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Transcript of Proceedings

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PUBLIC HEALTH SERVICE

HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Rockville, Maryland

Wednesday, 7 February 1973

ACE - FEDERAL REPORTERS, INC.

Official Reporters

415 Second Street, N.E.
Washington, D. C. 20002

Telephone:
(Code 202) 547-6222

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Public Health Service

Health Services and Mental Health Administration

NATIONAL ADVISORY COUNCIL ON REGIONAL MEDICAL PROGRAMS

Conference Room G-H
Parklawn Building
Rockville, Maryland

Wednesday, February 7, 1973

C O N T E N T S

P R O C E E D I N G S

DR. MARGULIES: May we please bring the meeting to order.

I have just a few announcements to make before we begin this session of the National Advisory Council, the first portion of which is, as you know, open to the public. There is within your agenda book the usual material on the confidentiality of the closed portion of the meeting. This particular portion of the meeting is, however, open to the public and will remain open until an announcement is made of the portion which is closed for review of applications.

Today, Dr. Musser is being represented for the Veterans Administration by Dr. Paul Haber, who is over on the right. Mr. Ogden cannot attend, nor can Dr. Roth, because of illness in his family, and I'm not sure at what point either Dr. Stone, who is acting deputy administrator, or Dr. Sencer, acting administrator of HSMHA, will be present, but we will adjust according to their time of arrival.

We already know of a number of people who are here representing public interest in the meeting and they will be given an opportunity to participate in the discussion within a relatively short period of time; in fact, as soon as we get into the agenda material on any of the items which come up.

We will also, for their convenience and that of the Council, if it appears to be the best thing to do as the

discussion flows, set aside a time for them in which they can say whatever they wish to say because I know a number of them have prepared statements which they wish to make.

I would also like to introduce to you, if you haven't already met him, Dr. Paul Teschan, who is sitting right there facing me. He's the coordinator of the Tennesse Mid-South program and he's attending the meeting in his capacity as chairman of the steering committee of the regional medical program coordinators.

Now, if there is anyone here who represents an organization or himself of public interest who we don't know about, please let your presence be known to either Ken Baum, who's here, or Miss Handal, who's over there at the desk, and we will make sure that there's room for you to discuss whatever you wish to discuss. Any presentations which are made by the public can be read into the record. They should be limited to about five minutes of time as a maximum, and there is a floor microphone as you can see at the far end for any kind of discussion which may be required.

As I said a moment ago, we would expect Dr. Stone to come here at some time and here he is. Good morning, Fred. Glad to see you.

I would like to read to you a letter which Dr. Wilson prepared before he left which is as follows:

"Ladies and gentlemen:

"By the time this reaches you I will have already left the position of administrator of 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 the health care of the people of our country." Signed, "Vern Wilson."

I think that you may recall from the last meeting of the Council that we did announce to you the fact that the RMP was to receive the Health Advancement Award from the National Kidney Foundation and that event in fact did occur shortly after the last meeting of the Council. It was discussed, but I suppose you might enjoy some concrete evidence of the fact that it did occur, so I will pass this around and you can admire it and make sure you return it to the head of the table so we can hang it back up on the wall. Hereafter, if you want to look at it, I will tell you where the wall is located.

There are a few vacancies on the Council which have not been filled and there are some people who, as you may recall, have completed their terms of service on the Council;

and by the rules of appointment will no longer serve. These include: Dr. DeBakey and Dr. Milliken; Harold Hines who resigned due to conflict of other kinds of demands on his time; Dr. Brennan, Dr. Komaroff, and Mrs. Weikoff and Mrs. Curry. Now, some of those may be reappointed based upon the time for reappointment and some of the technicalities of Council appointments, but for the time being they are not members of the Council for this particular session. Some of them, as I indicated, have served out their full period of time.

We have had a discussion at the last meeting of the reasonable time for another meeting within this fiscal year. We had set the dates of June 5 and 6, which we would like to continue to keep as the dates of the next meeting of the Council, if there are no serious objection to it.

DR. OCHSNER: I can't be here on the 5th.

MRS. MARS: I can't be here on either the 5th or 6th. The American Cancer Society has its annual meeting then.

DR. MARGULIES: That's two people. Are there any other objections to those dates?

DR. MEYER: Monday and Tuesday would be better.

DR. MARGULIES: Would Monday and Tuesday be acceptable?

DR. SCHREINER: I can't be here then.

MRS. MARS: How about the week before or the week after?

DR. MARGULIES: The week after gets to be extremely difficult. It's pretty late in the fiscal year.

MRS. MARS: How about the week before?

DR. MARGULIES: The problem there is if we continue as we have been we have foreshortened the time between review and Council by too short a time. Would the 4th and 5th be acceptable to people?

DR. SCHREINER: I can make it the 5th but not the 4th.

DR. MARGULIES: How about the 7th and 8th?

DR. SCHREINER: How about the 6th and 7th?

DR. MARGULIES: Let's have a vote on the 6th and 7th. (Show of hands) How about the 7th and 8th? Well, it looks like 6th and 7th is all right.

You have had a copy of the minutes of the last meeting of the Council and had an opportunity to review them. I'll be glad to receive any comments on it for corrections or a vote for their acceptance as mailed.

MRS. MORGAN: I move we accept the minutes as mailed.

DR. SCHREINER: Second.

DR. MARGULIES: It's been moved and seconded that we accept the minutes as mailed to the members of the Council. All in favor, say "Aye."

("Ayes")

DR. MARGULIES: Opposed?

(No Response)

DR. MARGULIES: I would like to report to you and have any members of the Council who wish to add their comments and those who are present on the meeting we had on the quality of care which took place last month in St. Louis.

We had, for well over a year, planned to have a conference on all of the issues involved in quality assessment and assurance. This was discussed in prior sessions of this Council and it was presented in what detail was available when we met last time for the formal meeting of the Council.

That meeting did take place in January. It was, I think, a remarkably successful meeting. It consisted of a cross-section of remarkably competent speakers presenting papers addressing the whole range of issues with which one is concerned in measuring and maintaining the quality of care. It was designed in such a way that each speaker was limited to 20 minutes. There were a total of 28 speakers. They stayed on schedule. We had asked that people come with papers prepared, written, and ready to be published. They all did. The only exception was the one who had to summarize the conference and therefore couldn't have a prepared paper.

We promised that they would be ready for printing, publication and circulation within 30 days after the conference was completed and that will be done. So that what will emanate

from this will be the best single collection of material on the subject of quality assessment and assurance that's available anywhere.

DR. SCHREINER: Will we automatically get a copy of that?

DR. MARGULIES: All members of the Council and members of the Review Committee will. We have prepared the first time around a fairly large printing and we anticipate having to increase that printing considerably because there's already a very heavy demand for it.

The format was such that it at least covers most of the fundamental issues and presents a very good sampling of the active work which is going on in everything from the development of effective medical records to the measuring of outcome of health care delivery systems.

Now, we did limit attendance to regional medical programs because we wanted to keep the activities on schedule. We felt that by early circulation and publication of the papers we would serve a much large audience much faster than we would have had we had a very large attendance and a lot of discussion. So far as I can tell, it worked out quite effectively.

I would, however, appreciate any comments which members of this Council might wish to make, those who were present. Mrs. Mars was there, Dr. Watkins, Al McPhedran and Mrs. Morgan. I would appreciate any comments you would like

MRS. MARS: I think it was very constructive thinking presented but I wish we might have come to more conclusions, more solutions, let's say, rather than conclusions. But certainly, it was a comprehensive coverage of the picture and all different aspects were presented, but no definite solutions reached, and I think we're floundering and floundering around here trying to find solutions which are very difficult to reach, but certainly it gave everyone food for thought.

MR. WATKINS: Are you going to send these to all departments of health?

DR. MARGULIES: Yes. We have a mailing list. We would be glad to get any further suggestions from members of the Council or others as to what the mailing list should be, but we anticipate certainly sending them to all the regional medical programs, to state health departments, to state medical societies, medical school libraries, etc.

MR. WATKINS: Can I give a name to someone here?

DR. MARGULIES: Sure. Do either of you have any further comment?

