assuming that the site visit team has looked at this very carefully as have staff, I ask specifically if anyone feels that there might be some breakage or some damage done to let the committee know about this sort of thing if they feel that this would do harm.

Mr. Dean, what does your slip stick say?

DR. LUGINBUHL: I don't think that the $2.3 recommendation for the first year would produce serious damage. I would be a little more concerned about the increase of $100,000 in the next two years. That is about a 4 percent increase, thereabouts. And I think that the escalation of costs would be

probably greater than that.

Their increase in the first year is based in part on a rather ambitious planning of new projects. And I think that if we gave them $2.3 and they then planned the projects and had $2.4 the following year, they wouldn't be able to carry many of them out.

I would be happier to see at least the potential for a greater increase in the second and third years, although I think the actual award should be based on an assessment on how they have done during that first year and whether they have indeed solved these potential management problems.

DR. SCHMIDT: Again, as we said, there would indeed be an assessment. And if these if's that you talked about did come to pass, then the staff review would surface these concerns.

All right, let me ask the staff if any staff has comments on the substitute motion?

MR. RUSSELL: I have been sitting here trying to separate emotional reaction and applying it to reality. I would just like to point out that this is a program that has had, I think, probably one of the strongest Regional Advisory Boards in the country.

The board has been deeply involved. They do make the decisions. Through the review process management survey, we have found out they do have very good management review processes.

They have responded to criticism in the past and have in the last, I believe it is, year, Ted, they have really expanded their community service organization.

MR. MOORE: Subregionalization.

MR. RUSSELL: And I guess I am saying I would like to see them get a little bigger vote of confidence. But I do think the concerns about this next year are valid, are real.

But going along with Dr. Luginbuhl, I would like to make a plea for greater movement in subsequent years if their plans do materialize.

DR. SCHMIDT: Bill.

MR. HILTON: I was just going to say, Mr. Chairman, I am following your suggestion and am not thinking about next year. And I am assuming that is what we are supposed to do in our review of all of these programs and to concern ourselves with the information before us which I think is more consistent with what has been the case in the past before next year looms so close to us.

DR. SCHMIDT: If what you are saying is we should not base decisions on a supposition of what might happen two or three years from now, I would agree.

MR. HILTON: Exactly.

DR. SCHMIDT: However, with the triennial review, we must make a recommendation for the three years of funding.

MR. MOORE: There are about six activities which --

DR. SCHMIDT: Use the mike, would you, please?

MR. MOORE: There are about six activities which they areplanning for 1974 which are not included in the first year's request. And these, of course, are patient care appraisal in Alaska, rural health care programs, hypertensive programs, Emergency Medical Services. So these and also health service education activities, they are moving very slowly as you heard earlier in the health service education activities. But with the first year's planning through various studies, they had planned to do some of these things for the second and third year of the triennial. And these are the things that really took up the half-million dollars in the $2.5 and $3.0.

So they are moving ahead in these areas for the second and third year.

DR. SCHMIDT: I think we are drawing to the time where we must begin testing sentiment of the group. If someone has some new point directed toward the substitute motion, they may have the floor. If no one demands the floor, I will call the question on the substitute motion.

MR. TOOMEY: I would agree with the dean. I think if we are --

DR. SCHMIDT: Would you use the mike, please?

MR. TOOMEY: I would like to suggest to Dr. Hess perhaps he might change his funding from $100,000 perhaps to increase the two additional years to $200,000.

DR. HESS: I would say at 5.5 percent increase annual something like that, that might end up $150,000, something of that nature.

MR. TOOMEY: I think that would be more reasonable.

DR. SCHMIDT: A 5.5 percent annual increment is what is usually calculated as the amount necessary to meet inflationary costs. This would not give them new program dollars probably.

MISS KERR: That is what concerns me in view of his statement in what they are planning in the years ahead that it is hardly enough room to move.

MISS ANDERSON: Wouldn't they be discontinuing some proposals?

MR. TOOMEY: May I suggest the 5.5 percent is on wages? And if you take the whole ball of wax as the Wage and Price Control Board has looked at it, you are closer to 7 to 8 as far as they are concerned, although I don't want to argue about the 5.5, 1.6, or --

DR. SCHMIDT: Well, we have got $2.3, $2.4, and $2.5. I won't accept another substitute motion. I would accept an amendment to the substitute motion.

If not, then I will call the question.

MR. TOOMEY: I would recommend it be amended to be $2.3, $2.5, $2.7.

DR. LUGINBUHL: I will second it.

DR. SCHMIDT: All right, I will accept that as an amendment to the substitute motion which is proper parliamentary-wise.

Any comments on that, then?

(No response.)

I think it is time to test sentiment, then. We are voting on $2.3, $2.5, and $2.7.

All in favor please say, "Aye."

(Chorus of ayes.)

Opposed, "No."

DR. KRALEWSKI: No.

MR. HILTON: No.

DR. SCHMIDT: To my ear, the eyes clearly have it.

I am running the motion through. I think we are done.

DR. KRALEWSKI: No, that was the amendment.

DR. SCHMIDT: Oh, that was the amendment, that's correct. So now we are to the substitute motion. That's right. Thank you. Which is $2.3, $2.5, and $2.7.

All in favor of that, please raise your hand.

We are voting now on the substitute motion of $2.3, $2.5, and $2.7.

DR. SCHERLIS: You have thoroughly confused me.

You control your faculties obviously by not letting them know what they are voting on.

DR. SCHMIDT: No, I write the minutes. That is where

I control them.

(Laughter.)

The original motion was $2.5, $3, and $3. We then had a substitute motion which was $2.3, $2.4, and $2.5. We then successfully amended the substitute motion to be $2.3, $2.5, and $2.7.

We will now vote. And if we adopt the substitute motion, the funding levels then will be $2.3, $2.5, and $2.7.

Is that clear?

DR. SCHERLIS: Yes, sir.

DR. SCHMIDT: Is it correct?

(Laughter.)

DR. THURMAN: Dr. Scherlis is suggesting you ought to hook up the computer.

DR. SCHMIDT: The chair declares that out of order and what I said to be correct.

Does anyone wish the floor before the vote?

(No response.)

If not, all in favor then of the substitute motion as amended please raise your hand.

(Hands were raised.)

It is nine ayes.

Opposed, no, raise your hand.

(Four hands were raised.)

Nine to four vote. The motion carries.

Thank you very much.

The question is do we need a special action on the 910? Who can answer that?

MR. RUSSELL: It is being considered as a separate application. Yes.

DR. SCHMIDT: All right, then, we have a separate thing to act on which is the application for funds under Section 910.

DR. THERMAN: Move their approval.

MISS KERR: Second the motion.

DR. SCHMIDT: There is a motion to approve that is seconded. Is there wish to discuss?

(No response.)

If not, all in favor, please say, "Aye."

(Chorus of ayes.)

Opposed, "No."

The ayes have it. You have your recommendation.

We will ask Phil to come up and join his old teammates at the table. And we will move on to Louisiana.

DR. SCHERLIS: Mr. Chairman, I would submit if you were to have a poll for that last vote that you just had, and I would urge you to ask that --

DR. SCHMIDT: I have a growing suspicion you are out of order, but go ahead.

DR. SCHERLIS: No, I question very much whether or

not the people who voted knew what they were voting on with that last bit. Would you please ask whether or not that is indeed so.

I, for one, abstained because I didn't know what the vote was about. Could you clarify what the 910 was?

Am I alone in that?

(Indications he was not alone.)

DR. SCHMIDT: If Mr. Hilton agrees with you, we are in bad trouble.

Would the primary reviewer please address the question?

MR. HILTON: No. I heard other questions like that.

DR. SCHMIDT: Well, I gave you all at least two seconds to comment.

MR. TOOMEY: Take a moment, will you?

DR. SCHMIDT: I will accept a motion from the floor to reconsider that if anyone wishes to make such a motion.

DR. SCHERLIS: I would ask for a point of information first to explain what it was, that last vote. I am not being facetious. There is some question here as far as what it includ This is the intent.

DR. THURMAN: Can I speak to that, Mr. Chairman, since I made the motion?

DR. SCHMIDT: Please do.

DR. THURMAN: I think the move for approval of the

910 application basically relates to somewhere between $66 and $89 thousand that is floating around in reference to organization structure and continuing communication for development of the cancer center concept. It does not relate specifically to construction funds or operational funds at the present time. And that was the genesis of my motion and the gist of it as well.

DR. SCHMIDT: Thank you.

Judy.

MRS. SILSBEE: No, he stated it very well. There are two separate applications in from this area, one having to do with the Regional Medical Program and the other a 910 having to do with this Fred Hutchinson Cancer Center that is now being constructed.

And in order to clear our books, we needed an action on that request which is for the first year $66,402, the second year $72,130, and a third year $75,346.

Our reason for asking for that is again shorthand. The site visit team didn't make a specific recommendation for funding with regard to this application, although they looked at it and talked about it. And we needed this action in order to clear our books.

DR. SCHERLIS: And this is not in violation of the Council's statement which said in addition except as outlined in discretionary funding policy, no special approvals are

required by an RMP program to carry out activities authorized by Section 910? This is not in violation of that?

MRS. SILSBEE: No.

MR. HILTON: Judy, I have a question. My figure for the first year, the 06 year, for the 910 was higher I got out of some of the documents here. I have a $86,000 figure. You said $66,000?

MRS. SILSBEE: You are probably talking about total costs. I am talking about direct cost.

MR. HILTON: Oh, I see.

MRS. FLOOD: No, there was one copy with $86,000, but that has been corrected.

MR. RUSSELL: Ted, wasn't that budget reduced after submission of the application?

MRS. SILSBEE: Where is Mr. Moore?

MR. MOORE: Yes, it was reduced half-time salary for Dr. Spielholz. So there should be an amendment in here with the $66,000.

DR. SCHMIDT: The figure is $66,402.

Does that give you the information required?

Really, my reading of this was this was something in a way we were at least politically committed to.

All right, we will move ahead then to Louisiana, Dr. Brindley.

DR. BRINDLEY: Louisiana, the region encompasses the

entire State of Louisiana, a population of 3.6 million. They have three medical schools. The average income is considerably less than the national average.

It has been an interesting complex to study. They made the original application in June of 1966. It was denied. They had planning funds in December of 1966. They asked for operational funds in 1968. That was denied. The second operation application was approved in August of 1969.

In November of 1971, we had a site visit. Dr. White was chairman of the site visit and will discuss that some a little bit later.

They related that they were impressed with the sound data base and that the planning framework was excellent but there were some deficiencies that we would like to show on the screen a little bit later.

The RMP is requesting $1,040,233 direct cost. This figure is $40,233 above the Council approved level for the fourth year. And although they were approved last year for $1 million, they actually received $738,818 for program staff and for projects.

However, in addition to that, they also were awarded $705,969 in earmarked funds for three EMS projects and four of the HSEA and a pediatric pulmonary project.

Now, the application for the triennial status was denied last year. They are not applying for triennial status

this year. They have indicated that they probably will apply for triennial status next year.

They did have a certification visit to the Louisiana Regional Medical Program. I have a letter of January 12 about that. The visit was made on December 14. I will give you a 12-word summary.

They thought everything was in good shape, and they recommended that it be approved. We can look at the details of that if you wish to.

A management survey visit was performed on November 7 through 10 of 1972. And a number of their items, we would like to discuss as we project some of these on the screen. But in essence, management seems to be good.

There does seem to be some room for improvement as far as program direction is concerned and perhaps in planning. But the management seemed to be good according to the survey.

Now, if we might show some of these, please.

(Slide.)

I have had a question about who the grantee was, and I will just mention that that in March of 1970, a nonprofit corporation of LRMP, Incorporated, replaced the Louisiana State Department of Hospitals as the grantee. There were some problems related to that. The corporation was governed by a 9-member board of trustees. They were not RAG members. And according to their bylaws, they seemed to pretty much have the

authority of decidingwho would be on RAG and what the monies would be used for.

Our first map up here shows the CHP B agencies that can see here. And we have four funded agencies -- New Orleans, Baton Rouge, Monroe, and Alexandria -- and three operational, but unfunded -- Lafayette, Shreveport, and Lake Charles.

Now, we will try another one.

(Slide.)

This shows the projects that have been terminated. And largely the conclusion is that it shows that the projects have been moved away from concentrating largely on New Orleans. Actually, nearly all of the projects were in the New Orleans area.

Next.

(Slide.)

Here are the ongoing projects thatyou can see. What is more, now we are becoming much more regional in distribution.

We have only one statewide project, but 7 subregional projects have been added.

Now, can we show the chart?

(Slide.)

This emphasizes the new projects. It does show the regionalization much better than we have had before.

Next chart.

(Slide.)

Now, Dr. White will probably discuss again in a few minutes some of the recommendations of their site review committee. But to relate to some of these as we go along, the first one, improved RAG involvement, Dr. White's group found that the RAG was not very much involved, that the grantee organization at that time was largely calling the shots and deciding who was going to actually be involved and mostly how their program might develop.

After this recommendation and after staff had been there and related these suggestions to them, three fundamental committees of RAG had been appointed -- program development, evaluation, budget and finance. There are a number of other subcommittees that have been developed also, but these major committees have been appointed. And RAG has become much more involved in the direction of the program.

The site committee did recommend revision of the RAG-grantee relationship. As I mentioned a while ago, this was not very tenable. The grantee group and especially the executive committee was largely controlling the membership on the RAG and the direction of the program.

Now, the grantee bylaws have been altered, and they have removed this restriction. And the RAG has become much more autonomous.

As a matter of fact, the evaluation groups that have

been there have said that now RAG does seem to be the group that is determining the direction of the program.

And in our management survey that went there, they felt this was even so good that it might be considered as a model, demonstrating the relationships between the three groups.

Dr. White's group suggested we should have increased minority representation. And it was not very good at the time that this group reviewed them. They have improved this. There now are five members of the minority on RAG and one on staff. And they have increased the assistance to the agencies serving the minorities.

There is still room for further improvement. We do not have enough either on staff or on RAG, but they are moving in the right direction and do show a recognition of the importan of this and of the intent.

They have recommended that they clarify the RMP/CHP implementing and planning agencies. Initially, there were not many funds in CHP and RAG took over the important planning group in developing the data. And they did establish a very firm data base and a planning program.

It seems important now that that largely be reversed and CHP would go more into planning as indicated and implementation be done by RMP.

RMP has indicated that it wished to take on this function and CHP actually has agreed to it and is cooperating

with them. They actually are the sponsors now of some of the projects.

Next.

(Slide.)

