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Mc/LMc

224

DIVISION OF REGIONAL MEDICAL PROGRAMS

AD HOC REVIEW COMMITTEE

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Alabama Regional Medical Program

Motion for Recommendation  
PANEL "A"

Alabama Regional Medical Program

Motion for Recommendation  
---

Alabama Regional Medical Program

Motion for Recommendation

Conference Room G/H,  
Parklawn Building,  
5600 Fishers Lane,  
Rockville, Maryland, 20852,  
Wednesday, May 22, 1974.

PRESIDING:

CLEVELAND R. CHAMBLISS, Acting Deputy Director.

PRESENT:

- MRS. FLORENCE WYCKOFF
- DR. PHILIP WHITE
- DR. WILLIAM VAUN
- MR. ROBERT TOOMEY
- MR. JOHN THOMPSON
- DR. ROBERT SLATER
- MRS. JESSE SALAZAR
- DR. WINSTON MILLER
- DR. ALEXANDER MCPHEDRAN
- DR. ROBERT CARPENTER

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(continued on next page)



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1                   Then the P R O C E E D I N G S and she will truly  
2                   be one of MR. CHAMBLISS: Let me take this opportunity to call  
3                   Panel "A" to order and welcome you here to this particular  
4                   work group.                   She will be here while these proceedings  
5                   I think you should know that as we get into our  
6                   procedures for the next day or so that I will have at my right  
7                   and at my left two Operations Branch chiefs, Mr. Lee Van  
8                   Winkle, who is the Operations Chief for the South-Central  
9                   Operations Branch of the Division of Operations and Develop-  
10                  ment, and Mr. Mike Posta, who is the Operations Branch Chief  
11                  for the Mid-Continent Operations Branch.  
12                  I think the panel should know that we had expected,  
13                  as Dr. Pahl mentioned, Mrs. Silsbee to have chaired this panel  
14                  and it's due to her illness that I've been asked, just in the  
15                  last few hours, to chair the panel.  
16                  Dr. Pahl and I, as he mentioned, have been looking  
17                  at other things over the last eighteen months and especially  
18                  these matters having to do with OMB questions, with answering  
19                  questions from the Department dealing with the congressional  
20                  relations, all the questions coming from the Congress having  
21                  to do with the phase-out and the status of the program, the  
22                  inter-agency aspects of operating the program, and both of us  
23                  have left all but entirely the operational aspect of operating  
24                  the division to Judy, who has, I might say, served with great  
25                  distinction.

1           When the annals of RMP are written, she will truly  
2 be one of the strong people of RMP, a great person, a great  
3 lady, a prodigious worker, and a good friend to all of us.

4           Hopefully she will be here while these proceedings  
5 are underway, but Mike and Lee will provide me with lateral  
6 support, and at the same time we will have support from  
7 members of the Operations Staff and also a representative from  
8 the Grants Management Staff in the person of Mr. Larry Pullen.

9           I think the committee is well-aware of the fact  
10 that we are operating under a court order and I will only say  
11 one additional thing: Dr. Endicott said that things are a  
12 mess; I agree. I will only add my word of wisdom, if you can  
13 call it that, and that is, we have lived in a chaotic commu-  
14 nity over the past few months and this, in a way, culminates  
15 some of the trials that we have undergone by reviewing the  
16 applications from the regions that came in on May 1st, their  
17 application for funding beginning July 1, '74.

18           I think, as we get underway, you should know we will  
19 be operating under the Mission Statement that we all know so  
20 well. We are operating under no restrictions as relates to  
21 the program activities of the RMPs.

22           And maybe I at this time should call upon Lee  
23 Van Winkle to just set forth in highlight fashion some of the  
24 review guide procedures that we'll be utilizing.