MRS. MORGAN: No.

DR. MARGULIES: Paul, would you like to comment?

DR. TESCHAN: I'm interested in the comment about the diffusion of efforts and, as you say, floundering in the various presentations. I think our reaction to that is that the conference clearly represented the state of the art today

and it clearly represented the kinds of efforts that are being made by people who are trying to find out how to do it. To me, this is the exciting feature because we still have that kind of pluralism, that kind of adventure, to see how we can do it better.

I hope that however things go in this entire standard setting, data base gathering, and medical audit arranging, we will be able to build on these various experiments and find new ones, find others, and that we don't make an early casting in bronze of any particular method.

So I think the idea of having a wide range of choices is exactly the message that came through to the coordinators and it stimulated the efforts in quality assurance across the country and it's a very interesting kind of reaction because you can see that this is a new field and really one that, for the first time, gives us a very sharp target for the educational efforts of RMP. To me, this is really where it comes home.

DR. MARGULIES: This leads in rather naturally to where things stand in a very broad way on the PSRO activities within the department. That, to those of you who haven't been following it closely, is the activity which was initiated under new legislation passed late during the last session of Congress which will establish a method of review of the quality of care which is provided and which will be associated with reimbursement

under Medicare and Medicaid. There is at the present time a fairly wide range of developmental activities going on in the department but so far as I can tell, no highly specific assignment of responsibilities. I'm sure as soon as the Secretary is confirmed and other positions are filled within the department, these will become more definite.

What we have done in HSMHA is what I think is a reasonable kind of thing, and that is to work together across programs within the agency to gain as effective an understanding as we can of many of the issues that will arise with the development of PSRO organizations, taking a look at some of the problems of data gathering, of the establishment of criteria, the general management of the PSRO structure.

This is being done not with any specific concept of a final action or responsibility within the agency but, rather, through a sense of professional needs to be prepared to respond to whatever is asked of the agency as PSRO activities are being developed.

There is required under law the establishment of a director for the program. He's not yet been named, and a national council to advise the PSRO activity and, of course, that council is yet to be named.

But it has created a wide flurry of interest within this agency, certainly within the Social Security Administration, and throughout the country. We deliberately,

in the conference in St. Louis, avoided the subject of PSRO because it would have trapped us into talking a lot about administrative problems and about some of the emotional issues which arise when we discuss PSRO and we were primarily concerned in looking at the subject of quality assessment and assurance, regardless of what setting it was placed in; and as a consequence, I think we were able to make better progress than we otherwise would.

Any questions or comments on this?

MR. WATKINS: Are the various disciplines expected to be represented on this PSRO?

DR. MARGULIES: I think the PSRO council is described within the legislation and, as I recall, that council is made up entirely of physicians. Now, I could be corrected on that.

MR. WATKINS: That's how it's listed, medical societies and physicians. What I'm asking is that --

DR. MARGULIES: Are you talking about the national council or the local PSRO?

MR. WATKINS: Local.

DR. MARGULIES: I think the local PSROs are expected to be made up of a fairly broad spectrum of the health providers. During the phases of its development -- that is, when the Bennett amendment was being debated -- the congressional intent was quite clear that this would provide an opportunity

for a very wide representation of the providers of medical care and it was also quite clear that it could not be the captive of any one segment of the health professional community. So even now, some of the foundations which have been established and which anticipate becoming PSROs have decided that they have to broaden their structure to make sure that they include some providers of medical care who have not been on their governing boards who need to be if this is to be a PSRO as they anticipate is required.

I think you might be interested at this point in the proceedings with a discussion of the President's budget message and the effect which this has on the Regional Medical Programs, and I assume that this is one of the things which has stimulated people to come to make some statement about the Regional Medical Programs.

If you have followed that budget, you know that it was one which was marked by austerity, which was designed around a very clear determination to keep government expenditures under control in this fiscal year and in the subsequent fiscal year, and has, as a consequence, gone through the entire panoply of government supported operations and reduced or eliminated whatever it felt could be reduced or eliminated with the maintenance of an effective federal activity and still with a consistent operation which will prevent inflation and uncontrollable or undesirable expenditures.

Certainly, a number of the decisions which were made have already been widely discussed. The actions on Regional Medical Programs are clearcut and we are taking appropriate steps to carry out those actions.

Let me go back over the situation as it was prior to the deliverance of the President's message on the budget. We operated during the entire fiscal year under what is known as a continuing resolution. That is a legislative arrangement which allows programs for which funds have not been appropriated to continue to operate until those funds have been appropriated. We won't go back over the rules of how that functions.

There were on two occasions appropriation acts reported out by Congress which were vetoed by the President because they represented, in his judgment, excessive spending. As a consequence, we were on a continuing resolution and technically still are until February 28, until Congress acted further or until the President's budget message was presented.

When it was presented, it represented two fiscal years so far as health activities are concerned, the remainder of this fiscal year and next fiscal year. The initial recommendation at the beginning of the fiscal year by the President for Regional Medical Programs was a total of about $125 million. With the amendments, two things occurred which led to the conclusion that the Regional Medical Programs will be phased out.

In this fiscal year, the total amount available for grants is approximately $55 million and there will be no funds available for Regional Medical Programs under Title 9 for fiscal year 1974.

Now, this is possible and logical because the legislation for Regional Medical Programs terminates on June 30 of this year. The Administration will not submit new legislation for continuation of RMP. Consequently, those operations which must be maintained after June 30 will be supported by funds which are placed under Section 304, which is in the National Center for Health Services R&D, so that the operational activities of RMP will be maintained in the next fiscal year as necessary during the phase-out processes of RMP and there will be no funds which will be appropriated for Regional Medical Programs in fiscal year 1974.

Now, this means that we had to take certain steps in order to go from where we are to where it is intended that we need to go. After it became clear what the message was and what the plans were, we sent out, with the approval of the Health Services and Mental Health Administration administration, a telegram, a copy of which you were also sent---I don't know whether they got to you in time or not -- which provides a series of steps for the RMPs in deciding what it is they propose to do to move from where they are to a termination of activities by a specific date.

Now, our primary goal is to reduce RMP activities from where they are to a point of phase-out as close to June 30 as possible of this current year. We have provided opportunities, however, for an orderly and an equitable phase-out because there are obviously some potential disparities based upon our method of providing grants and on the accidents of the past year.

You may recall that what has happened in the grant process is as follows: We have Regional Medical Programs now operating on three different fiscal years. One begins in September; one begins in January; and one begins in May of each year. It's the latter group that we are here to review during the closed session of this Council. Those that were reviewed for September were given a grant award for the following year, for a full year. Those that were reviewed for January were affected by the new budget message or in anticipation of the new budget message and were given grant awards to cover six months of operation, taking them from January 1 to June 30, and those which will be reviewed this time will have grant awards only for the remaining two months of our fiscal year in which they are operating, which means that there will be clearcut disparities in the funds available under these arrangements.

As a consequence, what we plan to do is ask all programs to come in by March 15 with a description of how they

propose to phase out their activities and we will look at the total of the sums available in this fiscal year from this fiscal year, distributed unevenly at the present time, and try to carry out some kind of distribution which leads to an equalization of the opportunities they have to phase out their activities in an orderly fashion.

Now, I don't know whether you have had an opportunity to review this telegram, but if there are any questions about that or about this process of phase-out at the present time, I will be glad to answer them and Dr. Stone, if he cares to, can add anything that I'm unaware of.

DR. MERRILL: In reading the telegram and thinkin about one or two of the grants which I was asked to review, it seemed to me there was no possibility that such a grant, if approved, could be funded since it could not be started before June '73. Is that correct?

DR. MARGULIES: Yes. One of the things which we obviously had to include in our requirement was that there could be no new starts at the present time. So what we really will be talking about -- and we have some ideas we'd like to discuss with you in the closed meeting about the present review -- what we will be talking about is a way of phasing out or of doing some rebudgeting for an orderly phase-out, not any new starts at all.

DR. SCHREINER: I just wondered how you're going

to handle contracts which have finite lengths.