One of the criticisms was that it become more action oriented in their program. They had more planners than they actually did people who were developing on program. And that they needed to stimulate funds from other than RMP sources.

In improvement, we have noted that the staff now has four project developers and three planners. They have secured $131,000 of outside support, and they have assisted other agencies in gaining another $612,000 in Federal support which is a rather remarkable achievement.

It was indicated they need to refine their goals and objectives. The goals they had first were large. They did not have many subgoals. There were very few means of evaluation, time of achievement, how much was being accomplished.

They have five pages of goals in here which I can read to you, but they now are relevant and understandable. They do have systems of recognizing priorities. There is a good criticism there that there is no time frame.

And I think one also might recognize the deficit that there is not a good method of evaluation of program.

There are projects, but not too much of evaluating progress or program. However, it seems like nearly all RMPs

we review have that deficit, too.

Criticism was made they needed to develop more relevant action plans. And in response to this, there has been a reorganization of the committee structure and staff. About five more committees have been appointed.

The action plans now are developing in primary care, rural and urban health care delivery and reading to more relevant projects. Those are a little bit superficial. They areshowing intent to move into those areas, and they do have some projects that are related to them. But they are not really as comprehensive as they need to be yet.

Now, in improving RAG involvement, the orientation is planned for new RAG members to include a new group orientation. The criticism was made that the group really needed to find out more about what was going on in Louisiana and how they could relate to them. So they are having an orientation program and a site visit by RAG going to the various projects and programs and evaluating their progress.

They have added more CHP and consumer and minority representation. I told you about their forming three new committees.

In the $612,000 that have been gained in Federal support, these were related to the New Orleans areawide Council on Aging, the New Orleans Sickle Cell Anemia Foundation, the New Orleans Health Development in Charity Hospital to develop

a statistical program.

And the more relevant projects that they have developed, some examples of those, are the homebound rehabilitation program, the continuity of care demonstration, the extension of the Lallie Kemp Pediatric Outpatient Service -- this is a nurse program -- a family nurse practitioner program and a hypertension surveillance program.

One of their weaknesses is that some of their projects really don't fit into their new emphasis of their plans that they have outlined themselves such as the training program for CCUICC nursing personnel, the outreach counseling program for diabetics, the care and transport of high risk neonates and the Louisiana Drug Information Center.

They justify these as seeing that the peril of the high risk neonate is a very first priority. And if they can accomplish this, it will not only relate a number of hospitals to the program, but they think it will bring the private and charity hospital systems together in providing what they consider to be a very scarce service.

You have had a staff analysis. I asked Dona if she could help tell us about how they are going to pay for these programs after RMP support is concluded. And she has given me these impressions.

Ongoing programs: The Metropolitan New Orleans Organ Bank Charity Hospital will continue the service. State

funds in Federal third party payment. The Louisiana Health Date Information Center program, State Health Officer says his office will assume this resource.

Tumor registry coordination and assistance -- Well, I won't read all these to you, but they have means of providing support for most of their programs at the conclusion of RMP. And they have shown recognition of the importance of this and the necessity for having someone to pick up the bill. And I have all these documented if you wish to look at them.

The Louisiana Regional Medical Program does have two kidney disease activities that are included in the staff review. One of them was the Metropolitan New Orleans Organ Procurement Program. And this is a local organ procurement program centered around New Orleans. And it largely relates to their renal transplant service.

They are requesting $29,295 of direct costs or $41,344 total cost for their final year of support. And the review committee that saw them that was headed by Dr. Jimmy Roberts, the health consultant, thought this was a good program and that it probably would be worthy of support.

They did make the criticism that no significant efforts had been made to get third party reimbursement for the cost of the organ procurement.

The other one that they have is a feasibility study on mass screening for renal and urinary tract disease using

low radioactive renal scanning. And this is for $19,500. And the consensus of opinion is that this probably was not too good a program and perhaps shouldn't be worthy of our support.

That is included under core and $19,500.

Then, I have from Dona -- I asked her what they plan to do next year, and she has given me these promises for us to look at.

(a) They plan to demonstrate extensions of primary care services in medically under-served areas. And they have underneath that five ways.

They plan to have nurse extenders. And those are going to be research models of use in private care sector, in deprived rural clinics, and in urban neighborhood clinics. They are going to work with private care sectors, especially pediatricians, and they plan to have an outpatient ambulatory care in public health clinics as an extension of the Charity Hospital outpatient service.

They have access clinics around the parish health unit, and those would be related to the northeast Louisiana tri-parish model.

They plan to demonstrate the use of a Charity Hospital medical school resident in outpatient care in underutilized rural hospital. And that would be in April of 1973.

Mobile health clinics in August of 1973. And they have specific ways in which they hope to accomplish that.

And (b) -- that is their second major category -- they plan to demonstrate impact of expanded third party payer such as Medicaid. And they have PAR study, a State Department of Hospitals contract, contract with the Calcasieu Medical Society, and then next to the last in primary care strategy, they plan to look into program and develop a strategy for the care of the rural and underprivileged. They have the men indicated that will do this. That will start in December or January.

And quality assurance, they have both the project and the workshop that they plan to use to try to evaluate quality assurance and guarantee it improvement.

As a 12-word summary, it seemed to me that this is an area that does have great need, that has made significant improvement, that has responded to each of the recommendations of the site review team and is worthy of support.

They have requested $1,040,000. Council approved last year $1 million.

I do have a suggestion to make as soon as we have the other comments.

Phil, do you want to talk now or after Dorothy?

DR. WHITE: Why doesn't Miss Anderson go along?

MISS ANDERSON: I think you covered it very well. I would just like to mention the things that came to my mind while I was reviewing the material was their relationship with

CHP. And it seems like they are working a little better with CHP rather than taking over CHP's responsibilities. And their HSEA has been developed in cooperation with CHP.

Another area when we talk about minorities, I was a little sensitive to the fact that there are so few women on the RAG and so few women on the staff. And I think this is another area where they need to concentrate.

The projects are very good. Fifty-fifty.

DR. BRINDLEY: Did we mention the extra monies they got for the other programs?

MISS ANDERSON: No, I didn't. Go ahead.

DR. BRINDLEY: Phil.

DR. WHITE: I think I must be here mainly to lend some perspective to the Regional Medical Program of Louisiana. Your reviewers have given you the details.

I would like to give you a recall of my visit. I found myself -- and the other site visitors, I think, agreed -- in sort of an encrusted reactionary atmosphere rather than just a conservative one. And I think this is important to understand because it gave rise to some difficulties in the genesis of the Louisiana program to begin with and continues to give rise to some problems.

These comments are not meant to denigrate the State of Louisiana. This is just the way things were.

I think that Louisiana Regional Medical Program was

looked on with suspicion from the very onset and barely got off the ground. And I think Dr. Sabatier is probably the Christ figure for the Louisiana Regional Medical Program. He was the savior indeed and was acceptable to the professions and providers of health care at that time.

But even he was not stalwart enough to plunge into a great deal of activity. He felt that it was not wise to put too many burrs under too many saddles at the beginning and found an acceptance for Regional Medical Programs by casting it in the image of a planning agency, a data collecting agency. And he proceeded to do this. And by virtue of that, I think he was non-threatening in that area and therefore did indeed become acceptable to the area.

I think that even before our site visit, some members of the Regional Advisory Group had begun to recognize that it may not be playing the role that it should. Mr. Smith was the head of a committee at that time analyzing what the role of the Regional Advisory Group should be. And he is now the chairman of that group and I think will indeed implement the changes which are necessary.

At the time we were there, there was sort of a nebulous shadow-like multiple-headed creature in the background which we finally came to identify as the Regional ADvisory Group. We are not sure they knew what their role was. And they were not sure what their role was. And they were even a little

confounded on why they were there at the site visit at the time.

But Mr. Smith and a few others have taken leadership and at least from the written comments I have available to me have made substantial changes in the role of the Regional Advisory Group and I think are taking leadership.

I think their new structure clearly points out that they do have some dedicated members who will participate in the establishment of the program and hopefully evolving in the evaluation of the program eventually as well.

There is no need to dwell on the grantee relationship. This came out clearly in the site visit at the time. The grantee was sort of a patriarchal group that deigned to let the Regional Advisory Group meet from time to time, but not do too much. But this has been corrected, I think.

Minority representation -- there were some token representatives there at the time of the site visit. This, I think, has been improved and certainly needs improvement more, I think not only because it would be helpful to have their input, I think it would be helpful if some of these non-white met on some of these groups and found out the problems that one is confronted with in trying to get the changes made in the existing systems that occurred.

I recall my own amazement and consternation when I moved from a simple faculty member to the dean's office and began to recognize that maybe the dean wasn't the all-powerful

figure that we all thought he was and that he couldn't wave a wand and create changes overnight even though he thought he could at times. But I think it would be helpful for minority groups to sit on a Regional Advisory Group for that purpose if for nothing else.

It was interesting, as we discussed the role of the RMP and CHP on that occasion. Neither group really knew what it was they were supposed to do. RMP had effectively filled the role of a CHP, filled the vacuum that existed. We queried a number of visitors who really felt that this was the proper role for RMP, and they weren't quite sure what the proper role for CHP was. There was just no clear understanding of what this was all about or what the relationships should be.

Apparently there is still some confusion existing, although a coordinating committee is in existence which will help clarify their respective areas of activity.

I think Dr. Brindley and Miss Anderson have fully related to you the change in direction that has taken place. Their projects now are indeed more action oriented.

I did not recall with great clarity what the goals and objectives were in the original application prior to the last site visit, but on page 39 of the present application as was pointed out, there are a number of pages beginning on page 39 which outline their goals and objectives. I think they are clear, understandable and quite pertinent to the needs of

Louisiana. And if this does indeed form the framework for their action, they will forge ahead.

I think also that as they have reviewed their own projects, they have taken seriously the comments made in the advice letter and in other oral communications. They have clearly looked at each of their projects to determine whether or not they are relevant to the comments that are made in those letters and in subsequent advice. So they have taken to heart what was told them.

I think that perhaps we could be a little impatient with how they have expedited these suggestions, but I think the atmosphere has not changed that great. There may be a need for them to kind of subtly invade the care system in this State still and that perhaps a neonatal intensive care program of some sort will provide that without general threatening attitudes of any kind. Perhaps a drug information service will provide that and certainly the extension of the pediatric clinics, the nurse practitioner and so on will.

So although there may be some question as to the total relevance of some of their new projects, I do think it is a mechanism from which they can enlarge.

I guess the only exception I would take as to the CCU coronary nurse training which is something that you have been dealing with for years and years, and it doesn't seem to ever want to phase out, so perhaps somebody has to take the bull by

the horns and say no once in a while. And if that were so in this particular case they wouldn't need that extra $40,000 more than they requested above the ceiling Council suggested and they could get by on the $1 million.

Those are about my only comments. I would like to state that I have enjoyed being here today. I used to look forward to these meetings remarkably well, not because I enjoyed all of you so much, but the trips were always kind of exciting, theairplane rides.

One time I had lunch with Diana Ross. Another time I met with a Mr. J. C. Agergani who owns racing cars at the Indianapolis speedway. I think it was time before last I came in on one engine. And this time I was with a bunch of apparently Democrats for Nixon from Texas. And they were all coming for the inauguration. And there was a very festive plane ride.

The only difficulty was I happened to be sitting behind a rather generously proportioned lady who did not join into the festivities. And she promptly put her seat full back into my lap. And I was kind of sitting there unable to enjoy myself or the festivities and was thankful when we landed finally and she was able to put her seat back up and I got here.

It is nice to be here. Thank you.

DR. SCHMIDT: It is nice to have you.

The planes will probably be empty going home, I would

guess.

I am watching the clock because -- let me test the sentiment of the group on a very important issue. How many feel like they must have a cup of coffee in the next little while?

(Hands were raised.)

All right. Then what we will do, let's go ahead and get the funding level to meditate on while we go get coffee.

I would suggest that committee members get their coffee in cups and bring it back here and we keep working.

Dr. Brindley.

DR. BRINDLEY: We would like to recommend a level of $1 million for one year. We feel that is a considerable improvement over what was actually granted to them last year. It is only $40,000 less than they have requested.

And then they intend next year to ask review for consideration of triennial application.

So I would move that we recommend $1 million for them for one year.

DR. SCHMIDT: Is there a second?

MISS ANDERSON: I second.

DR. SCHMIDT: There is a second. Is there a wish to discuss?

DR. KRALEWSKI: I have one question. The supplementary funds that were given to the region this past

year was that just a one year?

DR. BRINDLEY: Those are earmarked funds, one year.

DR. KRALEWSKI: They will not have a need for those funds this coming year?

DR. BRINDLEY: They did not say that. They indicated one of the programs -- I believe that was the pediatric pulmonary program -- that Tulane University intends to apply for funds. And the Health Service Education Programs when funds become available. And then they may try to apply for those. But that is not part of the application.

DR. SCHMIDT: The earmark was a one-shot deal, and they knew that. So that this application is to cover that.

DR. BRINDLEY: They are not applying for any more funds.

DR. LUGINBUHL: I would like to ask about the leadership of this program. They have been active since 1966. They still do not have triennial status. It is obvious that there have been problems with this program from reviewing the material.

The amount of money they are requesting is $1 million for a population of 3.6 million. We just approved the Washington/Alaska program of comparable population at a much higher level, obviously a much more developed program.

In short, I am concerned that this population may not be adequately served by the organization as it now exists.

Is that actually the case, or are there reasons to believe that this will develop into a program that will really adequately serve this region?

DR. SCHMIDT: Phil, let me ask you to field that.

DR. WHITE: I was hoping to clarify that in my remarks that there has indeed been difficulty with this region because of the attitudes that existed. It has not been a lack of leadership, I don't believe.

Well, partial lack of leadership. Let me put it that way. It has been a lack of leadership by the Regional Advisory Group, by the citizens who were participating. I think Dr. Sabatier has been a good leader. I think the staff members that he has around him are good leaders, good in working with the groups, both the consumers and providers in the Louisiana area.

But there has been a lack of leadership. It has been at the level of the Regional Advisory Group and perhaps to some extent at the grantee level, too, and perhaps even to some extent at the medical school level, but not at the staff level.

I think that this is turning around. Clearly in my mind, it is. If we were to deny them what they have asked for particularly since the additional sums this year, $368,000 or something of that sort for the new projects, now are action oriented projects rather than data collecting and planning ones. But they would question our understanding of their problems, th

would question the seriousness of any advice that we sent them if they have indeed done what we told them to do and now we do not reward them by giving them substantial sums to do what they need to do.