DR. MARGULIES: Contracts, where there is a clear-cut commitment, will require some special consideration. Certainly, those which were funded out of fiscal '72 funds and which are contracted to carry out their activities over a finite period of time will have a level of protection which is different from grant activities. Those which have been initiated in fiscal '73 will be looked at as contracts which should be allowed to continue if the total amount of funds available for orderly phase-out will allow it, but there may have to be, as we finally get to the point of total funds available in the fiscal year, some reassessment of that as well. We would hope not, but it would be difficult to tell until we see what the response is on March 15.

Now, if the Council would like to wait for a moment for any further comments or questions, I do think that if there are members of the public who would like to comment at this time it would be highly appropriate. I will do this in the order in which I just happen to have the names written down here unless someone has a reason to come in some other order I'll be glad to have them do it. We would like to have you indicate if you represent an organization, what organization it is, and if you wish to leave something for the record we will be glad to include it in the record of the Council proceedings.

The first name I have is Dr. Frederic Burke.

DR. BURKE: Dr. Margulies and distinguished members of the National Advisory Council of the Regional Medical Program, I appreciate this opportunity to submit a brief statement in support of continued assistance to develop and maintain programs for children with chronic lung diseases. I have just a one-page statement to make and some appended material summarizing the essential thrust and mission of our efforts in pediatric pulmonary disease which I will leave for your perusal.

My name is Dr. Frederic G. Burke and I am professor of pediatrics at Georgetown University and Vice President of the Association of Pediatric Pulmonary Centers. I represent all the pediatricians of the country and all of the staffs of these Pediatric Pulmonary Centers. The National Tuberculosis and Respiratory Disease Association is fully in accord with the objectives of these centers and has in the past supported these objectives aided by the Regional Medical Program.

We are deeply concerned about reports indicating deep financial reductions and indeed elimination of the services offered by the Regional Medical Program. Approximately 32 Pediatric Pulmonary Centers, proposed or existing, are threatened to be aborted or eliminated by such a step. Twelve of these centers are currently supported by RMPS.

Representing over seven million children afflicted

with lung diseases, I would like to plead most strongly for them and urge continued financial support to the splendid network of pulmonary centers intitiated by the Regional Medical Program Services. A listing of these centers and a map indicating their geographical and regional distribution is appended to this statement.

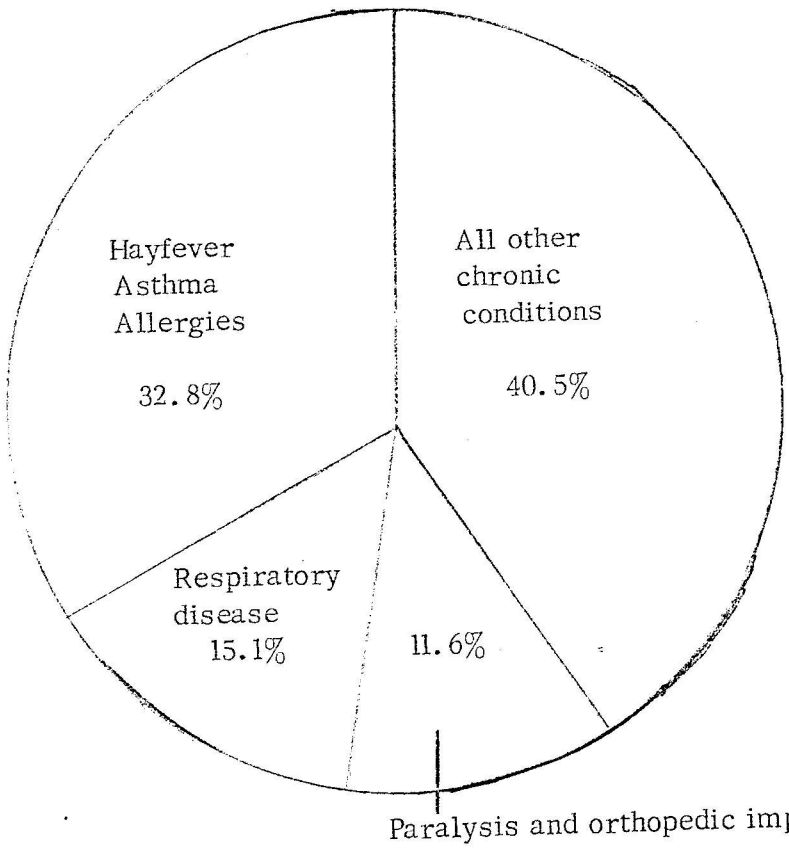
The Pediatric Pulmonary Centers provide care for children and young adults afflicted with lung disease. We believe that much of the high incidence of chronic lung disease in adults has its beginnings in early life and by early diagnosis and proper treatment in this period, much of the tragic consequences of pulmonary crippling can be reduced. These centers tress preventive services, improved clinical diagnosis and management. They are also committed to the education of professionals and the training of paraprofessionals in the care of children and young adults with chronic lung diseases. Figures documenting the scope and importance of these diseases in our young population are also appended. It is precisely because of these figures that programs for the care of individuals with chronic lung disease have consistently received high rankings in the priorities established locally by the Regional Medical Programs.

The needs of these seven million children and their families demand a continuity of support that must not be interrupted by political and jurisdictional change.

(Appendices follow)

Incidence and Importance of Recognition of Chronic Pulmonary Disease in Children

Forty-eight percent of all chronic conditions in children under the age of seventeen are due to allergy-respiratory conditions. This is a significant part of pediatric practice, so much so that we believe more emphasis needs to be turned to early recognition and treatment of these problems.



Incidence of Chronic Diseases of Children Under 17 Years of Age

DATA ON CHRONIC PULMONARY DISEASE IN CHILDREN

Source - National Center for Health Statistics - HEW, Washington

Unpublished figures from interview survey of civilian population, non-institutionalized.

1967 - Prevalence of Selected Chronic Pulmonary Disease among Children under 15 years

Hayfever without Asthma	1,934,000
Asthma with or without hayfever	2,040,000
Sinusitis	1,130,000
Bronchitis	1,401,000
Other	723,000
	7,228,000 *

Rate per 100 Population

Hayfever without Asthma	3.2%
Asthma with or without hayfever	3.4%
Sinusitis	1.9%
Bronchitis	2.3%
Other	1.2%

*The figure of 5 million children in the U. S. afflicted with chronic pulmonary disease did not include hayfever without asthma.

THE IMPACT OF ACUTE AND CHRONIC ILLNESS IN RESTRICTING CHILDREN'S ACTIVITIES
(National Health Survey, 1968)

	LIMITED IN SCHOOL OR PLAY FOR ILLNESSES	LIMITED IN SCHOOL (alone) FOR ILLNESSES	DAYS SPENT IN BED FOR ILLNESSES
	(age 0 - 15)		(age 0 - 15)
HILDREN WITH CHRONIC ONDITIONS (1966-1967)	1,097,000		
ER CENT OF ALL CHILDREN ITH CHRONIC CONDITIONS			267,655,000 (4.5 days lost by every child)
OTAL DAYS OF RESTRICTED CTIVITIES FOR ALL HILDREN (1968)	597,133,000 (almost 10 days lost by every child)		
	(age 0 - 17)	(age 6 - 16)	(age 0 - 17)
AYS LOST FOR LISTED CUTE CONDITIONS (1968)	605,629,000	191,562,000	266,973,000
. Infections	99,020,000	33,209,000	49,561,000
2. Acute Respiratory	343,605,000	122,683,000	169,288,000
a. Acute URI's (colds)	(175,067,000)	(59,005,000)	(73,211,000)
b. Influenza	(143,409,000)	(60,719,000)	(84,996,000)
c. Other Acute Resp.	(20,128,000)	(2,959,000)	(11,080,000)
3. Gastro-Intestinal	25,563,000	7,772,000	10,459,000
4. Injuries	81,130,000	12,035,000	15,388,000
5. All Other Acute	57,261,000	15,873,000	22,277,000
DAYS LOST FOR LISTED CHRONIC CONDITIONS (1968)	62,912,000	27,667,000	11,067,000
1. Asthma (22.3% rate set in 1959-1961)		6,336,000	
2. Other Allergies (4.5%)		1,245,000	
3. Other Respiratory Diseases (27.6%)		7,636,000	
4. All Other Chronic Conditions (45.6%)		12,450,000	
DAYS LOST FOR ACUTE AND CHRONIC CONDITIONS	668,541,000	219,229,000	278,040,000