DR. SCHMIDT: O.K., I see there is a need to discuss this, and I don't think we would be too well served by trying to jam this many people into the coffee place as they are trying to slam the doors. So we will adjourn now for going down and getting coffee. And I would ask the committee members to get it in a cup with a cover on it and bring it back. And we will try to reconvene here in about 10 minutes.

(Whereupon, a recess was taken.)

DR. SCHMIDT: All right, to recapitulate, then, we are talking about Louisiana.

We have a motion on the floor for funding level of $1 million for one year. This is essentially exactly what the Council recommended for this year. It is $40,233 below their request.

Dr. White pointed out one $40,000 project in there that wasn't all that exciting.

We were discussing the funding level. And the question has been raised as to the leadership. And the point has been made that the program leadership was really quite good. It was in a very conservative, more than conservative, atmosphere, meaning the problems went much beyond the program

staff leadership which has been quite good.

Yes.

MRS. FLOOD: I have some concerns about the minority and really down to earth non-knowledgeable consumer representation in the development of these great five pages of objectives and priorities that they developed. And whether the objectives and priorities are valid is probably not questionable.

Dr. White has assured me they are valid, and they do give a true picture of what need to be done in Louisiana. But my concern is then that the emphasis in apportioning funding to projects is questionable that it answers these needs that they have so well documented in their many years of data gathering. And if there was no input from minorities and consumers into the development of the objectives, then there is also no constituency to coerce or -- I won't use the word "coerce" -- to encouarge the Louisiana Regional Medical Program to spend their project dollars to answer the well-documented needs, especially in the urban poor. And the rural poor, too.

DR. WHITE: I think the point is a valid one. It was pointed out by our reviewers there was at one time practically no minority representation at all. These data were accumulated. These statistics were compiled at a time when this was an end in itself, I suppose.

There have been some actions taken to improve this,

I think, Mrs. Flood. There is at least some minority representation at the present time.

I think regardless of that, the most encouraging thing to me at least is it is no longer the staff of the Regional Medical Program which is defining what needs to be done, but indeed the Regional Advisory Group.

Now, as I was saying, it depends upon your definition of consumer, I suppose, as to whether you feel the Regional Advisory Group is consumer oriented. I think there are 17 out of 44 that are physicians, and the rest are in a variety of walks of life. So perhaps there is some consumer input at least to this. Perhaps it needs improving. And I wouldn't deny that.

I would like to point out, though, that these people have been rather busy this year. They were attracted by the earmarked funds, and I presume spent a considerable amount of time developing what were presumably first rate programs because they were funded for those funds.

At the same time, they were trying to reorganize their Regional Advisory Group and have substantially done that, but need to do more.

So that perhaps the projects which they are now presenting to us may have suffered from a lack of time and people in developing them as fully as we would like to see. I don't think this should persuade us they can't do it in

the future.

This is the beginning, at least. And I think a fairly decent beginning in view of the circumstances that existed.

DR. SCHMIDT: Any other comments or questions directed at the funding level?

(No response.)

If no one wishes the floor, then I will call the question.

All in favor please say, "Aye."

(Chorus of ayes.)

Opposed, "No."

(No response.)

That motion is carried.

Joe.

DR.HESS: I would like to suggest that along with this recommended funding level that we include our hope that there will be further vigorous development of programs which are more effectively addressed to the health needs of the people of Louisiana.

I reviewed the yellow sheets here, pages 10 and 11, things that were pointed out a year ago. And there has been relatively little movement. And perhaps that needs some reinforcement along with these recommendations to try to move the RAG and the other forces there that may be tending to

resist what Dr. Sabatier may indeed like to do, but can't because of the internal forces. And perhaps this would help that process along, try to bring this region up to a level of funding and the kind of activities they really ought to be engaging in.

DR. SCHMIDT: All right, that is approval with advice about the activities.

Dr. Ancrum.

DR. ANCRUM: This is not related to the funding; it is somewhat related to what Mrs. Flood, I believe, said.

I don't think RMP has defined what they mean by consumer for this group. And I think frequently it means anybody who is not a physician or some health profession.

And one definition I saw for another program was that a consumer meant people who were eligible for the services. So that maybe this might make it a little bit better. I think she is speaking more of grass roots consumer rather than having a retired banker who is not a health professional, but not the type of consumer she is talking about.

DR. JAMES: I could carry that one step further to be sure the consumer might sometimes be a provider. And it depends what role he is playing in the community.

DR. SCHERLIS: I think the best definition I heard that excluded provider was that by Dr. Spellman. I think you recall that. He said at best a physician really can't be a

consumer. At best, he is a sick provider.

DR. JAMES: In one of the programs that is included here today, I think there is a description of providers being consumers. That is in the role that they are playing on the RAG committee. And I think that often as I have looked through many of he programs in regard to minority interests that if it is a general opinion that the consumer who represents the minority must be a grass roots level who is not knowledgeable, I think that the RAG committee would be better off not having that consumer on the board.

But I would like to think that this committee would think in terms of minority consumers being those who are knowledgeable in the field so that they can best contribute. And that sometimes is a physician. He might be black or he might be an Indian or he might be a Puerto Rican. But he acts in that capacity as a provider and can then support.

DR. SCHMIDT: O.K., I would like not to get too far into a discussion of what is a consumer for RMP purposes.

All right, I will take one more comment.

MR. TOOMEY: I think I would just like to join the crescendo which is kind of a P.S. to the action that has already been taken and say in different words than Mrs. Flood and Dr. Ancrum that with the known needs that exist in the State of Louisiana, with the opportunities that are potential through RMP, that probably are short-stopped because of the inadequacy

of representation of people who are in need, that everything possible should be done to encourage the Louisiana RMP to expand its services because its rate of poor people, people in need who are underserved, probably are as great as they are anywhere in the country.

And I think as a P.S., there should be encouragement. The encouragement should come about in terms of getting a larger representation of people who can use the services of RMP. And I think that it is a shame to say, "Here is a million dollars, you are doing fine."

Perhaps it ought to be, "Here is a million dollars, now go ahead and do the work necessary to expend the $5 million.

DR. SCHMIDT: All right, I will accept that as a very valid P.S. to what Joe said that this is approval of a funding level with advice. And the committee has been discussing a number of points that should be conveyed to the region.

Thank you very much, Phil.

DR. WHITE: My pleasure.

DR. SCHMIDT: We will move on way up in the northeast part of the country to Connecticut. The reviewers are Dr. Scherlis and Dr. Ellis.

Dr. Scherlis.

DR. SCHERLIS: First of all, I should express a certain note of thanks for the various site visits that have

been arranged for me over the years. I think I am batting about 80 percent replacement of the coordinators after I have been in these areas.

And I guess among the notches that I have on my site visit sleeve would go North Dakota, Oklahoma, and as of this week, I guess, Connecticut. There is one I have missed, but that fortunate coordinator was better than you all thought so he stayed.

The visit to Connecticut was one which was really done with a great deal of fear and trepidation by some members of our site visit group.

DR. SCHMIDT: Pardon me, can you hear in the back of the room? If you ever can't hear, stick your hand up.

You have to kind of get within four or five inches of that mike.

DR. SCHERLIS: The members of our site visit group included Mr. Hiroto from L.A. I had the pleasure of being with him on another site visit previously to Hawaii. Miss Jackson, Mr. Noroian; from staff Mr. Van Nostrand, Miss Faatz who is Miss Connecticut of 1972 and 1973, Miss Woody and Mr. McKenna.

The visit itself was a very interesting one because the Connecticut program is a different program and not just by evaluation of outsiders, but certainly from the point of view of the group in Connecticut as well. And let me begin by

saying there is a great deal about the Connecticut Regional Medical Program which is excellent and deserves a great deal of commendation.

On the other hand, there were some aspects of it which had been subject to a great deal of discussion previously for reasons that I hope will become apparent as the discussion goes on.

A little reference was made before about some of the problems with Connecticut. And I think you noted its rating was bumped upward at a Council meeting. And this, I guess, bespeaks the fact there are difficulties in evaluating the Connecticut program.

We were there under rather unusual circumstances to begin with. And that is that they are operating within a triennium period having been approved by the Council for roughly $2.0 million for the fourth year, $2.3 for the fifth and $2.5 for the sixth. And they requested an increase in the Council-approved levels for the fifth and sixth years. And therefore the site visit was made.

The setting for our visit was the New Haven Lawn Club. The facilities were excellent. We were told as the visits began that we were there at the invitation of the Connecticut Regional Medical Program and we were there because of the fact that they wanted to enlarge their program along the levels that I have indicated.

It also requested a developmental component that I will get to.

And early on, we were reminded that the Connecticut program has, and these aren't words of my own -- these are words that the staff and the coordinator used in describing the Connecticut program -- that we were there because this is the only program in the country that set a grand design early on and that this grand design was really what was being presented to us to enforce by our approval hopefully of increased funding.

And this then was the import of the meeting to either approve or not approve the grand design. It became apparent very early on -- I just want to get some highlights before I get into the details -- that there was some disagreement in the State of Connecticut as far as the acceptance of this program. The State Medical Society was represented by an articulate -- I won't say an official -- spokesman, but certainly an articulate spokesman who when he was scheduled came to the head table with a suitcase. And there was a tape recorder. And he opened the suitcase to indicate the wealth of material which is circulated by the Connecticut Regional Medical Program. And this was quite a large suitcase.

And then he put on his tape recorder to indicate that he would use the tape recorder for his presentation. And I questioned whether the tape recorder was to be his speech or to

be a recording of his speech. I reminded him if we were going to listen to a speech on tape, I was prepared to leave my tape recorder there to listen to his tape recorder.

(Laughter.)

It turned out he wanted to document what he had said in some detail in case any questions arose.

Again, another representative speaking on a totally different project, the Emergency Medical Service project, at the conclusion of it stated he wished to use the time to make public his attitude towards Dr. Clark, the coordinator. And again began a rather strongly worded statement which I, using the prerogative of the chair, chose to stop, indicating it was not scheduled for this, and we would be willing to receive any statement in writing at the national office. I don't know whether you have received this statement or not.

He agreed this was the proper executive statement for the chairman to have made under the circumstances.

We had equally strong statements made by Comprehensive Health Planning agencies. There were two, each one of whom made very strong statements to the fact that the Connecticut Regional Medical Program was not cooperating with them, had not supported them, was not giving them an ear. And these were not just objectively given, but I think rather emotionally given.

It became apparent, though, in questioning them that

at no time had they really evolved any plans nor had they presented any plans to the Connecticut Regional Medical Program and that they were now being very well represented on the RAG group.

There were also just as strong statements made to support the grand design of Dr. Clark.

I am giving this introduction to indicate that people are not lukewarm in Connecticut about the Regional Medical Program. You are either for it or against it. And if you don't state one attitude or another, then you just don't know that there is a REgional Medical Program in Connecticut.

Dr. Clark has in his grand design divided the State horizontally so that one part of the State is allied with the University of Connecticut, referred to as UCON, the other with Yale, and thatmost of the hospitals in the State are now affiliated with one or the other by way of full-time coordinator. And in discussing the success of the program, Dr. Clark enumerates that over the years the numbers have grown as far as the chiefs are concerned and the hospitals are now approximately 55 and some 25 hospitals. And that as he points out, the troops are marching, the numbers are increasing, and this has been going on progressively over the last several years.

In terms of the goals as set under the design, there is no question that one would have to indicate that there has been an amazing success of this program. The number of full-

time chiefs have indeed increased, the number of fully affiliated hospitals working with UCON or Yale have increased. And he used this, as he states, as a threshold of fulfillment of local medical leadership based on community general hospitals.

And it is this program that he wished to have reviewed that he wished us to understand and become familiar with. He used community hospitals as becoming community health centers and that the local leadership would be based on creating local medical leadership by way of the chiefs in the hospitals and that they would be the new level of medical leadership in Connecticut.

He describes this as remarkable linkage of the university and of the various hospitals.

There are sequels to our meeting. One is I have received letters from the Connecticut State Medical Society -- Dr. Margulies received the original -- indicating that the words which were heard were, I guess, official for the State Medical Society as far as what was expressed at our meeting.

MR. TOOMEY: I didn't hear that.

DR. SCHERLIS: The Connecticut Medical Society forwarded a letter to Dr. Margulies stating their attitudes towards the Connecticut Regional Medical Program. They have felt that the needs of the State transcend just the full-time coordinators. They felt there are local needs they felt

obviously should be met and be given a higher priority than what the program has been to date.

Let me review our site visit draft because I think this will give a more coordinated presentation of some of the problems which came up.

As I said, the national reviewers have over the years been generally impressed with the concept of the grand design as I have outlined it, although there has been some obvious disagreement at times with it. But nevertheless certain criticisms were expressed in the past, and this was one year ago at the last site visit.

The suggestion was made that increased attention be given to the further development of outreach activities relating to primary care.

Other sources of funds be pursued with long-term support of university-based regional faculty. I have alluded to that.

That the core capabilities be strengthened and that in filling staff positions minority representation in the professional ranks should be given consideration. This has not yet, by the way, been done.

That the Regional Advisory Board and Executive Committee increase or change its membership to include active involvement of minorities.

That the Connecticut Regional Medical Program work

vigorously to improve communication with the Connecticut State Medical Society Comprehensive Health State Planning personnel. I have alluded to what has taken place over the years, at least as reflected in our meeting.

That a system for organizing the full-time chiefs be developed and that they pay increased attention to creating positive public relations.

I told you the reason for our being there. They wished additional support for the fifth and sixth year of the already approved Council levels for the triennial period.

Connecticut also wished this to be done, to look at their total program. We were there then to assess the progress they had made since the last site visit and that as I have said we review their total program.

The grand design has been their basic instrument for affecting change in the system of health care in Connecticut And they view their function as being essentially that of a catalyst. And there is no question that they have been somewhat successful in this regard.

Connecticut is divided into 10 health service areas. And basically by RMP, but this has now been agreed to by most of the other groups such as CHP, Hil-Burton, and so on. And the key to understanding their system is to understand the community hospital viewed as their base of entry into the system of care.

Over 40 percent of the basic program money is devoted to the support of full-time chiefs and university back-up. So this is a very heavily based university and community hospital program. It is a partnership between the medical schools and the various hospitals in the State. And as I have said, the State has been divided between UCON and Yale.

In this State, unfortunately, the Comprehensive Health Planning has been comparatively new and is just getting organized. There is a wide disparity as far as the effectivenes of CHP. And one of the criticisms which they have made is that they have not been given the documents to review in time.

There was an argument about the calendar on this. The RMP said yes they had, CHP said no they hadn't. And we have received a dossier of some exchange of correspondence which I won't have the temerity to judge as far as who was told what when.

Suffice it to say there could be better liaison and coordination of their functions.

They have set up full-time formal affiliation agreements between the community hospitals, the universities, and I need not remind those of you who are deans that this is a very significant support to university function. The cadre of university faculty which has been developed is large which would assist the affiliated hospitals. And the attempt to set these hospitals up as centers of excellence is really

the key to Dr. Clark's program.

Twenty-nine of the 33 community hospitals in Connecticut are affiliated with university centers -- 29 of 33. Seventeen with UCON and 12 with Yale. There were no such affiliations before the program. There are now 30 full-time chiefs receiving partial support which is up to $15,000 for three years. The total number of full-time chiefs has increased from 6 to 50 since 1968. And then these are usually phased out after a three-year period.

It should be emphasized that this is not just one per hospital. These in some instances get to be 2, 3, or 4 as the hospitals facilities increase and as there become increased demands for this.

Now, we felt that in evaluating this entire program, the only real evaluation one could give is the fact that the numbers are increasing. And there are bits of anecdotal information available. But there is no other evaluation which one can speak to. And this is, I think, trying to be objective about it.

The amount of money which has gone into the system is tremendous. In terms of saying what it has accomplished, what would have taken place otherwise, one can't say.

The affiliated programs do serve the universities well because they do give additional beds, provide for training of students, house staff, and by affiliation provide for some

degree of care on a stratified basis. I am sure it improves the hospitals themselves.

Whether or not this can be the prime mission of the Connecticut Regional Program is a significant question.

During the course of the discussions, Dr. Clark did indicate that he thought that the request for the remaining two years of both the university and community components were at their peak level in the next triennium would see a gradual decrease. There was some question about this, I think, in terms of how realistic this was in terms of the overall goals of the Connecticut Regional Medical Program.

Minority interests, I think, on RAG, it appears that there is somewhat adequate representation, but certainly no evidence that there is adequate minority representation in the professional group, no minorities in the professional program staff nor executive committee. And only one of the 24-member review and evaluation committee is a minority member.

I don't regard women as being members of minorities, but they are also inadequately represented. No inadequate persons of this sex are on that committee.

There is no question that Dr. Clark provides strong leadership. He has a very devoted, although small, but very strong program staff. And Mr. Morrissey who works with him, Mr. Bradley, these are very, we think, strong people.

The statement is in the site visit report that he is

personally dedicated to the successful implementation of the grand design. I would say that that is inadequately a weak statement of his devotion to the grand design. Dr. Clark really views the grand design as being what should be the model for RMPS.

And I was told this before I went there, and it certainly comes across as per his presentation of this. He is devoted to the concept. He feels it should be a model, that this is what RMP is all about, and that unless one understands the concept of the grand design -- and he was willing to come to Baltimore and spend some time with me to make sure that I thoroughly understood the grand design. And I don't mean anything more except that he is devoted to what in Connecticut has proved to be a very effective link. It depends on your judgment whether these are the primary needs of Connecticut and whether this should be of the highest priority of RMP. It has not been a successful organizational accomplishment.

The Regional Advisory Group does have six CHP representatives. We were concerned about the review process. There is a very, very, very strong review and evaluation committee which screens the projects, performs site visits, conducts technical and scientific reviews, determines program relevance and funding allocations and so well documents its suggestions that by the time it gets to RAG, I don't think anyone would have the gall to dare differ with any of the

recommendations of the review and evaluation committee.

And this was discussed in the feedback session because I think it is such a strong group and everything has been handled so effectively and the documents are so impressive, there is no way I think for RAG to really become as mature as it should in passing judgment on making decisions as far as what should go on in that area.

The grantee organization is Yale. And apparently this is satisfactory and in line with RMPS policy.

I have discussed the medical society in CHP. This is a very, very difficult relationship and one which has not been solved over the years. I think Dr. Clark's attitude that they are forming a new power base through the medical leadership of the community hospitals has to be taken as an attitude which he has to express in terms of what has taken place.

There were some projects presented to us that concerned us. There is an EMS program which is being formulated. They have gathered some good data, but in questioning the group -- and Yale has been very helpful as far as getting data for many of their studies -- it became apparent that their emergency system is almost purely trauma.

In asking whether or not -- and here my personal bias came out -- I asked what the cardiac input was to the Emergency Medical Service program. And there was a moment of silence. And then they stated they are still in the planning

stage, but along the line somewhere they would get some cardiac input to this.

Is this your impression?

MR. ROSE: Very much so.

DR. SCHERLIS: And their stating that they had probably done the best job of anyone in the country as far as evaluating services in the emergency rooms and so on.

I asked two questions. One, if there had been any feedback of any of that data to the hospitals. And they were thinking of doing that and hadn't decided if they would.

They had gathered data and really hadn't been able to make use of it.

So I think they have a long way to go, but apparently the people who are involved with this I think can with some planning money move along in that regard.

I should say that one of the CHP agencies, the South Central Agency, provided one of the best reviews we saw provided by any CHP agency. There is unevenness, but this agency was a very effective one.

There is a peculiar aspect of their developmental request. And that is that we had presented to us two projects by two individuals which were presented beautifully in terms of what could be looked at as model types of programs.

One for multiple hospital ambulatory pediatric care system, the other for hospital-based medical care system for the

elderly by two extremely knowledgeable groups. Dr. Markowitz was one group and then there was another.

I am wrong. I forget. Not these two. I forget the two who presented them. But both of these men were excellent. They presented their systems, and they have been introduced as presenting model systems which the Connecticut Regional Medical Program would then submit to all of the different hospitals in the State. And they would all come in and say whether or not they could handle it. And there would be some method of determination who would get the programs. This is how Dr. Clark had presented it.

But in asking each of these individuals, it became apparent that each was presenting something he was ready to do and set it up for his own area. And they were both upset that this was going to go out for others to bid on.

They really should have been submitted as projects and would have received the whole-hearted endorsement because they represented excellent outreach programs involving the potential and in many instances good community support. They had been excellently researched and had the potential for good staffing.

And it gets down to how you define developmental component. We did not think these were developmental component These should have been projects which were ready to become operational.

We spent two full days there. And I think the committee came away with, I hope, a full understanding of what the Connecticut Regional Medical Program has been and may very well continue to be unless there is firm indication that there is time to change from having 30 or 40 or 50 or 60 full-time men in the community hospitals and having most of the funding go to the universities and that this is a time where decision had to be made as far as changing direction of the grand design of the Connecticut Regional Medical Program.

And we made several recommendations at the end of our meeting which included the following:

Number one, they should reconsider the goals and priorities in terms of developing efforts in community outreach. This sounds like what they said a year ago. Although they had developed an excellent network through their system of university-hospital affiliations, these should not be supported further as far as any expansion is concerned, but the new programs were available as shown in both their supplemental and developmental components and that these should be supported in preference to their expanding university and hospital affiliation.

That they have to set up some criteria for measuring the effectiveness of the full-time chief system. I don't see how one can measure it, really, but they have to at least try to do something and get some data which they at least can say

means it has been successful or not.

That they needed a more affirmative action plan as far as employment and training opportunities for minorities and women.

That they should make their RAG more responsible in program decision-making.

That they should do and we suggested a task force as far as Connecticut Regional Medical Program and Connecticut State Medical Society because this is a must if they are to be able to affect that area.

And that their B agencies have to come into some agreement with Connecticut Regional Medical Program about details of logistics of review. And that their evaluation needed a better coordination.

We suggested some levels of funding which I don't want to refer to at this point.

I do have to give a follow-up which came to us as a surprise -- namely, that Dr. Clark submitted a letter indicating that he wished to leave his position as of May 1st and was willing to serve until that and to be an advisor after that until they got someone who could handle his position.

I don't think this really reflects on any hostility or animosity at the site visit. We certainly did not feel that way. We think that in Connecticut, and we told them so, the network he has set up is a most effective one for the mission

that he had defined and the Connecticut Regional Medical Program had defined.

I can't help but feel that the obvious need for this working with the Medical Society and with Comprehensive Health Planning, this probably played a role. Of course, this is no better off than it was before. And at an open meeting, it is embarrassing to hear the sorts of things that were said at this meeting by both of these groups and by others who would have liked to have been on the program to have expressed this.

I would like to leave it here and then give the sums recommended after there has been additional discussion.

Miss Faatz.

MISS FAATZ: Dr. Ellis is secondary.

DR. SCHERLIS: Oh, I am sorry.

DR. SCHMIDT: Dr. Ellis.

DR. ELLIS: I did not have the advantage of making a site visit, but I would like to just make a few comments -- maybe just really one.

I think that the grand design which really brings together the community hospitals with the teaching services does provide the opportunity for bringing about institutional change in the way health services are delivered to the poor. Because it will only be by utilizing the community hospitals that these kinds of people can be admitted in large numbers

to teaching hospitals.

In some of the States with which I am very familiar, one of the big problems in getting poor people admitted to hospitals is that you have no full-time staffs. We have nobody to take care of them. Medical education and health in general ispoorly funded. And so we can't take them.

I think we would all agree that this certainly is institutional change. And what we are simply saying is that the grand design could and must be extended to do some other things.

Now, I have listened to the wonderful discussion that Dr. Scherlis made and really can't add much there. But I have heard over and over again that minorities have not been involved in this program and in many other programs. And it is one of the things that I spent my time with every week, at least.

I think that maybe one of the things that needs to be recommended in addition to what we have recommended is that there be some special consultation on how program leadership that is not leadership of the poor or blacks or browns or reds or poor whites -- and we don't understand the culture -- on how we can communicate with those groups and actually find out what they are thinking and what their needs are. I really am not impressed that the kind of communication which takes place between the groups is done in a way that puts both the leadership of the program and the people being served in a

position so that they talk respectfully.

This is a serious problem. And I therefore would suggest the use of specialized people with special skills in cross-cultural communication to be brought in as consultants to the program director so that they can immediately move in the right direction.

Then, the other thing I thought it was interesting Dr. Scherlis brought it up, but he did not mention the kinds of things, you see, that we are still talking about like the need for health education in primary and secondary schools in the State. This is the medical push.

If you do not have community hospitals to whom these children can be referred for services, you don't get anyplace either. So it is just a constant up and down kind of thing.

DR. SCHERLIS: Let me respond to one point which you raise which was troublesome to me as well and to our whole group. Imagine if you will that most of the hospitals now are affiliated and indeed the full-time chiefs have been funded through Regional Medical Program. How wonderful this would be if you could utilize that network.

Well, Dr. Clark had about three of his full-time staff there who were working in the various community hospitals to discuss what they did in their hospitals. One such person spoke and obviously a very capable individual. And after he finished his presentation of how long he had been there and

what his hospital was like and how they had upgraded the level of care in the hospital, I said, "What is it that you do for which you are supported that really fulfills any of the Regional Medical Program aims in Connecticut?"

I would still be waiting for the answer. And it was embarrassing because the silence was absolutely formidable. I think it is the first time he had ever been asked what is the Regional Medical Program in Connecticut about. And this in many ways answers the question that you posed.

I think that the relationship to the community hospital can be utilized as one of the best networks I know anywhere in the country for really affecting outreach by the hospitals, for looking at a system of peer review in each of these hospitals to look at quality of delivery of care. It hasn't been done in this way.

These individuals in their own hospitals serve several functions. They attract house staff. They maintain training of house staff. Students rotate through. And they help teach the students. In one or two instances, maybe a few more, it may even be beyond this, but there is no attempt to even form these people into a cohesive group.

We suggested that there might be an organization of such directors working with Regional Medical Program to establish an organized basis when it would occur. The orientation isn't that way. The orientation is to have more

chiefs in the community hospitals affiliated with the universities. And it is sort of the university responsibility to seek out ones to work with them.

It doesn't take too much alteration to affect the sort of things you referred to.

DR. ELLIS: No, it doesn't. It really doesn't take much. It just takes an insight into how to program. You could pull these two things together very easily, I think, if you knew how to communicate with the people.

DR. SCHMIDT: Eileen, do you have any general comments before we do get a motion on the floor?

MISS FAATZ: No.

DR. SCHMIDT: All right, then, back to Dr. Scherlis.

DR. SCHERLIS: No comment, after all your years with Connecticut?

MISS FAATZ: No, I think you covered everything.

DR. SCHERLIS: If you differ, I wish you would so state.

MISS FAATZ: No, I don't.

MISS ANDERSON: Dr. Scherlis, did they show any interest in being flexible or adjusting their roles from the old patterns?

DR. SCHERLIS: We had a feedback session. And at the feedback session many of the positive points were referred to. The success of the full-time chiefs, the increasing

number, the good affiliation and acceptance of the community hospitals. This is an important aspect. They do accept and they do welcome this. There is no question they benefit as well as the universities do.

But as we pointed out to them, and I headed this in our site visit feedback as the dilemma of the site visit group, we cannot discern any attempt to set priorities as between the new programs which had been presented to us under the supplemental development component and getting more full-time chiefs. We wanted to know if he had another $500,000 would he get another 30 full-time chiefs or would he develop some of these developmental components or fund some of the ones that had been presented. And I guess we really don't know what he would do under these circumstances unless there was some firm indication.

We have no idea at what point in time he will say he has enough chiefs. Because those hospitals that have one would like to have two. And those that have two would like to have three. And those that have three would like to have four.

And the point that we made very strongly was that as far as our recommendations are concerned, we felt that the point had now been reached, and he was told this in the feedback session, that the medical schools and the community hospitals would have to find alternate funding as far as any expansion

of this program.

Now, as far as dollar marks, we have a dilemma. Remember, I said at the beginning we were there at his invitation. We were there to view the grand design because they wished increased funding. A lot of the increased funding could go to expansion of the full-time chiefs all thrown in with these other primary projects.

What we recommended is that they fund these new projects, not as developmental, but as real projects including the supplementary ones. But they do this at the expense of their full-time chiefs. So we recommended no increased funding, no developmental component, but that they with their same level fund the projects and no more chiefs.

And I guess the response, I guess Dr. Clark sensed that in our discussion. This may be the reason for the letter, Dr. Margulies. I am not privy to the exact reasons for it. But I don't think we should consider that in our decision.

DR. SCHMIDT: Let me be sure I understand now. The previous levels that had been approved were going up.

DR. SCHERLIS: Let me tell you the full recommendation

DR. SCHMIDT: Yes, let's have that.