PREVALENCE OF CHRONIC CONDITIONS AMONG CHILDREN IN THE UNITED STATES OF AMERICA

(National Health Survey, 1968)

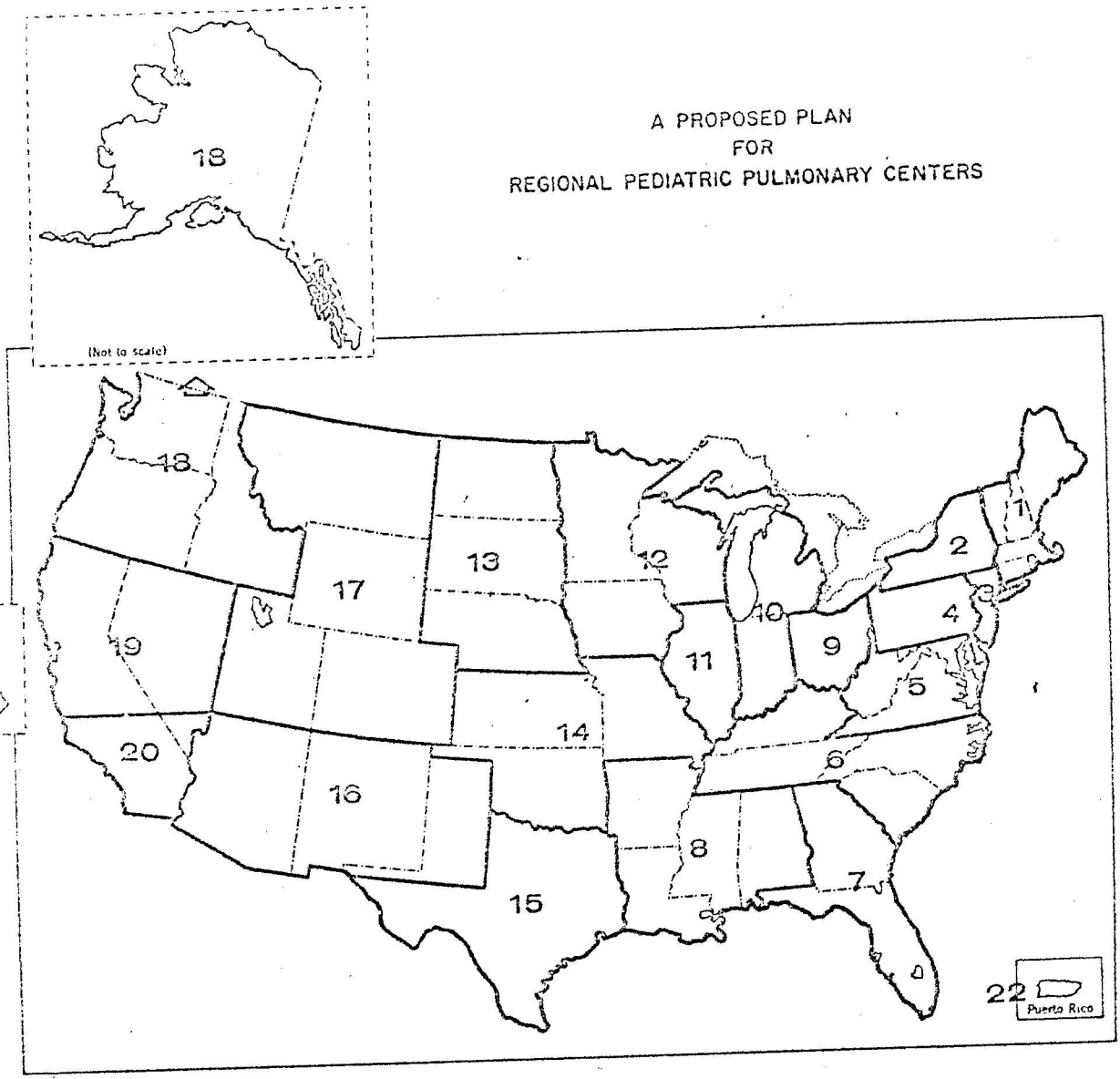
	BOYS		GIRLS		BOTH
TOTAL POPULATION	51.90%	34,776,000	48.10%	32,230,000	67,006,000
ALL CHRONIC LISTED CONDITIONS	25.42%	8,840,000	21.04%	6,780,000	15,620,000
1. Hayfever, Asthma & other allergies*	10.67%	3,711,000	9.02%	2,907,000	6,618,000
2. Other Respiratory Conditions*	5.99%	2,033 000	5.10%	1,644,000	3,727,000
3. Orthopedic & Paralytic	2.48%	862,000	2.20%	709,000	1,571,000
4. Skin Diseases	1.43%	497,000	1.58%	509,000	1,006,000
5. Digestive	1.32%	459,000	0.85%	274,000	733,000
6. Speech Disorders	1.19%	414,000	0.50%	161,000	575,000
7. Hearing Problems	0.96%	334,000	0.63%	203,000	537,000
8. Visual Disorders	0.65%	226,000	0.56%	180,000	406,000
9. Mental & Nervous Conditions	0.73%	254,000	0.60%	193,000	447,000
* ALL CHRONIC RESPIRATORY	16.66%	5,794,000	14.12%	4,551,000	10,345,000 (15.4 %)

CHILDREN WHOSE ACTIVITIES ARE RESTRICTED BY CHRONIC DISEASES

	NUMBER	PER CENT OF ALL CHILDREN	PER CENT OF ALL CHRONIC CONDITIONS
ALL CHRONIC CONDITIONS	15,620,000	23.3%	100.0
[illegible]SE WITH ANY LIMITATIONS	1,427,000	2.1%	9.2%
[illegible]HOSE WITH SOME LIMITATIONS IN SCHOOL OR PLAY ACTIVITIES	825,000	1.2%	5.3%
[illegible]SON WITH "LESSER" [illegible]TIONS	602,000	0.9%	3.9%

(Data from the National Health Survey, 1968)

A PROPOSED PLAN
FOR
REGIONAL PEDIATRIC PULMONARY CENTERS



CENTERS CURRENTLY CONSIDERED ACCEPTABLE FOR CONSIDERATION AS PEDIATRIC PULMONARY CENTERS

No.	Area	Center	Location
1	Northeast	Combined Boston Medical Schools and Boston Children's Hospital	Boston, Mass.
2	Northeast	Yale University	New Haven, Conn.
3	Upper New York	Albany Medical Center	Albany, N. Y.
4	Upper New York	Rochester Medical School	Rochester, N. Y.
5	Metropolitan New York and New Jersey	Combined New York Medical Schools and Babies Hospital	New York, N. Y.
6.	Greater Delaware Valley and Pennsylvania	Combined Philadelphia Medical Schools and Hospitals	Philadelphia, Pa.
7	Washington, D. C. Maryland and the Virginias	Combined Washington, D. C. Medical Schools and Hospitals	Washington, D. C.
8	Mid-Atlantic	Duke University Medical School	Durham, N. C.
9	Southeast	Medical College of Georgia	Augusta, Ga.
10	South	Tulane University Medical School	New Orleans, La.
11	South	University of Mississippi Medical Center	Jackson, Miss.
12	No. Ohio	Case Western Reserve Medical School	Cleveland, Ohio
13	So. Ohio	Ohio State Medical School	Columbus, Ohio
14	Michigan	Detroit Children's Hospital	Detroit, Mich.
15	Indiana	University of Indiana Medical School	Indianapolis, Ind.
16	Illinois	Northwestern University Medical School and Children's Memorial Hospital	Chicago, Ill.
17	Minnesota	University of Minnesota Medical School	Minneapolis, Minn
18	Wisconsin	University of Wisconsin Medical Center	Madison, Wisc.
19	Plains	University of Nebraska	Omaha, Nebr.