DR. SCHERLIS: We recommended that for the five years, they receive $2,332,820 which is what had been approved before instead of the $2,737,000 they had requested. And because of the nature of our recommendation that they be site visited

again for the next year.

I did this knowing full well that the request might be that I would be one of those site visit crews. And that is not a trip I would relish. But under the circumstances since this does require a complete change in their program direction, we did not feel that they should have two years without a site visit. And so, therefore, the recommendation was for one year approval and that we come back before the sixth year.

I don't see how else we can move into this. The grand design is there, but it has to be altered if there is to be any change at all in direction of the CRMP.

DR. SCHMIDT: The Council recommended for year 02 $2,332,820 as you said. And then the next year $2.5 million.

DR. SCHERLIS: We are only going along with $2,332,820 with the significant recommendations that we have made as far as program change.

DR. SCHMIDT: With then a site visit before the $2.5 million year.

DR. SCHERLIS: Yes. I don't know how else we can handle that.

DR. SCHMIDT: Is that kosher now? They have been approved for the triennial.

DR. SCHERLIS: The Connecticut program is one that has excited a great deal of interest in both the review

committee and Council level, I take it. The point that even their rating gets bounced upwards at Council meeting.

If we approve for two years, there is absolutely no indication in sight that they would not continue as they have been, funding new full-time chiefs instead of getting involved with additional projects.

If you have another mechanism to assure this, such as a staff review, I would certainly prefer that to a site review. But now the fact that they are also getting a new coordinator may make it even more imperative they be seen at the end of this one year.

I would like to have some direction on this.

DR. SCHMIDT: I just want to clear the point is what he proposes legit?

MRS. SILSBEE: We don't have any precedents for this. But in relation to the reason the site visit was held this year, Dr. Scherlis, in terms of the fact that Connecticut requested developmental, that wouldn't automatically call for a site visit. The fact that they requested more money wouldn't call for a site visit.

Actually, the reason the site visit was held was because Dr. Clark requested it. And after much deliberation, we decided --

DR. SCHMIDT: Are you going to stick with the word "request"?

MRS. SILSBEE: After much deliberation, we decided the only way we could handle this request, knowing about his program, was to send a team up there to see whether any of the things that had been suggested in terms of change had occurred.

DR. SCHERLIS: Thank you.

DR. SCHMIDT: All right, Dr. James and then Dr. Luginbuhl.

DR. JAMES: There is something that bothers me in regard to what is afoot here. I hear you stating that there was a meeting with representatives from the State Medical Society, but he was not an official representative, he did not represent the medical society officially.

I wonder perhaps if there is not in this grand design an area of threat to the private practicing physicians represented by the State Medical Society that looks like there might be a town and gown takeover of the private practice of medicine that possibly could cause some anxiety among the State Medical Association people.

Yet, if what you are saying that the grand design does represent an institutional change in the delivery of health services, what is it all about?

And relative to a continuation of the old, if there could be some clarification of someone here today relative to what is the stance, s-t-a-n-c-e, taken by the State Medical Association and the CHP agencies and the other agencies in the

community, is it that the university and the community hospitals who are for the first time moving into delivering a community service, something that should be continued or is this something that offers a threat to private practice of medicine?

DR. SCHMIDT: If I might try to tackle that one myself, I think from the beginning the grand design was somethin that was held up by the Connecticut RMP as a model. And certainly Dr. Clark who really kind of devoted his life to this general subject of regionalization considered this to be the best way to go in Connecticut.

The Medical Society very early on did not necessarily agree. And indeed, they did look on this as a threat. And in the past number of years, there have been various number and kinds of steps taken by the Medical Society, including telegrams in requesting there not be any action until they had a chance to be heard. There have been special visits of the Director of RMP to Connecticut. There have been meetings up ther and so on.

And as someone said, the RMP really did do the whole thing for the State early on. And there was not a CHP in evidence.

What has happened gradually is that people got used to the grand design. The Medical Society and RMP are kind of settling down into some kind of a coexistence. The Medical Society is awkward about stating its case. And what really

happened was that the official representative didn't show at the site visit and the site visit team was a little confused as to whether they were hearing an individual doctor and chose to hear the doctor that did come as an individual rather than an official representative of the Medical Society because he had not been so designated and they were just left without this official voice.

CHP is struggling, and the grand design in a way umbrellas some of the things that ordinarily CHP would do.

I think that the site visit team is suggesting that the RMP must do some other things and not keep expanding this grand design in the way Dr. Clark might. And so we are obviously in the recommendation putting a stop to that, giving them strong advice that they implement new types of activities and do this with the funding that they might otherwise have used to further what indeed the Medical Society has in the past objected to.

The question you asked could be answered with the word "yes," but I don't think that anyone would necessarily imply by that yes that the Medical Society was right and the RMP was wrong.

As I take a long view of the Connecticut situation, it is that they are kind of settling down and in a little bit more, perhaps they will have settled down into a relationship that won't create all of the sparks and so on that it has in

the past.

Is that an unfair statement?

DR. SCHERLIS: No. I think to assume that you are going to change either the delivery of health care or make it more accessible on the basis of the network that has been described for Connecticut is an assumption. It isn't set up to do that. The purpose is not to accomplish that. And unless the goal is altered, it won't do it merely because the network happens to be there.

Being university based, were I a dean, I would relish the financial support that RMP is giving. I in no way should be assumed to be criticizing the value of such relationships and affiliations with community hospitals. I think it is very important. I just question whether you should use 40 percent of Regional Medical Programs money in order to accomplish that when there are other needs.

So you know I am waring two hats in this as I am sure the chairman is and others around this table.

DR. JAMES: The only question I would have is there any evidence where there would be a takeover of the funds that were initiated by RMP, say by the universities? Is this possible? Or is it possible through any other agency? So where RMP may have initiated this and certainly if there is evidence that further chiefs would be funded, there must be evidence for additional health care needed in the communities.

I wonder could you comment in regard to whether or not there is evidence for continued support on the part of other agencies?

DR. SCHERLIS: Two responses. One is I did indicate that a certain number of these full-time chiefs every year have reached the three-year period of support. And they get supported through other funds.

The Blue Cross representative was there. We, of course, asked can you include into the cost of care of a patient in a community hospital the cost of a full-time director And he said of course you can. So there are other ways of funding this.

And I think that whether or not such sources are there is an issue. Whatever is done in the educational basis may have to be supported through the medical schools affiliation. And one could really question whether you need 29 of 33 affiliated with a medical school. It may be wiser for the medical school to have a smaller number and concentrate quality in those.

DR. SCHMIDT: Mr. Toomey.

MR. TOOMEY: Yes, one question and then a statement. And let me ask the question first, please.

Did you have any input from the hospital end of this program?

DR. SCHERLIS: Yes. When the various hospital full-

time chiefs were there, directors of the hospital usually came with them. There were representatives from Hospital Association They spoke strongly in favor of this as you might gather they would.

MR. TOOMEY: The statement is really it is a strange thing, but hospitals are changing in terms of (a) moving away from the community, (b) moving in an attempt to parallel the changes in medicine which, of course, are more finite. They are greater, bigger programs, more equipment and this kind of thing.

The medical school is making a dual attempt as I see it at the moment which is to move ahead in terms of research, knowledge, education, and to move backwards in terms of primary care through their community practice programs. Hospitals have not achieved this yet. They are still at the end of the spectrum in which they are attempting to provide more complex and complicated services.

And I am really in agreement with you. This is not the mechanism to be used in order to get services to people in the community who are underserved. Because the community hospital is really now a misnomer in my opinion.

DR. SCHMIDT: Mrs. Flood.

MRS. FLOOD: Well, historically, this review body has criticized and sent strong advice to other regions who have augmented the staff of university settings through their

part-time coordinators of categorical areas, etc. And I see really no difference in concept from the actual formal university setting, medical school setting.

And then, too, this affiliate health delivery institution in the community hospital. And I just don't find any other comment to make except to firmly feel that they should be urged to discontinue this and perhaps even sooner than the triennium completion.

DR. SCHMIDT: Well, I don't know. I think if you look for firm evidence as to what this sort of thing does, you really get into principally the distribution of health manpower issue. And there are data that would suggest that this sort of thing might do something with the distribution. If they are putting medical students and residents across the State, then there is evidence to support the contention that this will distribute health manpower and services across the State.

Dr. Luginbuhl.

DR. LUGINBUHL: What about the effect on health care in the hospitals, though? Are medical students actually in all of these hospitals? Are these full-time chiefs of service doing teaching of students? Have they developed residency progr Are they delivering care to the indigent in their communities or are they simply supervising the quality of care that is given to private patients?

What is the actual effect of these full-time chiefs in community hospitals?

DR. SCHERLIS: You are asking me the very question that we would like to have information on. I can give you numbers. I have tables here which show how many medical students there are in each one of these hospitals and so on. In terms of whether or not -- you notice, they are clustered around what are the two or three chief teaching hospitals. But you do get some distribution in some of the others.

In terms of does it affect the quality of care, I would have to assume that it must. I would assume that if you take a hospital and put in a knowledgeable individual who is going to be chief of medicine, he is going to ride herd and he will attract house officers, he will get his own house in order before he gets into teaching students from the medical school. Once he does this, then he can be thinking about going into the community.

The question that I raise is is this essentially the goal of the Regional Medical Program to the exclusion of other goals? I think it is good. I think it is great. Being in a medical school and needing teaching beds, I think this is fabulous. And if I could get funds from RMP, I would be after it.

I think, though, it is a question of the overall goals and priorities of a Regional Medical Program. Should this be

first? That is the only point I am making.

DR. LUGINBUHL: If this does become first, let me know very early on so I can apply.

DR. SCHMIDT: You missed out because you had been all the way back with Connecticut's grand design as one of the early programs and get it established then.

Of course, they defend it as vigorously on the basis of the planning of the Connecticut grand design by a number of committees and so on that they set up.

Bill.

DR. LUGINBUHL: It may be a very worthwhile program, but I really must add my voice to those that are expressing concern over the appropriateness of this being maintained in the Regional Medical Program. To me, it is an anomaly. Here you have one of the wealthiest States on a per capita basis that has put $80 million in capital into a medical school, yet the RMP is being asked to fund their developing programs to the community hospitals.

And you couple with that one of the more affluent private medical schools, and again we are being asked to fund th development of community-based programs.

They may be excellent programs, but I really do have a very hard time with accepting that as a major thrust for a Regional Medical Program and with maintaining this. I really feel it should be phased down if not out and that there should

be plans for having this taken over by other funding sources.

DR. SCHMIDT: Dr. Thurman and then John.

DR. THURMAN: I would like to ask Eileen what she thinks Clark's departure will do to the grand design. Do you have a feel for that at all?

What I guess I am really asking is are we joisting with shadows? Is this going to collapse when he walks out the door?

MISS FAATZ: I don't think it will collapse because many of the influential RAG members are not mesmerized, but they believe in it as strongly as Dr. Clark.

However, I think it will be easier for the program to add different sorts of things, perhaps level fund and then scale down full-time chiefs in the universities and do some different things.

DR. SCHMIDT: They may not be addicted, but they are habituated.

DR. SCHERLIS: Well, the question asked the chairman of RAG by the past chairman sounded very much like a carbon copy of Dr. Clark. So I talked to the present chairman who sounds like the original.

(Laughter.)

They are totally convinced that this is the way to go.

DR. SCHMIDT: I am sorry, John is next.

DR. KRALEWSKI: I like your suggestion on the funding,

but I wonder if they will really do it or continue the same program they have now and not implement anything else. As I sit here, it seems to me that I have heard a good bit of this conversation a year ago and a good bit of that the year before. And the program is just going straight on in one direction.

And I think we had advice letters to them with this in it, didn't we, or didn't it get through Council?

DR. BRINDLEY: We sure talked about it.

MOR MORALES: If I can interject at this point, going back to previous review, as Len has indicated and some of the others, the difference in perspective in the reviewers towards this program has made it quite hard for us to gain a consistent kind of view toward it. The review committee took one position, the Council took another position. And it was a complicated and in many ways an unsatisfactory review process.

I think one cannot overstate, however, even with the position of the Regional Advisory Group the significance of Dr. Clark's departure. Because he describes himself as a missionary, and he is. He believes and has believed all his life in exactly what has been established.

The question now and one that I think you are beginnin to deal with very effectively is what are the possibilities of doing something useful with what has been designed.

I was terribly disappointed sometime ago, and we

discussed it in one of the review committee sessions when a proposal was made for supplementary funding for Emergency Medical Services, and there was just no relationship between that request and the grand design.

Now, if there is to be a Connecticut statewide Emergency Medical System and you have an affiliation between university health science centers and hospitals and between hospitals, one would think it would just drop into place very naturally and produce an appropriate effect. Or if one looks at something like PSRO activities in which you have linked together institutions with somebody in them who is concerned with quality of care, it would appear to be a very appropriate kind of a setting in which to establish the AHA approach to it or some other kind.

We have talked with them in the past. This review committee has. So has the Council about trying to make the hospital now a part of the community and extend out so that it includes a way of organizing ambulatory services, all of which are potentialities. But I think that if there is to be a decision made on what happens in CRMP with Dr. Clark's departure with this current review process, we are at a moment when we can be effective in making some very strong advice to them about just what exactly ought to happen.

I think it will be susceptible. But any time you spend on it is going to be of great assistance to us. It is

the time to take some kind of action.

DR. LUGINBUHL: Is there a motion on the floor?

DR. SCHERLIS: Before I make a motion, perhaps I can ask -- There is a motion on the floor, and the motion that I made was that they be approved at what has been the Council level for the next year; that strong recommendations go out as we have indicated. And remember, there will be a different coordinator. And I understand the selection committee has already been or is being appointed for that representation from the Medical Society. And that the following year take into account the fact there is a new coordinator, there be another site visit.

I think it puts them very much on notice they are going to be looked at very hard. I think we drop down their funding, we are going to be in a position of a new coordinator coming aboard who is going to begin by antagonizing half the State by firing full-time coordinators. They are going to be phased out anyway. A group gets matured every third year, and they fall by the wayside.

DR. SCHMIDT: The question isn't maintaining those. It is doing the rest of it by some other means and doing other things with RMP and RMP money. And that advice can strongly go.

So that the motion, then, is as he said the level, no developmental component, the strong advice, and the site visit in one year.

Dr. Ellis, do you second that motion or not?

DR. ELLIS: Yes, I would like to second the motion, but I would like to make one change if he will agree to this. I think we should have very careful staff work with them so that they clearly understand the options and the things that they can do. Because I am afraid that with the difference in feeling about delivery of care, with one group feeling that what they are saying is decidedly different and doesn't relate to what Dr. Clark has done, it may destroy a very important base.

And I think that the staff really needs to work perhaps more closely with this than they have with other things because it does have a very important facet.

As I said before, there are so many places where the community hospitals, community affiliated hospitals, are not available to take poor people in. And we have all of the friction that we have in the large cities. So it is so important to keep what has been built up and to relate it to the other important aspects which we discussed here.

DR. SCHMIDT: I am sure Dr. Scherlis agrees with that. It is complementary to the point Dr. Margulies made. And it really is an assessment of what they have created and to build on that without destroying what they have accomplished to get at some of the pressing health needs of the State.

All right, Dorothy.

MISS ANDERSON: I was wondering if maybe Dr.

Scherlis' suggestion earlier about enlarging the RAG and broadening the RAG might help make this change possible, if that could be included.

DR. SCHERLIS: This is part of the recommendation that they do.

DR. SCHMIDT: John.

DR. KRALEWSKI: Could you repeat the advice that will go along with this again? I am not sure I understand exactly.

I would be in favor of some very, very strong advice like within one year show us how this program is going to lead into a broad program to improve the delivery of health care to underserved, to tie in with Emergency Medical Program that you are developing, etc., down the line.

DR. SCHERLIS: Actually, these are listed in the site visit report on page 27. I can refer to it very quickly.

The program must reconsider its goals and priorities in terms of developing efforts in community outreach and delivery of health care to inner city and rural areas. Although an enviable network has been developed through the university and hospital affiliations, the site team feels CRMP should not support further expansion of these areas. Rather, the new program directions exhibited should be supported by new program priorities.

Over the next year, there must be developed measurable criteria for an analysis of the effectiveness of

these full-time chiefs.

CRMP must immediately develop and implement an affirmative action plan which provides equal employment and training opportunities for minorities.

CRMP must take immediate steps to restore to the Regional Advisory Board its responsibilities.

These are listed in detail and one or two have been added in the discussion.

I think any new coordinator coming aboard, I assume, would receive this full site visit report.

I assume he would know that he isn't going to begin his first year by saying, "We are not going to follow anything they tell me."

Maybe I am naive in this regard, but I think if he knows he is going to be site visited in one year, he is going to have to shape up and follow these recommendations. He isn't going to have the longevity of having been there for several years and having built it up.

DR. SCHMIDT: Eileen.

MISS FAATZ: When the Connecticut Program makes its funding decisions, it very likely will not have a coordinator on board. And I would like a point of clarification. We are saying do not expand your full-time chiefs and the university counterparts. Are we saying do not expand the number of dollars you put into this thrust? Do not expand the number of

people supported? Do not support any additional full-time chiefs? And let those who are now being supported phase out?

You know, that is the sort of information that I think may be --

DR. SCHERLIS: May I respond to that?

The intent of the group would be that no new full-time chief be appointed. In effect, this reduces the number.

So if you were to accept that as a modification, no new additional, no new full-time chiefs are appointed.

DR. SCHMIDT: In other words, they stop appointing them. If the case hasn't been made for the value of these now, it never will be.

DR. JAMES: That wouldn't have anything at all to do with the influence that CRMP would have on encouraging the universities or others to follow suit in the developing of this kind of service in areas that have not been assigned new chiefs, would it not?

DR. SCHMIDT: Well, they have gone statewide with this now. And I believe that essentially all of the hospitals are tied in.

All right, we have a motion on the floor then. Unless someone wishes the floor, I will call the question.

The motion is understood?

All in favor please say, "Aye."

(Chorus of ayes.)

Opposed, "No."

(No response.)

All right. Thank you.

MR. HILTON: I probably should have made my position clear earlier except I don't like to bother the committee with such personal problems. But the Hiltons are expecting a baby sometime in the next 48 hours, and I would like to discharge my responsibility toward Washington today so that I can get back and be a delivery room daddy.

DR. SCHMIDT: Then, we will move to Metro D.C.

Joe, did you have something?

DR. HESS: I didn't want to prolong getting to a vote, but just one additional comment or two perhaps.

First, I think part of our ongoing problem with Connecticut has been that Connecticut has disagreed with us. I have been hearing the same thing. This is the third time now I have heard Connecticut discussed, the same issues were raised. And then the thrust of what we have said has seemed to have been blunted at the Council level and things sort of go on as they have been before.

DR. SCHMIDT: Maybe we ought to cut off the funds to Council.

(Laughter.)

DR. HESS: That there somehow needs to be a better meeting of the minds at that level.

But the other major point I wanted to address had to do with the recommendations. And that is to actually strengthen what is stated here in the number two recommendations having to do with the evaluation of the effectiveness of the system.

I had thought that Dr. Thompson and his group in Connecticut were developing one of the better data-gathering systems in the country and that I had assumed as we went along that this somehow was going to be used by Connecticut RMP to determine what the impact of their grand design was on the health care of the people of Connecticut.

And yet when I see the report there is apparently next to nothing in terms of evaluation, I am rather appalled when there is the talent in that State and in the grantee institution that we know is there. And what I am leading up to is I think that ought to be strengthened by saying that they ought to get if necessary more consultation participation of the people who have that kind of capability within their region to help them strengthen that evaluation aspect.

DR. SCHMIDT: O.K., staff.

DR. SCHERLIS: We did meet with them, and this was referred to.

DR. SCHMIDT: O.K., on to Metro D.C.

DR. SCHERLIS: Well, Mr. Hiroto was with us. He is on Council, he strongly supports the site visit findings and would be a voice to this group there.

DR. SCHMIDT: John.

DR. KRALEWSKI: Well, the Metro D.C. area, the area is outlined in this briefing document that is included in the report here today. It covers the District of Columbia, Montgomery and Prince George's Counties of Maryland, Arlington and Fairfax Counties of Virginia, and the City of Alexandria.

This is an area of a great many resources. It is an area of about 2.3 million people, an area that is rumored to be an area of high unemployment soon -- I don't know about that but anyway it has a lot of resources including three medical schools.

Now, this program was sponsored with the D.C. Medical Society as the grantee. And it has had a very stormy history right from the beginning.

At the present time, now, they are in the third year of their triennium. It has not been site visited this year, although the program has been site visited for the last three years.

A great deal of advice has been given to them each year. Some changes have been made as a result of the advice, but progress is very slow.

As I said, they are in their third year of the triennium right now, coming in for an increase in funding, a substantial increase. And the application has been reviewed by the staff here at RMPS, has been reviewed by SARP, and I

reviewed the application. But we did not site visit the program.

Last year, they requested, as you may recall, $2.1 million. After a great deal of anxiety and discussion, we awarded them $1.1 million. And they are now coming in with an application for $2.3 million. So it is a substantial increas again for the program.

A bit of the history. As I mentioned, it has been site visited many times. And each time, it undergoes some reorganization, some restatement of the goals and objectives. But they have a very difficult time really getting the program off the ground.

To start off with, they had their staff disbursed into many agencies. What they were doing was funding staff members in health departments, etc., with these individuals supposedly then carrying on a specific role for an RMP.

Unfortunately, they didn't have the strong central staff to handle that kind of activity. And they never were really getting much production out of these individuals.

The leadership and the core program was not strong. Dr. Wentz is a nice guy, and he is pleasant to chat with, but his leadership, I think we have to admit was minimum. His staff was disbursed, as I mentioned, into a number of organizations.

He had some of the core staff with him at his house

with him in the core building. But that staff was quite ambiguous about their roles. They didn't know who they reported to. There was a great deal of dissatisfaction among them. And in general, it was just not a working unit and had never really become a working unit.

There was a lack of minorities included in their core staff and lack of minorities on their Regional Advisory Group.

To make things more complex, given that set of circumstances, the grantee organization, the Medical Society, did not give them a lot of support. And as a matter of fact, some of their regulations regarding salaries and fringe benefits, etc., over the years were quite restrictive and hindered the real advancement of a core staff.

Similarly, they developed a large Regional Advisory Group made up of various health agencies in the area. And as a result of the large Regional Advisory Group and the weak staff they really were unable to get the group to work as a concise unit.

As a result of that, they had a large number of Regional ADvisory Group that didn't attend the meetings, didn't participate in setting the goals and objectives, and really in many cases were unaware of them. This is all data from the past site visit.

To make things further difficult, the program became

involved in a number of subcontracts. Again, while you can carry out subcontracts to great advantage, you can't unless you have a real strong central staff to initiate the contracts, determine what they are supposed to do for you and to monitor them. And, again, they just didn't have that.

So again and again the site visits come up with these difficulties. And again the program would sit down and record these suggestions from the site visit teams. They would bring their tape recorders along to the meetings. They would pay supposedly attention to the written advice.

And in a way they kind of remind me of some of my graduate students who have this poster that they bring along. Andwhen they talk themselves into a corner on some issue, they have this poster they put up. And it says, "I am not sure that you understand what I mean because I don't know what I am saying."

This is the kind of thing we have between the Regional Advisory Group and our Review Committee here.

Anyway, following last year's review, we suggested to them that, number one, they bring their staff together in one cohesive unit physically if nothing else.

And then, number two, try to reorganize the staff into a functioning unit so they know who they report to and what they are supposed to be doing in the organization.

And then take a look at the goals and objectives again

and get a large advisory group involved and make sure some minority members get involved in this whole process.

Again, they reminded us of the difficulties of getting minorities involved. And we discovered that there were some available in the area and made some phone calls and brought them in that afternoon at our site visit and so we put them in contact with some of their minorities right there that day. And we had hoped that that would grow into some kind of mutually agreeable arrangement.

Well, we have now had this application. And as I mentioned, they are asking for about $1.2 million increase. And the situation is this:

The Regional Advisory Group has been reorganized somewhat, has not been cut down, but rather has been expanded. It has been expanded in an attempt to bring some minority groups into it. And I think that is a plus, although now they have a larger group to handle and more problems organizationlly.

DR. SCHMIDT: What is it up to in numbers?

DR. KRALEWSKI: Sixty-three, I believe.

MR. CHAMBLISS: With the alternates, it is around 120.

DR. KRALEWSKI: They have primaries and then they have alternates, but the alternates only come if the primary doesn't. I think 63 is their primary.

They have brought their staff together in one setting, and they have lost a few staff members in the process. But

the ones now that they have are in a closer unit.

The coordinator has resigned, Dr. Wentz, and has left. So they have now an acting coordinator, a fellow by the name of Choate who was there before as a deputy. And he is a pretty good guy administratively. He is a pretty good guy in terms of internal administration. That is where I think his abilities lie. And I don't think he is going to do much in terms of taking these goals and objectives and doing something with the program for the community.

The Regional Advisory Group looks as though it is better organized than it was in the past. They have more committees formed, and they have minorities on those committees. So it shows some promise.

And they have been able to bring more minorities into their core staff with some changeover in, I believe it is, at the secretarial level, however.

They have revised their goals and objectives, and the revision looks as though they are making progress.

The way Dr. Wentz chose to do this after he received our advice letter was really to turn it over to RAG and form subcommittees and get them involved in the goals and objectives. And he started phasing himself out of it.

I think they are at the point now where they have tried to look at these, they have tried to pick out a couple of areas they want to deal with. And what they need now is some

kind of leadership to put the whole thing back together and make it work.

This is kind of how they sit today. And it is the kind of program you would like to put into receivership in a way, but there is no one that wants to receive it. And we have invested a fair amount of money in the program. And the question now is what we should do with it.

As you recall last year, they had an application in for a kidney project. And that was funded. And perhaps it will continue on. And they have funding also for a pediatric pulmonary regional program. And that essentially they are tied into.

They have a couple of new projects that they are submitting along with the grant application this year. But they are projects essentially that are warmed over from before.

Really nothing new has been developed to fit into any new goals and objectives that have been developed by their Regional Advisory Group.

Now, as I mentioned, there has been a review by the staff here and SARP. And there is a recommendation that I would read from SARP.

Maybe I better wait until the secondary reviewer makes some comments.

DR. SCHMIDT: O.K., Bill.

MR. HILTON: I would add just a few things to John's

good overview on this. He and I -- or I was with him actually. He was chairing the site visit that he referred to to Washington. One of the first obvious positive things I noted -- well, there are several positive things over last year, very small steps, however. They do talk about addressing themselves to underserved populations.

I recall stressing, I vividly recall stressing one of the ways that might be done would be to involved minority staff on the core staff, on the project staff, to really provide some effective tentacles into the community.

One thing that became very clear when we had the lady in who had been a RAG member and had not really been involved in RAG from D.C. itself, one of the things that became clear was that no one in the outside community, she told us, really had any awareness of what the Metro D.C. Regional Medical Program was all about. There was no effective dialogue. There weren't enough people from those communities who would talk to RMP. And I stressed at that time that increased staff would certainly help in their outreach efforts in the District itself.

The increase has been slight on the professional staff end of it. And I don't know that it is adequate to this day. And I don't believe it is adequate to this day to handle the proportion of work that they should be doing in the District in addition to the other commitments.

I have not heard Dr. Kralewski's funding recommendations. I would suggest I favor a conservative level of funding far more conservative than they are asking for, not only because of these continuing problems, but because of the prospect of a new coordinator about whom we don't know what directions he might take. Certainly, we hope that he would bring a stronger leadership to the program than Dr. Wentz has had. I don't recall Mr. Choate very well in terms of what his abilities might be even now as an acting coordinator.

I need to touch base with John on something I don't understand in the application. There was some talk about the RAG disallowing responsibility for considering individual projects. Did I get that right? Was this their feeling that the RAG should not be involved in setting priority?

DR. KRALEWSKI: No. It was my impression they were quite involved in it at the moment.

Spence, you might want to comment.

MR. COLBURN: They review projects and set priorities and so forth through a subcommittee system for all RAG members.

DR. SCHMIDT: All right, John, let's get a recommendation on the floor.

DR. KRALEWSKI: I would like to read this recommendation from SARP and then ask Spence if he would make some comments on it since he stayed pretty close to this. And then we might go from there.

SARP would recommend that program be placed on a one-year probation and that they be funded at $850,000 level.

Within that $850,000 level, the kidney project would be funded not to exceed $144,000 which is really what they need, and that the pediatric pulmonary project be funded at $147,000.

And they recommend that no funds be budgeted for project 51, the cancer detection clinics, until they clearly establish that this project will not support basic education. It goes along with policy.

The developmental component be denied.

And that the Director of RMPS be authorized to award an additional $200,000 to the project if he believes that their progress so merits during the year.

I think that this is a good suggestion.