No.	Area	Center	Location
20	Missouri	Combined St. Louis Medical Schools and Hospitals	St. Louis, Mo.
21	Kansas	University of Kansas Medical Center	Kansas City, Kans.
22	Oklahoma	University of Oklahoma Medical School	Oklahoma City, Okla
23	Texas	Baylor Medical School	Houston, Texas
24	Southwest	Lovelace-Bataan Medical Center and The University of New Mexico Medical School	Albuquerque, N. M.
25	Rocky Mountain	University of Colorado Medical School	Denver, Colo.
26	Intermountain	University of Utah Medical School	Salt Lake City, Utal
27	Washington/ Alaska	University of Washington Medical School	Seattle, Wash.
28	Oregon	University of Oregon Medical School	Portland, Ore.
29	No. California/ No. Nevada	Combined Medical Schools and Hospitals, San Francisco and Oakland Bay Area	San Francisco, Cal
30	So. California/ So. Nevada	Combined Los Angeles, Orange County Medical Schools and Hospitals	Los Angeles, Calif
31	Hawaii	University of Hawaii Medical School	Honolulu, Hawaii
32	Peurto Rico	University of Puerto Rico	San Juan, P.R.

Grants

on	Began	'68 DC	'68 Total	'69 DC	'69 Total	'70 DC	'70 Total	'71 DC	'71 Total	'72 DC	'72 Total	'73 DC	'73 Total
fornia (Irvine)	7/68 #23 #84			206,100	272,600	206,500	237,700	125,600	175,400	108,388	135,550	110,000	137,4
rado/Wyoming	1/69 #13 #33			58,100	71,000	76,000	91,000	33,800	38,600	40,000	51,211		
rgia	7/68 #14			133,600	156,600	170,800	209,400	114,100	143,500	73,333	90,305	33,300	49,2
ater Delaware Valley	4/68 #4, A, B, &C			188,270	247,500	242,477	319,200	?	161,556	177,083	247,599	$47,649 (50, [illegible] (54,[illegible] (32,[illegible]	
[illegible]	2/68 #11			210,900		114,600		82,700	107,000	94,853	121,000	82,285	
w Mexico	11/68			59,600		95,700	121,200	73,700	99,100	66,900	94,424	Contract for $135,0[illegible]	
w York Metro	2/68 #2 #31 A & B			157,500	255,300	141,600	191,100		172,000	Plus NCHS Contract for $150,000 7/1/72 148,732	213,736		
erto Rico	5/70 #3					125,000	137,300	134,135	137,558	104,337	118,393		
ashington/Alaska	2/68 #19 #49		54,800		53,400					53,954	75,724		

	'68		'69		'70		'71		'72		'73	
	DC	Total	DC	Total	DC	Total	DC	Total	DC	Total	DC	Total
ana illiam Waring									230,000	273,581		
olitan D.C. rederick Burke									105,000	133,826		
ska Gordon Gibbs									45,083	55,718		

Previous Contracts

getown University Frederick Burke	7/68 to 7/71	$216,891	→	See Metro D.C. RMP
emann Giulio Barbero	6/68 to 6/71	$209,164	→	See Greater Delaware Valley
Angeles Co-USC Daniel Wiseman	6/68 to 6/71	$217,500	→	New proposal turned down by RAG Tech Rev Panel in Cal.
lane University William Waring		$216,916	→	See Louisiana RMP

DR. MARGULIES: Thank you, Dr. Burke.

I don't believe Dr. Moses is here. He called and indicated he would not be here. He was going to send a telegram but I haven't seen it yet. If it arrives I will read it into the record for him.

Next, Bob Blum, representing the National Student American Medical Association.

MR. BLUM: Mr. Chairman, ladies and gentlemen of the National Advisory Board to the Regional Medical Program, I am here today representing the Student American Medical Association to urge continuation and support for the Regional Medical Programs. My name is Robert Blum; I am a senior medical student at Howard University and am presently the Chairman for SAMA's National Student Health Projects. I speak from the perspective of the health science student and as one who has spent two summers doing community health work with Indian American communities.

SAMA wishes to register strong support for continuation and strengthening of the unique nationwide network of 56 Regional Medical Programs. From the viewpoint of the health science student, RMP has represented programs rooted in community concerns with a greater willingness to experiment with new modes of health care delivery and a wider concern in incorporating the various health provider groups into such plans than most any other program in the nation. It has

represented a neutral body offering quality programs respected by most health science institutions, yet not restricted by the parochialism of those institutions. And, it has provided opportunities for the development of new educational experiences and patterns of cooperation. It is in this arena where SAMA has worked most closely with the local Regional Medical Program.

In Appalachia SAMA has been sending interdisciplinary teams of nursing, dental, medical and pharmacy students for the past five years. These teams work not only under local health providers who act as preceptors but also work with the community on specific public health concerns. A number of Southeastern RMPs have assisted us there. North Carolina, South Carolina and Tennessee Mid-South have provided not only funds, but expertise as well. The end result is to bring increased health services to the region while also stimulating local health manpower.

The American Indian Health Project which extends from California to Arizona, New Mexico, Montana and the Dakotas involves communities who have requested student health teams to work on specific projects for the summer months. There again, the local RMP in Arizona has assisted not only with funds and administrative support, but with the generous advice of Drs. Thompson and Melnick.

In terms of migrant health, the Oregon RMP supported a student project in its region; support which has

led to the establishment of a permanent clinic serving migrants. And the Colorado RMP has funded a student health project which has meant two ongoing clinics and constant student and health professional input in migrant areas of Southern Colorado.

As regards premedical and preclinical students, the Student American Medical Association's Medical Education with Community Orientation (MECO) program has placed over a thousand students annually in small community hospitals in almost every state of the union. There, too, local RMPs have been of great support -- specifically, Nebraska, Illinois and North Dakota.

And in South Dakota, the Regional Medical Program has supported a health science coalition, which, among other activities, has provided services to area Native American communities.

Prior to the Administration's announcement of its planned phase-out of RMP, SAMA had developed with RMPS a proposal whereby students throughout the country would establish local planning committees with the 56 RMPs bringing together students, local health providers and consumers, academicians, and various state and county agencies to deal with specific health needs of the area. It represented a mechanism where the experiences of Appalachia, migrant camps and Native American communities could be amplified many fold. And it was the first attempt at an interface between providers and

consumers on a state level, where future health professionals would have significant input.

There were other plans, too, which had been made. South Carolina RMP expected to support the first year-round project starting in the fall, 1973. And new training programs for interdisciplinary team function were being explored.

Presently, all these plans are in question. If the Regional Medical Program is not supported, not only will future health professionals be the losers, but more importantly, those communities which are suffering under the blight of decreasing health services will lose. Over the past two years the Regional Medical Program has served a vital role as a change agent as regards health science students.

We, of the Student American Medical Association, urge you to bring this case to Congress and press for continued support for the Regional Medical Program. Since SAMA's charge is in exposing young health professionals to community health needs and to the organization and delivery of health services and since we see a tremendous potential for the Regional Medical Program to play a significant role in this mission, SAMA is prepared to offer testimony before Congress in support of retaining and strengthening the Regional Medical Program.

DR. MARGULIES: Thank you, Mr. Blum.

I have been asked to read into the record a

statement from the American Nurses Association. I will do so. It's not terribly long. It is signed by Eileen Jacobi, Executive Director of the ANA.

"The American Nurses' Association would like to have its concerns about the proposed complete cut-off of funds for the Regional Medical Programs brought to the attention of the Advisory Council.

"A program of the complexity of RMP which crosses the usual institutional and geographic boundaries for cooperative efforts takes several years to become fully operational. As is expected, there is a variation in the effectiveness of the programs depending on the individual leadership available and the readiness to cooperate that exists in that area at the time. Nursing participation in Regional Medical Programs was often rather minimal in the beginning.

"In recent years, however, there has been solid achievement evident in most RMPs. Their continuing education programs have met the needs of many health practitioners. In just the past week we have heard cries of anguish about the budget cuts from nurses in the States of Washington, Wisconsin, District of Columbia, Georgia and New York. These people feel strongly that RMPs are achieving their goals and that patient care is being directly improved through these efforts. The intent of this legislation is to make the advances in health care made possible through research more readily available to

to the average citizen. The need to continue efforts in this direction is still obvious. The planning and coordination efforts of RMPs have also been important contributions.