Really, what we are saying is we will authorize them about $1,050,000 and that that last year, as you recall, I mentioned they had $1.1 million which is awfully close to this.

It gives them some running room and yet you give them only the $850,000 to start so they have some indication they are going to have to make some progress before they get the other $200,000. But the level is there.

Now, the probation bit, I believe the staff might clarify this for me. I believe we have had some other

programs on probation in the past and essentially what it means is that you have a year to really show that you have been able to reorganize the program and make some substantial progress or we are really going to stop it all at the end of that year.

Can I get the staff to comment on that?

DR. SCHMIDT: All right, Spence.

All right, we have a motion on the floor. Bill, do you second that or not?

MR. HILTON: Yes, I do.

DR. SCHMIDT: All right, Spence.

MR. COLBURN: I really have no additional comments. I think the overview was very good.

We did question the terminology used, the word "probation" in SARP, and really didn't come up with any defined definition of what it means. But essentially this was the intent.

DR. SCHMIDT: I think we will say that probation means at the end of a year obviously there will be a site visit and that if substantial progress has not been made toward meeting the goals set out in the advice given, the program will go to zero funding.

MR. HILTON: Mr. Chairman, have we ever canned one of these things?

DR. SCHMIDT: Well, in previous times, the Director

of Regional Medical Programs has in effect said this to regions, yes. I am not sure we have ever kind of officially used the word "probation." There have been a number of regions combined, as you know, and in effect phased out and phased into a larger region.

I personally see nothing wrong with saying this.

MRS. SILSBEE: In a sense, isn't this the third year of its triennial support? By putting that probation in, you are really making a stronger message than you would be by just talking about this year.

DR. SCHMIDT: Mrs. Flood.

MRS. FLOOD: May I ask a question?

DR. SCHMIDT: Please speak into the mike.

MRS. FLOOD: They were budgeted for $787,000 and $800 for staff. Did they expend that in year two, this current year, entirely?

MR. COLBURN: I don't know what their exact rate of expenditure is. But they don't expect to have any funds left over. About $200,000 of that goes into contracts. $195,000. So it is about a $500,000, $600,000 for the staff.

MRS. FLOOD: Is that actually staff?

MR. COLBURN: Staff, some consulting activity, rent, that type of thing.

MRS. FLOOD: My concern was that the recommendation of the SARP was a potential expenditure in kidney and a

potential expenditure in pediatric pulmonary of $290,000. And if they were expending $787,000, it didn't add up to $850,000.

MR. COLBURN: Now, this is a reduction of funds.

MRS. FLOOD: Yes, but I mean it will actually mean also cutting staff.

MR. COLBURN: It is going to require some hard decisions. They will not necessarily have to cut staff, but they will not be able to fund all their activities within the period of continued support. There was a project which was a number one priority which they wanted to renew for a year. And they will not have any funds for contracting activities in new areas if they continue to keep the same level of staff support.

DR. KRALEWSKI: They will have four vacancies they can fill with that level.

DR. BRINDLEY: And they can get another $100,000 if they do a good job.

DR. LUGINBUHL: Is it really feasible to zero fund a program? Is that actually a political possibility?

DR. SCHMIDT: Sure. The President is talking about doing this.

(Laughter.)

DR. LUGINBUHL: I am not sure that answers the question.

DR. SCHMIDT: The answer is yes.

DR. LUGINBUHL: The other question I have is who is going to be threatened and who is going to be challenged so that they do address the serious problems of this program? You have no coordinator at this point. You have a very large RAG, 65 or 70 people. And in my experience, large groups rarely are able to seize initiative and direct a program.

There has been a serious problem, I gather, with the grantee. It is the Medical Society of the area. And they have clearly not shown leadership. Who is going to respond to this challenge that we are placing on this program?

Are we simply going to have no one to respond? And should we think about other measures such as merging the program into another program or trying to get another grantee or other devices to strengthen management?

DR. KRALEWSKI: I didn't mean to indicate that the Medical Society at the moment is not supportive. In the initial years, they were not very supportive. And as a matter of fact, in our site visit last year, they had a changeover in a leadership of the Medical Society. And they at that time indicated a great deal more interest in the program. And I think that they will come through on this.

I also think that RAG, if what I read in this application has any bearing on the truth, will initiate or exhibit more leadership than they have in the past as they becom more organized.

It is iffy, and I don't know. But I think that is where it will come from.

DR. SCHMIDT: Dr. Ellis.

DR. ELLIS: I would just like to ask one question. When we made the site visit before, there was a woman physician there who Dr. Wentz told us really worked to coordinate all of the programs and make the changes as had been suggested several times. What happened to her?

DR. KRALEWSKI: I believe you might be referring to Dr., I believe, Woodside is her name. And she is no longer with the program. But as I understand it, she is one of the candidates for the coordinator's job and I think that probably would do a good job if they can get her.

DR. SCHMIDT: Spence.

MR. COLBURN: That is correct. Dr. Woodside is a candidate. They have had a search committee. They interviewed about, or they considered about eight candidates. And this is a search committee of the RAG. And they made the recommendation to the grantee and gave them three candidates that would be acceptable to them. And the grantee has interviewed them all. And there is some indication, although it is not official, that Dr. Woodside is the first choice.

However, due to the uncertainty of the future of RMPS right now, she is hesitant to make the decision. I think if in the future it becomes evident that RMP will remain in

business that she will accept the position. I think she is interested in the job.

The question was where is she now? She is at George Washington.

DR. SCHMIDT: Are there other issues?

MR. COLBURN: I wonder if the committee has a reaction to the size of the RAG or has any definite recommendation or suggestion to make to the program. Because this is kind of a --

DR. SCHMIDT: My reaction is that across the country there are some large RAGs that are effective by virtue of their being advisory in nature. They give advice and consent. That is all a very large group can do. The successful ones have very sound subcommittee structure that does the work.

And a large one like this can meet two or three times a year and vote yes or no. But the measure of the effectiveness, the strength to which the individual RAG members in groups of six and eight and ten get at the work of the program and the size of the RAG per se isn't as important as what they do on the subcommittees, what type of subcommittees they are and what effect they have on the program direction in some way.

MR. COLBURN: But this RAG does have the ultimate system and has a volume of about 120 people that are eligible to serve one time or another either in the primary capacity or

alternate capacity.

There is a jeopardy, I feel, by accepting this alternate system. You dilute continuity.

I just want a reaction.

DR. SCHMIDT: The alternate thing doesn't sound -- everyone on the group who has a serious concern about that alternate system please raise your hand.

(A number of hands were raised.)

We could convey to them the weakness of not a 60-man RAG per se, but certainly 120.

MR. NASH: I think one of the problems to the RAG is that each member has to represent an organization. This is where the alternate system comes in.

MR. COLBURN: It is not each member, but it is a high percentage. It is probably 85 percent of the membership institutionally affiliated or an agency or something of this nature. That is the basis for the RAG.

DR. LUGINBUHL: Do they have a strong executive committee?

DR. SCHMIDT: Is there a strong executive committee of the RAG?

MR. COLBURN: Yes.

DR. LUGINBUHL: How large is it?

MR. COLBURN: I think it is seven members.

MR. HILTON: I think Bill's question is he asked

how strong.

MR. COLBURN: They are meeting more frequently, and I think it is becoming stronger. Some of the chairmen of the subcommittees are new and have shown a lot of interest and promise.

DR. SCHMIDT: John.

DR. KRALEWSKI: I think the whole question over the Regional Advisory Group and how functional it will be is really one that is only going to be answered after they get the core organized. If they organize a core, I think they will be able to handle that large RAG group without any trouble and organize them well and get them to participate pretty well and an executive committee to do the same thing.

At the moment, they don't have that organization. And as a result, you have got a disorganized 63 or 119 or whatev shows up at the meetings coming in. And that is difficult.

Now, on the other hand, during our site visit the last time, we visited with a number of the individual RAG members. And there are some real strengths in that group. And I think that these strengths will come out once that second level group gets organized. And I suppose that is really where we are placing our bets.

DR. SCHMIDT: Spence.

MR. COLBURN: Just a correction. There are 13 members on the executive committee. And the form indicates

they only met two times last year, although I know they have met more recently than that since July.

DR. SCHMIDT: That is not a very strong committee.

MR. COLBURN: It is really on the threshold.

DR. SCHMIDT: O.K., we have a motion on the floor for probation for one ywar, site visit at the end of the year, $850,000 level with the director having the authority to add to for good behavior and progress during the year if there is a strong coordinator who does indeed need the money to advance the good cause of the program with zero funding for project 51 unless some substantive issues are answered by the program.

With this, they would fund the kidney project at no more than $144,000 and the pediatric pulmonary at $147,000.

Are there questions to the motion?

(No response.)

Is that the motion?

DR. KRALEWSKI: Yes, sir.

DR. SCHMIDT: All right, then I will call the question. All in favor please say, "Aye."

(Chorus of ayes.)

Those opposed say, "No."

(No response.)

And that motion is carried.

DR. KRALEWSKI: Shall we rate this one? Do we rate

all of them or just the ones that are site visited?

MRS. SILSBEE: Rate them all.

DR. SCHMIDT: Heretofore, we have rated them all. SARP did rate it. They rated it down if you look on this one sheet here.

DR. KRALEWSKI: Right.

DR. SCHMIDT: Metro D.C., SARP, 176 from 207.

MR. CHAMBLISS: I might point out it is your option to accept or rerate. We leave that entirely to the Committee.

DR. SCHMIDT: Let me ask just speaking for myself, I could hold out through North Dakota. Would the Committee like to go on?

DR. BRINDLEY: One more.

DR. SCHMIDT: All right, Miss Kerr.

MISS KERR: I am pleased that you did because I know Dr. Scherlis has to leave.

Let me just say that the review materials and I ended up in the same place finally late Saturday.

North Dakota Regional Medical Program and I have gotten acquainted between the hours of 3 and 6:30 this morning. But I feel fairly well acquainted with it, and I am glad that Dr. Scherlis who was chairman of the last site visit team in December of 1970 is a secondary reviewer and also Dr. James. And I have asked Harold O'Flaherty from the Mid-Continent Branch Operations Officer to join us because he has spent so

much time with this region in the last year.

First, let me tell a little bit about North Dakota. North Dakota is the most rural State among the 50 with a total population of 618,000 is all. I was amazed. Three percent Indian population, 3 percent non-White population, average of 9 people per square mile. And yet I look at the available physicians and registered nurses and combined registered and licensed practical nurses, and I will bet you North Dakota is better off than any other State I know of as far as ratio is concerned.

But they do have geographic problems. And the capital, of course, is at Bismarck which is in the south central part of the State. And Grand Forks is where the Regional Medical Program is based. And that is in the very northeast part of the State.

And I tell you this because the grantee agency is located at Bismarck. And the grantee is North Dakota Medical Research Foundation which is a subsidiary of the State Medical Society. And so there is some distance between the grantee and the Regional Medical Program based at Grand Forks in which city also is the University of North Dakota which is the fiscal agent for this Regional Medical Program, although this seems to be working very well.

This is an anniversary review prior to triennium. There were some problems, and I would like to identify those

as they were shown following the last review.

Early in the process, the RAG was made up of physician period. And, of course, this was questioned, and they were advised to broaden their advisory committee.

The staff have characterized the Regional Medical Program as being ruggedly individualistic. And I think I would have to agree.

To date, the project that had been funded had been centered around providing continuing education for the physicians. There was some continuing education for nurses, however there was no nurse educator or nursing service input into these.

The offerings were developed by the physicians for the nurses. So there was concern about domination of the program by the State Medical Society. There was concern about the failure of the region to delineate an action panel which includes time frame objectives and terminal points of evaluation.

The failure of the program to recruit a deputy director and an assistant director for management planning and evaluation.

Another concern was the lack of involvement of minority group representatives on the program staff in the Regional Advisory Group in the committee structure, and it was felt that the Regional Medical Program had not developed its activities in terms of changing RMPS mission.

Therefore, at that time, it was not accorded triennial status. It was interesting to note that when Dr. Arneson became the coordinator in August of 1972, in his letter, cover letter, for the proposal on October 27, started out by saying the Regional Medical Program is at a critical stage in its growth, faced with problems that verge on dilemma.

And having reviewed what has transpired between then and now, I don't think he would make that statement quite so strongly, at least.

There have been minimum of six staff visits out to assist this region. And it would seem to me that they have responded pretty well to the problems that were identified at that particular time.

They do have a new executive director in Dr. Arneson, as I said. And he was appointed in August of 1972. Apparently his public relations are superb. He evidently knows the State real well and has good contact within the State. And he works well with the core staff.

He by his own admission is not as competent in the field of budgeting and finance as he would like to be.

Just today since having arrived here, there is information before me that says that a deputy director and assistant director for management planning and evaluation has been employed as of this month and also there was a third person employed as director for community and public relations which

gives them, as I counted, a total core program staff of 18 including 5 secretaries which means 13 highly prepared professional people.

In speaking of the program staff, I would have to say at the risk of being called a feminist which I profess not to be, I do think a look at the differentiation of salaries and level of preparation on this staff between the men and women is quite remarkable.

At the time, it was thought that tensions existed among the several CHP B agencies and the RMP. Apparently since Dr. Arneson has come aboard, these relationships have improved considerably. And there is much support, there is mutual representation on the respective advisory groups, and they seem to be working much better together.

At that time, the objectives were felt to be vague. I note by the material that they do have them delineated. The goals are within keeping of the mission of the RMP.

They had not at this morning's reading shown too much progress in the area of setting priorities. However, in the information that came to me today, they now have set their priorities.

The review process was not certified because of several major identified deficiencies at the last time in the staff observations. However, the information before me today says that their review process has been approved.

The CHP agencies were involved in reviewing the proposal prior to the time it was admitted. And of the four who responded, three were very supportive. One felt that they could not support the funding for four projects requested, and I think this needs some explanation in that it was determined early that this Regional Medical Program had much to do to get its house in order. And I think it was not felt that it probably could do it as readily as it has nor as rapidly as it has. And so at that time, it was recommended to them from the staff that they may want to consider spending the next year picking themselves up by the bootstraps rather than to get involved in a lot of new projects.

However, as they moved along and felt themselves that they were maturing, it was the RAG itself that identified four projects which they would like to be pursued and for which they would like to request funding.

So again it was a CHP B agency in Bismarck which was theone before that was a little cantankerous, but of the four, this was the only one that had reservation about this particular proposal.

All the projects which they had undertaken before were continuing education as I mentioned earlier. All of those have been taken over by other sources of funding. So they are really in essence starting from scratch at this point in time in their request for funding.

Their third year, they received funding at the level of $323,401. At this particular anniversary review, they are asking for $707,025 with no identification as far as developmental component.

In Dr. Arneson, it would seem that they have a person who is going to be able to provide better leadership in a better atmosphere. And he has a core staff evidently that are highly motivated, I would say fairly sizable in number for the size of the operation to date. However, I do need to draw attention to this group. And I have strong feelings about this in view of the adequacy of the review committee about the lack of minority representatation. And it was treated, I thought, quite adamantly last time to my disappointment. And perhaps I am a little biased on it because it was from my presentation last time relative to it.

But I have heard this afternoon three or four times we have talked about regions where the minority representation is noticeably lacking or absent. And yet I haven't heard that adequacy today. But this particular region has been told about this a number of times, and we still find only one minority on the RAG. And this is an American Indian.

There is no minority representation on the program staff or among the committee of which there are two and provision for others as needed.

The Regional Advisory Group, the grantee and the

coordinator evidently are working very well together. And they have set out and accepted the policies of their own and describe their roles and relationships. And it seems to be working well. So this is apparently a major improvement over the last, and they did follow the recommendations.

So their review, their technical review process has been approved. Their relationships with CHPs are considerably better. The policies on the relationships of the coordinator, Regional Advisory Group, grantee organizations, seem to be moving very smoothly.

It is my overall opinion that it has made an about face. It has found other funding for its formerly ongoing programs. And in submitting its request for funding, the funding would cover program staff and four projects. Program staff of this $707,000, $411,000 of it is for program staff which is 7.6 percent which seems pretty heavy. However, they have also asked funding for four projects. And just grossly, those are Emergency Medical Services, Regional Extension Center for Rehab Services, communications to serve diabetics and educational center for allied health personnel.

They have in their priorities put Emergency Medical Service assessment No. 1, asking $63,241. They have put the education center for allied health personnel No. 2, the regional extension center for Rehab Services No. 3, and communications for diabetics No. 4.

The EMS would be an assessment in feasibility and the educational program for allied health, I would like to speak to in a positive manner because this would be done with North Dakota State School of Science at Wahpeton. It is not for preparatory programs. They have many ongoing preparatory programs at less than the baccalaureate level. The purpose for this is for in-service education of allied health workers. And they have developed a good network to get this out throughout the State, take it where the workers are, rather than require that they come into a central place for continuing education which is too often impossible for many of our people as I know from where I sit in our State.

So they have asked $707,000 for program staff and for these four projects. Because they have recently made these changes, although both were good, before I make a recommendation for funding level, however, I would ask Dr. Scherlis and then Dr. James and Harold O'Flaherty if they would have any comments.

DR. SCHERLIS: Will you reverse that and ask Dr. James first?

MISS KERR: All right.

DR. JAMES: Well, my comments are going to be very few for the first time. However, I was very much impressed to learn of the complete about-face that the new director of North Dakota RMP has taken.

I think perhaps that if we had had one of the relief maps that were passed around, we could really see the vastness of the terrain in North Dakota because I think it like Alaska and so forth probably offers the greatest problem toward the dispersion of services in the area and because of the paucity of the population. Their clusters of population are into several areas.

I think that, too, the efforts that have come about in the development in the proposal of the four new programs involving all the CHP B agencies which was not before, I think a part of their program probably lends support to the fact that there is going to be more community involvement. Because I had understood that prior to this time there was a tremendous hold on the organization through the State Medical Association.

I would have to say something in regard to minority representation when one looks at the figures. That is if the Census people counted everybody because we are well aware of the fact that a lot of people just don't get counted. So I don't know whether or not there are 16,000 Indians or 2,500 blacks in North Dakota or not. But anyway, we have to take what the figure says. It says that. But I would have to strongly wonder how many people on the reservation still haven't been counted or vice versa.

But the fact of it is that you can only have in this community a 3 percent population. And I am not willing

to say that everybody should be represented on any kind of Council or anything by a quota. That is out as far as I am concerned. But I certainly believe that because there is an Indian, large Indian population that certainly the organizations should be represented.

I understand that the Indian is a very intelligent, highly articulate person who is a representative of the Indian Council.

MISS KERR: Chief.

DR. JAMES: He is a chief? He is a big man.

Well, he is President, then, of the Indian Council.

MISS ANDERSON: That changes frequently, though.

DR. JAMES: I would just simply echo the sentiments I think I hear you stating in that apparently after many years of really being sort of stymied that this program looks like it may begin to take off. I am especially impressed with the cooperation between the medical school and I believe the North Dakota State school at Wahpeton.

MISS KERR: Yes.

DR. JAMES: To establish the residency training program, the internship program, to bring the medical students again out into the community, into a community network, which as far as I am concerned is combined also with general education. And I think that this will have a tremendous effect on the distribution of health manpower. And I believe

this is one of the areas we are really confronted with -- distribution.

I have no other comments to make.

MISS KERR: Len, would you excuse me if I make just two comments before you?

DR. SCHERLIS: Go ahead.

MISS KERR: I neglected to say that the advisory committee has been expanded from 16 physicians historically to 39 members, broad representation from all health professional from community people , from consumers, and so forth. There are 16 physicians on it, one from each of the ten, I guess it is, county medical societies. And that doesn't seem unreasonabl I felt.

And I was very much impressed with the change that has been made in the Advisory Group.

The other thing I wanted to say is of any bylaws I have ever read anywhere for any organization, I think these are the most outstanding, the ones they have recently. They rescinded their original bylaws, and they have a whole new set of bylaws. And they are just worth reading. I think they are well done.

DR. SCHMIDT: I hope you will forgive me if I just interject a comment here. I was sort of amused.

I think a relief map of the State of North Dakcta would be a waste of money. The highest point in the State of

North Dakota is in the Turtle Mountains up near Bottineau, North Dakota, up near the Canadian border. The lowest point is in the Badlands in the southwestern corner. The difference in those two heights is less than the height of the John Hancock Building. And it is a lot of land area, though, I will agree.

Leonard.

DR. SCHERLIS: When we made our site visit to Grand Forks, the point you just made was brought home to us because when we went out that evening to Dr. Wright's apartment, as we approached it, we were struck by the fact that it was one of several units in a large brick building in which there wasn't a single window outside. And this was built on the basis that everything faced inside where they had built for all of the units an environment of plants and some greenery and some water. And it was the only place I have ever been where you effectively insulated yourself from the outside, both by view and everything else. Everything faced in instead of out.

And if you have been out there, you would know why you faced in and not out as you pointed out.

When we were there, the program was totally dominated by the Medical Society. Dr. Wright provided a very strong leadership by virtue of the fact that he in the State was one of the strongest people medically. I think his plan as far as either subregionalization or CHP B agencies was to

have the county medical society serve for the B agencies and the State society for the A agencies.

But anyway, it is very, very medically dominated.

After a feedback session which I remember very well, he thrust his index finger in my chest and told me that you people from Washington just don't know what is going on out here.

As we drove to the airport, he obviously didn't get any happier because we had a minor accident.

I think the feeling out there then was that they knew what they were going to do with their program and didn't want to have any direction. And I am impressed with what you have described in terms of new direction.

I was interested did we know anything about the Medex program. Is that being funded through RMP at the present time? Because they were very excited about it then because they make reference to it. But I don't know who is funding it.

MR. O'FLAHERTY: Department of Labor.

DR. SCHERLIS: It is being funded through them.

Also, at that time that was the only Regional Medical Program that wasn't receiving Government funds for overhead.

MISS KERR: It is asking for them.

DR. SCHERLIS: It is now so they have learned a great deal.

I think the change in direction is apparent. The programs do show outreach. They have always had good physician educational programs, and they have had a base for developing, I think, further ones. And I would be interested in what the financial recommendations are going to be.

I think the document at least indicates a significant change. I don't know Dr. Arenson, but the document would relfect a change which is a significant one from essentially a pure county medical society or State medical society based program to a broader base.

MISS KERR: It certainly reads a great change.

DR. SCHMIDT: Harold, do you have anything to add to this discussion?

MR. FLAHERTY: I think the group has very aptly depicted the issues, the growth and again some of the weaknesses that are apparent within the North Dakota Regional Medical Program.

They are inordinately more outreach oriented, and there is a sincere desire on the part of the staff to change the image here as well as to do something tangible in the State of North Dakota. And I must add when Dr. Arneson first came here, he met most of the key RMPS staff. He had been a practicing surgeon for a while, for a long time, and left the staff with a mixed impression. I guess that would be kind.

But he has stuck to it. He has engrained himself in

the process and has learned a great deal and is again very much committed and believes very much in the concept of participative management. He takes his staff, and they sit around the room and they manage by group style. He has gone from one end of the continuum almost to the other.

And I was telling him the last time I was there I would sure like to see North Dakota hit a balance between the complete participative management and management by fiat which had been the case for four years previous. But I think we have some reason to be encouraged.

I met this summer with the Board of Directors of the Medical Research Foundation, the group that tenaciously had clung onto this program and went over with them the RAG grantee policy statement. And it was their perception that they could live with it, and they have adopted it, which is before you in the application, the set of rules that are most pragmatic for a State such as North Dakota.

Their house is in order with respect to the RAG grantee policy. Representatives from Grants Management Branch have reviewed this and have echoed Miss Kerr's sentiments with respect to the efficacy and feasibility of the bylaws.

They need to lay out for themselves a three-year plan which we should see one year hence and time frame their objectives and to build in more of a viable system for evaluation. But they are well on their way to doing this.

DR. SCHMIDT: O.K., let's get us a recommendation then.

MISS KERR: All right, because of these areas that still need some strengthening and because of the areas that already have been strengthened and because there is a feeling that perhaps they will be expending a great deal of time inhouse still to continue strengthening themselves, I am recommending funding at the level of $525,000.

DR. SCHMIDT: This is a one year?

MISS KERR: Yes.

DR. SCHMIDT: And then they will be coming in.

All right, then, the secondary reviewer was Dr. James. How does that hit you?

DR. JAMES: I was looking at the funding of the previous years, and I could very well, I think, understand why the funding levels were all of such a small nature when it is obvious that one can see perhaps a change in direction with obvious involvement of the community resources and the progress is to be made.

I wonder perhaps if we would not want to consider not to put a program in jeopardy because of insufficient funding to give them a little bit more. Because I think it looks like that they just had $431,000 and to give them $70,000 more with such a tremendous change in direction, I wonder would we not stymie their efforts and probably break

their spirit.

DR. SCHMIDT: They were at $323,401.

MISS KERR: For 16 months.

DR. SCHMIDT: The 431 was 16 months. So the annualized level was $323. So this would be $200,000 addition in essence.

DR. JAMES: I would like to recommend around $600,000.

DR. SCHMIDT: Well, that is out of order. There is a motion on the floor. I will ask for a second. And then if the motion dies, we will have to --

DR. LUGINBUHL: Second.

DR. SCHMIDT: All right, there is then a seconded motion on the floor at $525,000.

Mr. Toomey.

MR. TOOMEY: No, that answered my question when you annualize those dollars for salary.

DR. SCHMIDT: It is $323,401 annualized.

Dr. Hess.

DR. HESS: I notice that substantial part of their increase is for core staff. And I didn't hear too much about what that was going to do.

We do have a letter here which says all their currently budgeted staff positions are now filled. And do you have a good feel for what the additional core staff money will do for that program?

MR. POSTA: Excuse me, if you take a look at page 6 on the yellow sheet, there is last year's request and also an attempt to break down to the annualized level for the last year. So that that would give you some basis for comparison all the way down the line.

MR. FLAHERTY: In a nutshell, to compromise the two positions that existed at the time of their RAG meeting approving this application, one was to come in for the full-blown package with no feasibility studies. The other was to come in with core staff and feasibility studies only. So what they did was to come in with a full-blown operation one-year package with feasibility studies. So there is $120,000 of the program staff request that is for feasiblity studies as was recommended by their planning and evaluation committee to further design and assess their needs that exist in North Dakota.

MISS KERR: The orientation of these three new people who are in key positions will take a spot of time, too, as we talked about it.

DR. SCHMIDT: Leonard, comments on the $525,000 level?

DR. SCHERLIS: I think that is realistic. It is a very significant increase over what they have now. And it is compared to what. As compared to $323,000 that we are talking about $525,000.

I don't know if they could spend as much as they are asking for with new leadership. I am sure they will spend

the $525,000 very well. They would probably spend $550,000 or $575,000, too, but I think $700,000 is high. Where you place it in between, I think is a matter of judgment.

MISS KERR: If there is a strong enough feeling among the group, I will rescind the motion for a compromise.

DR. JAMES: Let me say that now that I have had a clearer understanding of what the annualized funding was, I can more readily accept the figure.

DR. SCHMIDT: John.

DR. KRALEWSKI: This committee is getting too friendly.

I like the --

DR. SCHMIDT: I am interested in what is coming now.

DR. KRALEWSKI: I like your suggested amount, but I wonder if you would have some advice to them as to how much of that should be spent for core staff and how much should be spent on projects or can we do that? Maybe we can't. I think their core staff is getting pretty large for that small area.

DR. SCHMIDT: We can give them advice. Generally, our funding level we arrive at by saying so much for ocre, so much for projects, but then the money is theirs.

DR. KRALEWSKI: If they keep using it up with core, they are going to do some really fantastic studies that really look great, but --

MISS KERR: It is a little over 70 percent of the

total amount budgeted for core.

DR. SCHMIDT: Again, it is 70 percent of what?

MISS KERR: Well, their total.

DR. SCHMIDT: All righty. Going once, going twice.

All right, I will put the question then. And the motion is one year at $525,000.

All in favor please say, "Aye."

(Chorus of ayes.)

Opposed, "No."

(No response.)

And that motion carries.

All right, the group has done well. We have five major reviews out of the way. Tomorrow we have five more and then a number of anniversaries within the triennium of another 9 regions.

So that in answer to some questions about how long we would go, I would wish that people not change their planes to too early in the day. I would think we would probably go until after lunch unless we don't discuss regions an hour at a crack which is kind of what we have been doing.

So I will predict we will finish at 2, 2:30 type of thing tomorrow.

DR. THURMAN: Metro New York will carry us to there, Mr. Chairman.

DR. SCHMIDT: All right, let's make it 3:30. In

other words, I don't think we are going to finish at noon.

Your rating sheets, you can leave right here with the material, and we will reconvene at 8:30 and begin sharply then.

Thank you.

(Whereupon, at 5:30 o'clock p.m., the meeting recessed, to reconvene at 8:30 a.m. on Thursday, January 18, 1973.)