"We speak now to urge reconsideration of the budget decisions relative to closing out Regional Medical Programs. That is not to say that renewal legislation should not be altered to meet changing needs or even that funding levels should be greatly increased. At this time our concern is the proposed closing out of valuable programs while offering no alternative ones to fill the gaps.

"The public, as well as health personnel, cannot repeatedly plan on certain services only to find them abruptly cancelled.

"We urge the Council to use its good offices to provide reconsideration of this important subject and we are more than willing to provide any assistance we can for that purpose.

"It is the position of the American Nurses' Association that high quality health care is a right of every citizen. At this time we think RMPs are making a significant contribution to improving that quality.

"I hope this statement can be made a part of the record of your meeting on February 7, 1973, and I regret that I could not personally address you."

Dr. Teschan, would you like to speak at this time?

DR. TESCHAN: I think all of you can understand what the impact of this development has been on the 56 regions. I think it's important, however, for you to understand that the professionalism of the teams assembled for RMP in the 56 regions are recognizing the necessities that Dr. Margulies is confronted with and we shall comply precisely as required to the requirements laid on him and upon us.

The net effect is that we are having to deliver to the various people with whom we are associated the fact that those expectations which have been raised as a result of the cooperative arrangements laboriously put together are now going to be washed out, and this comes at a time when, as we see it in the country, it's critical that the delivery of health services be orchestrated with some kind of cooperative partnership between various levels of government and the people who actually deliver most health services, namely, the private institutions and the private providers of health care.

Now, when you think about it, there is no other existing mechanism available today for that kind of arrangement to occur. In the counties, in the geography where the action is, when you have as widely regionalized arrangements as the RMPs and as many participants, it follows that like multiple human institutions there will be untidy development. It doesn't proceed in nice, clean, square marching order, however nice that might appear to bureaucratic thinking. But, on the other

hand, it has all of the excitement of individual creativity where the action is.

So I think that quite aside from even grant support in terms of actually moving money, the thing that is in jeopardy today is the issue of the private providers of health care largely the people who do the health care providing being able to get together and organize a response to community defined needs.

Now, that's a fundamental mission which has to be, as we see it in the country, performed some way. It seems to me the alternative then is whether we do it with the existing organization or whether we try to develop some new one. Our feeling is that if RMP -- the RMP coordinators are unanimous in feeling that if the RMP mechanism which exists is phased out, then the chances of developing anything like that in any other way will probably either not occur or will take so long as to be useless.

I think the thing that probably has led to most outrage and most upset among coordinators and their staffs is the enormous disparity between the facts as we know them and the language of the FY '74 budget message; that is, the narrative in the budget. Statements made there clearly imply or communicate that the authors of that language do not know enough about what goes on in the RMPs to be able to make those statements.

So, essentially, we have felt it essential to

develop the information which will clearly point out that the allegations made in the budget statements are simply not true.

I am delighted to inform you that as a result of a national data project, we have the figures to prove the effectiveness of the expenditure of a half billion dollars in five years. We have the data to prove that patients have been served and that, given the situation of trying to organize individual private enterprises throughout the country, that what has actually happened is really a very creditable record in achieving them. That kind of organization has involved the secondary and specialized care as well as the primary access services and the issues now being addressed of quality assurance and of the continuity and the relationship between these kinds of care.

So, essentially, we have got a going concern that is doing the job in the experience of the coordinator group. So, essentially, knowing that, you see, the staffs tend to be very tightly woven and are very coherent at this point. They are remaining together and we are going to proceed together and respond to Dr. Margulies' direction and we are going to remain together as long as possible so that these instruments for doing this job will be available whenever it is finally determined the direction that RMP really should take or what ultimate form it should ultimately have. That kind of talent and capability will be needed in some form.

I think the coordinators also will agree that a particular name, a particular means of operating in a changing situation, as a change agent, means that the RMP structure may have to change. That's not a threat. We are not looking at ourselves as a bureaucracy. In the words of Alvin Toffler, we are looking at ourselves as an adhocreaucy; that is, an arrangement that changes as the need changes. But the basic mechanism, the basic process, the basic talent must be preserved in some way and this is an extremely valuable instrument which has responded to the administration's interest and directions according to Mr. Nixon's White Paper and in accordance with the administration direction up to now, the programs have responded. As such, they have demonstrated their capability of being a change agent and of responding to new requirements.

So it's this capability that I think the coordinators most wish to preserve and I think that's as much as we need to say. Thank you.

DR. MARGULIES: Thank you very much, Dr. Teschan.

Next on the list I have Dr. Mackintosh, Virginia Academy of Family Physicians.

MR. MACKINTOSH: I am Alan Mackintosh and I am President of the Virginia Academy of Family Physicians and Vice President of the county medical society. I'm a practicing physician in Vienna, Virginia, just across the river, in Fairfax County.

I am not representing these groups, although each has endorsed RMP in the past. I did not have enough time, frankly, to ask for resolutions pertaining to the continuance of Regional Medical Programs for my separate organizations because I just heard about this meeting yesterday. However, I can speak from experience in that I have been a member of the Regional Advisory Group of VRMP for the past two and a half years and chairman of its review and evaluation committee. I am also a member of the Medical Society of Virginia Liaison Committee to RMP since its inception.

As a refugee from the British national health system, I never thought I'd see the day when I would endorse any federal program in the name of health care, but I am pleased with the results in Virginia where all health professionals are being involved. Quality assurance programs are directed into nursing, pharmacy, and dentistry, as well as the medical profession. Private practicing physicians have available systems for self-evaluation to delineate their deficiencies and thereby point out areas in which they can concentrate their continuing education efforts.

You might say that doctors can well afford to pay for their own post-graduate education and basically I agree; however, RMP in Virginia have studies ongoing at present specifically geared to other less affluent health care providers. For example, coronary care nurses, family nurse practitioners,

pharmacists in rural areas, technicians in radiology and laboratory disciplines, medical librarians, dental assistants. Even for M.D.s money may be no object, but finding a nearby course or facility to educate himself or herself is difficult instead of having to leave his practice for days.

Virginia Regional Medical Program is bringing the consultant to the periphery. This relieves the consumer of the need to seek temporary care while his provider is off in some medical center having a good time.

I am sure there are other methods of achieving the same results, but until RMP began no one coordinated areawide efforts in this area. No one had that obligation. A plethora of programs will always be available in this great nation but the individual provider will be left very much on his or her own to seek out experiences to make him or her a better professional after the demise of RMP.

Lastly, it has taken quite a few years to develop the confidence of health care providers in RMP and I am finally seeing my colleagues lose their natural reticence to accept a federally sponsored program. I do not wish for my testimony to sound like blackmail, but I will be very hesitant to recommend any future federal health care system to my fellow physicians. After all, RMP has only been in existence five or six years and now plans are afoot to phase it out.

I respectfully suggest that this Council consider

the continuance of RMP and that this statement be placed in the official record. Thank you.

DR. MARGULIES: Thank you, Dr. Mackintosh.

Dr. Weinzettel, representing community hospitals.

MR. WEINZETTEL: I will correct you, Dr. Margulies. Mr. Weinzettel is not an M.D. I am executive director of the medical center at Savannah, Georgia. I represent the State of Georgia as a delegate to the American Hospital Association where I presented a resolution before the delegates which convened in Washington, D. C. this date.

The resolution requests that the Regional Medical Programs be reevaluated to give necessary budget consideration to make RMP viable and on going and I presented it to the House of Delegates yesterday. The entire resolution is available for the record. I will not read the resolution in its entirety in view of the fact that most of you know the advantages of this program to the rural, urban and ghetto areas of this nation.

The Georgia Hospital Association, however, has endorsed this program and we also have the endorsement of the American Hospital Association.

As an administrator, I would like to speak to the problems that I have to face as an administrator down in Savannah, Georgia. We believe that this program represents the expertise of specialists in the field of health care that can best provide the services required or requested by government -- that is

required to be provided as requested by government because this is the only program that I have been familiar with -- and I have been involved in Model Cities programs, in OEO programs and outreach programs of this type where they have had no expertise really to perpetuate their programs in a manner that has been carried on in Georgia, with the development of innovative concepts of delivery of health care that this program has fostered, such as area health facilities programs, family planning, publications, health access stations, development of coronary care units tied to medical centers out of small community hospitals, continuing education in small community hospitals to bring the level of education in those hospitals where there has never been an opportunity of educating the nurses and the continuing education of nurses and other paramedical specialists in small hospitals.

We have carried on this program as an outreach program of the medical center and 11 small hospitals surrounding the Savannah area where we have specialists who go out in the field and teach in these small hospitals to try to raise the level of education of all personnel within the organization. We feel all this will go down the drain if this program is discontinued.

I think the other facet that is so important is we have developed health access stations in rural counties in Georgia where there has been no doctors whatsoever. This has been in cooperation with the Emory University where nurses have

been trained to perform the functions of doctors under the guidance of doctors in counties adjoining the counties where there are no physicians. What type of financial support are these counties going to have in the future if these moneys are no longer available from the Federal Government?

The action of the President or the Administration with regard to cutting off funds is not consistent with the program itself. As an administrator, I'm going to be faced with additional expense problems in view of the fact that in this year's budget I have budgeted for programs that I am affiliated with with the Regional Medical Program. Obviously, if these funds are cut off, what is my position to explain this to my board of trustees? How do I do this? I have a deficit operation as a result of the RMP pulling out. As I say, it's not consistent with the normalcy of the program in view of the fact that the program normally contains a three-year program of projects whereby you try to develop during that three-year program a financial position which would enable you to fund the project as soon as the federal moneys are withdrawn.

The RMP has developed really a seed program of special projects for hospitals and other providers that has a proliferating effect because over and above that they provide other projects in which the hospitals become involved. We are being squeezed financially by the Federal Government because we are still under the economic stabilization program and any effect

to our budgets as a result of withdrawal of funds of this program will also be an added cost program to hospitals throughout the nation.

We urge that this program be continued and assist state planners, medical directors and hospital administrators in developing alternative funding methods. It would be required that we have alternative funding methods if this program is dropped.

As I stated earlier, we would like to have the American Hospital Association as well as this organization reevaluate the position relating to RMPs and to give necessary budget consideration to make RMPs viable and ongoing.

DR. MARGULIES: Thank you very much.

Are there other members of the public who would like to speak to the Council at this time?

There is a telegram from Dr. Hurst, Past President of the American Heart Association as follows:

"The American Heart Association has followed with great interest the activities of the Division of Regional Medical Programs and is greatly concerned by the zero level of funding proposed in the 1974 presidential budget request. We urge the advisory council to take a strong stand in support of the continuation of those RMP activities that have successfully demonstrated their ability to improve the quality of local and regional medical care."

Is there other comment from members of the Council?

DR. McPHEDRAN: On this subject?

DR. MARGULIES: Yes.

DR. McPHEDRAN: Does it have to be entered into the record now or would there be any reason why it couldn't be put off until later on?

DR. MARGULIES: It could be. We will have other opportunities.

DR. McPHEDRAN: Okay.

DR. MARGULIES: Let me just add a little bit to what I discussed with you earlier in the presentation of the phase-out activities, by telling you something of how we are proceeding.

Our experience in phasing out the Regional Medical Programs is limited so we have had to devise some techniques for operating it as effectively as possible. We are meeting as a group of key staff people every day so that we can consider, in the light of what kind of responses come in through telephone calls and direct visits and so forth, some of the issues which must be addressed. We are trying to establish some kind of grid of action which we could use to advise the coordinators, the regional advisory groups and grantees as they prepare their response to the telegram, and so that we can have some basis for what action we have to take in deciding on the final distribution of funds by April 15.

This has led to a further elaboration of some of our concerns with such issues as how we handle contracts versus grants. The issue which several people raised of the potentiality for maintaining those areas of competence which RMPs have established over the past several years, so that they can be of value in other structures is an issue of concern to us, as well.

To be more specific, where RMPs have proven themselves to have a kind of professional capacity which is multiform in nature and which could be utilized in other kinds of ways, there should be consideration within the states or within regions of ways in which these kinds of skills can be put to their best possible use.

As a consequence, we would hope that as the phase-out activities are progressing, there will be consideration by state legislative bodies, departments of health, planning commissions and so forth of the uses to which the experience and skills of RMP staff people might be put. This will be as much as possible a part of the general consideration which we will give to the material which is transmitted to us and the kinds of decisions which we will then have to make based upon those submissions which are due on March 15.

This means that there is a fair amount of shifting of detailed decisions from day to day, but I think we are gaining a reasonable level of understanding. This has been interrupted

only by the meeting of the Council, which is of great help in these deliberative processes in any case.

DR. McPHEDRAN: Dr. Margulies, maybe I will enter this into the record now.

I feel that the Administration's plan to end RMPs is a serious wasteful error and I think that this error is based on ignorance about what the RMPs have achieved. As Dr. Teschan implies, the budget message implies or asserts that RMPs have not met the aims that they should have and the implication is that they should have done so by now. For my own part, considering human frailty and the huge task to be done, I'm surprised at the progress to date.

For example, in fostering cooperative arrangements among "health providers," everyone who knows anything about medicine knows how insular physicians are, how jealous they are of their prerogatives and how sure they are that they are right. If the Administration is really serious about its stated wish to improve the quality of medical care in this country, including the prevention of disease through voluntary -- that is, specifically not compulsory -- arrangement, then it will need the active cooperation of doctors and hospitals, medical schools, medical students, in regional organizations.

The RMPs are beginning this task which will doubtless take decades, and no other organizations have even made a start on the enterprise.

This ought not to be regarded as a political matter. It would be irresponsible to waste the resources we now have by ending the RMPs and I, too, urge that the Administration reconsider its decision to do this.

DR. MARGULIES: We will, of course, not only enter these comments in the record, but they will be transmitted, as the records of this meeting are, to the administrator of HSMHA for him to bring to the attention of the department, and you may be assured that there will be full consideration of all of these comments.

Well, if there's no further discussion on this subject or if you would like to return to it later during the open session, we may do so. I would like to move to some information for you and then specifically on RMPS. After that, I will provide you with some further data regarding the work we have been doing with the Social Security Administration on dialysis and transplant reimbursement; and after that, bring to your attention the planning of the Urban Health Conference.

I think you would be interested in knowing some of the changes which have taken place during the past several months within the Regional Medical Programs. I will go through these very swiftly for you.

In the Albany RMP, Dr. Girard Craft has replaced Dr. Woolsey as coordinator. In Iowa, Dr. Charles Caldwell has been the new coordinator since October. In Oklahoma, Mr. Al

Donell has been the coordinator since January 1. You may recall that Dr. Groom retired around September of 1972. In the Intermountain RMP, the Regional Advisory Group has nominated Dr. Ward Studt to be the grantee to be the coordinator of that program.

There have been some resignations from programs. Metro D.C., Dr. Wentz has resigned; in New York Metro Dr. Brightman has resigned; in South Dakota, Dr. John Lowe has resigned; and in Connecticut Dr. Henry Clark is resigning as of April 30. Indiana has Dr. Beering still acting and in Western Pennsylvania David Reed is going to continue as he has been for the past year to be the coordinator of that RMP.

Finally, there is a new grantee arrangement in Texas where there's a nonprofit organization rather than the University of Texas system. This was arranged with the backing and cooperation of the University of Texas system and on their part indicated a better way of managing a statewide system which will allow the university to play an active role but which will not run into some of the bureaucratic encumbrances of being in the University of Texas system with the complications which are involved in that rather large kind of a plan.

Dr. Hinman, would you like to summarize the letter which has been sent out and the purposes of it? I think we have copies of it for distribution.

DR. HINMAN: The Social Security Administration is

charged with the implementation of the end stage kidney program under H.R. 1. We have been requested, through the RMPs and through the Comprehensive Health Planning Service and their local CHP agencies, to assist in the identification of facilities to provide this treatment throughout the country.

To this end, about two weeks ago a memorandum was sent to the coordinators of the RMPs and the director of the state CHP agencies alerting them to the fact that they would be getting additional informational requests to submit to the Bureau of Health Insurance certifiers in the local regions. Tomorrow and the next day the Social Security Administration is convening an expert committee to give them suggestions and advice concerning some of the criteria that may be applied to facilities, both hospital-based and self-standing limited care facilities, to provide this care.

RMP has been asked to participate in this activity and we will do so. After they have decided upon the criteria and the regulations that will be applied, this information plus data that has come to us from the contract we have with the Joint Commission on Accreditation of Hospitals, will be forwarded to individual RMPs to meet with our regional advisory groups and the health planning agencies in the area to then furnish a list to the local Social Security representatives.

As you are aware, we have a contract with JCAH to survey hospitals as to the specialized facilities they have.

This was in furtherance of the implementation of Section 907. The deadline for this is the SSA has to be operational, at least have the plans out to the people in the field, the forms and certification, around April 1st, because the law becomes effective July 1. So it's a very tight deadline that the RMPs and CHPs are working under.

Any questions?

(No Response)

DR. MARGULIES: Dr. Chandless, would you like to bring the Council up to date on the Urban Health Conference?

DR. CHANDLESS: I would indeed. We thought that the Council would like to know of planning that's gone on for an Urban Health Conference. The date for the conference has already been set as May 13 through 16 in Chicago. It will be held on the campus of the University of Chicago at the Center for Continuing Education.

Prior to the St. Louis meeting on quality assurance, there was a planning group that met which consisted of six coordinators, members of the staff of RMPS, and members of the planning service of a number of regional medical programs. It is anticipated that the conference will invite or will have some 300 invitees which will consist of the 56 coordinators, the chairmen of the regional advisory groups, members of their planning staffs. There will be a list of special invited guests and participants and speakers.

At the St. Louis planning meeting, the agenda for the conference was spelled out and now the planning for the conference in May is getting down to very precise terms. At the conference, it is expect to have wide ranging discussions on the issues in urban health and an attempt to find some of the solutions to improving the quality and quantity of health services being made available to those who live under the urban condition. Certainly it is expected to tap the resources and the expertise inherent in the RMPs so that that expertise can be focused along with other expertise at the local, state and federal level to get at some of the solutions and issues in urban health.

Each member of this Council will be invited and we will keep you informed by mail as to the details of the conference.

DR. MARGULIES: Thank you.

Are there any questions or any further comments either from the Council or members of the public on the agenda up to the present time?

If there are not, this will conclude the open portion of the meeting of the Regional Medical Program. We will have a coffee break and reconvene at 10:15 at which time we will have the closed session for review of applications.

(Recess)

CLOSED SESSION

DR. MARGULIES: I'd like to call the Council into session again. I think we have a couple people missing but we can probably initiate the business in any case.

As you know from looking at your agenda books and as you also know from the discussion which we have had up to the present time, we do have 11 programs with applications in to review at this meeting of the Council. However, with the phase-out of Regional Medical Programs, it means that whatever action you take -- and it is necessary that you take some action for us to do this -- we will be providing grant awards which, at best, would be the equivalent of two months out of twelve months of the year that those programs would be receiving awards.

In other words, you can take action. The maximum that we could award in any program would be one/sixth of what the Council level of approval is.

Now, as a consequence, we are going to propose that rather than go through a detailed review of the individual programs, we take bloc action, if you find that acceptable. Now, if this should prove to be a questionable activity in the light of any subsequent circumstances, we are scheduling another meeting of the Council in June, as you know. At that time, a number of other issues may come up, such as policy decisions affecting ways in which segments of RMP activities can be

maintained. There will have been some new analysis of other programmatic activities and of transfers and so forth which we are going to need Council advice on, but if you think it's reasonable, it would be possible for us at this time, rather than go through a detailed review which would lead to the kinds of Council actions which usually take place, we can, if you want to initiate a vote of that kind, simply carry out a bloc action which would be to approve the recommendations of the review committee, in which case we would have authority to expend those limited funds for the remainder of the fiscal year for those programs which are affected.

DR. OCHSNER: I so move.

MRS. MARS: Second.

DR. MARGULIES: It has been moved and seconded for us to take bloc action accepting the recommendations of the National Review Committee for the applications which are submitted for this round of the Council. Is there any further discussion? I will list them for you. They include under triennium, Intermountain and Washington/Alaska; anniversary prior to triennium, Louisiana, Maryland, New York Metro, North Dakota; anniversary within a triennium, Arizona, Connecticut, Iowa, Metro D.C., Tennessee Mid-South.

If there's no further discussion, all in favor please say "Aye."

("Ayes")

DR. MARGULIES: Opposed?

(No response)

DR. MARGULIES: Now, we also have an application from the New York-New Jersey Regional Transplant Program, which is an application which came before this Council on a previous occasion and Council deferred action so that some of the issues which were involved in the application could be resolved.

Would you like to speak to the status of that 910 application, Ed?

DR. HINMAN: The critical issues were that there was a question as to whether the institutions listed in the application actually had agreed to participate or not. In other words, we had two letters withdrawing support which arrived a week before the application. There were also some budgetary issues and the issues of representation on the advisory committee.

Staff has worked with the local RMPs and with the applicant and feels that these issues have been appropriately resolved. So staff is recommending that this application be approved. We raise the issue as to whether it would not be more appropriate for the grantee to be the Metro New York RMP rather than the Council of Blood Banks, so our recommendation is that it be approved to the Metro New York RMP as stated in your books.

DR. MARGULIES: Is there a motion for approval of this application?

DR. OCHSNER: I so move.

DR. MARGULIES: It's been moved. Is there a second?

MRS. MORGAN: Second.

DR. MARGULIES: Any further discussion?

DR. MERRILL: Excuse me, Harold, is this the 910 application I was supposed to review?

DR. MARGULIES: Yes. You were not here, but we took action on the preceeding programs. I think it would be perfectly appropriate to review this one. The problem is one of phase-out. So what we are doing is acting on the application. I think it deserves some discussion because it may be turned to other sources for its support. So we would appreciate your input at this time on that 910 application.

DR. MERRILL: Well, I essentially agree with the final words of what Ed said. I know the operation. I know the people involved. I think it's a little bit of a jungle, but I think they have made considerable efforts to look very hard at some of the problems and to resolve them in the most appropriate way. I think it deserves a try.

I would certainly, if it were going to run for a three-year period, want it very, very closely monitored because it's a very mixed bag of people who, frankly, I think may find it a little difficult to get along with each other over the long haul. But I think certainly action taken under these circumstances is appropriate.

DR. HINMAN: The acting coordinator, Metro New York, Dr. Aronson, has taken an extremely active interest in this and a strong leadership role. He feels that this may be the one opportunity to get some of the institutions in the metropolitan New York area that have not been in the habit of talking to each other to at least participate, and the way it is being done is that instead of bloc dollars being allocated to any one institution, it would be on the basis of services rendered. So the quality of your work and the quantity of your work is what determines whether you get any money, and he feels that this may be a vehicle to achieve the basic tenents of RMP.

DR. MARGULIES: Any further discussion?

All in favor say "Aye."

("Ayes")

DR. MARGULIES: Opposed?

(No response)

DR. MARGULIES: Well, that completes the necessary action for this Council. We have acted on the applications. We have acted on the 910 application. Unless there's other business which the Council wishes to bring up at this time, surprisingly enough, this will bring us to a termination. Any other comments, questions or issues?

DR. CANNON: I'd like to move that the Council send Vern Wilson a letter expressing appreciation of his interest in RMP during his tenure.

DR. OCHSNER: I second that motion.

DR. CANNON: I would say, off the record --

(Off the record discussion)

DR. MARGULIES: We will certainly accept the sense of the Council. We will omit the P.S., and we will write him in the name of the Council.

The meeting is adjourned. Thank you very much.

(Whereupon, the meeting was adjourned at 10:30 a.m.)