25           Lee, won't you --

1 MR. VAN WINKLE: I just primarily want to call your  
2 attention to the review guides that you have, and I know that  
3 Dr. Pahl said it earlier, but I think it should be repeated  
4 that I think this group has to focus on the over-all program  
5 of the Region and the proposal as submitted rather than on a  
6 technical review of the individual projects, and we do have  
7 the criteria listed.

8 I think the only other thing that I want to mention  
9 at all is the review sheet that you find attached in there.  
10 We will expect the two reviewers to fill that out and we'll  
11 collect those as we go along.

12 DR. MILLER: When do you want them?

13 MR. VAN WINKLE: Sir?

14 DR. MILLER: When do you want them?

15 MR. VAN WINKLE: We'll give you time to complete  
16 them --

17 MR. CHAMBLISS: At the end of each review as we sit  
18 here.

19 DR. MILLER: As we sit here?

20 MR. VAN WINKLE: Yes. Before we go to the next  
21 application, we would like you to fill it out -- in talking  
22 with Miss Leventhal -- and pick it up at that time.

23 DR. SLATER: I want to have some time to rewrite my  
24 commentary on those, so I'll get it back to you during this  
25 session, but it won't be immediately after my oration.

1 MR. CHAMBLISS: Thank you, Lee.

2 I should mention that, as you have probably noted  
3 in some of the background materials, that the focus of the  
4 review will, by and large, touch on about eight elements.

5 The first is program leadership; second, program  
6 staff; third, regional advisory group; four, past performance  
7 and accomplishments of the region; five, the region's objec-  
8 tives and priorities; six, the proposal; seven, feasibility;  
9 and eight, and finally, CHP relationship.

10 I think one additional item of procedure may be in  
11 order here, and it's a further elaboration on the focus for  
12 review. Dr. Pahl mentioned that the policy issues would  
13 simply be flagged and we would not necessarily attempt to  
14 resolve them here; that the target amount should be the  
15 principal benchmark for a backdrop for the review.

16 Lee has mentioned that the two reviewers will review  
17 and the second reviewer will simply add additional comments or  
18 observations.

19 We hope to follow the exception principle if we are  
20 really going to get through in our appointed time.

21 We also will have Staff comments as necessary and  
22 required and for each of the regions under review the Staff  
23 person handling that particular region will be at the head  
24 table here.

25 After that, a brief discussion, and we will attempt

1 to clarify any items or matters that need to be clarified,  
2 looking forward to the presenter giving us a recommendation  
3 and the rationale for his recommendation, ending up with a  
4 motion on that particular recommendation, and from there we  
5 will ask each reviewer to complete the rating sheet as we've  
6 touched on.

7 There are applications at the back table, complete  
8 applications on the back table, for each of the reviewers who  
9 will need them, and we would simply ask you as a final matter  
10 of procedure, kindly speak into the microphone so that our  
11 recorder can get all of the details.

12 Are there any questions at this moment before we  
13 begin to proceed?

14 Dr. Vaun?

15 DR. VAUN: I've heard Lee refer a couple of times to  
16 the fact that we're not going to do a technical review, if I  
17 understand what he's saying. However, I'd like to know how  
18 we're going to reach a judgment about funding levels unless we  
19 address some of the technical aspects of the programs.

20 On the basis of the guidelines submitted, namely,  
21 leadership, past performance, it's going to be very difficult  
22 to arrive at a funding level.

23 Lee, how do you want us to work this magic if we're  
24 not going to look at the projects?

25 MR. VAN WINKLE: Well, I think that you do have to



1 look at the projects because that's a part of the total pro-  
2 posal that came in, and if what you see in here is not  
3 related to the goals and objectives of that region, then I  
4 think you have real cause for concern, and certainly if there  
5 are items included in here that are strictly against policy  
6 of the Regional Medical Program, that also has to come out.

7 But I think you have to look at what they've sub-  
8 mitted, the individual pieces; but as to getting into the  
9 individual technical aspects of a particular activity, that's  
10 what we're trying to avoid.

11 DR. VAUN: Okay.

12 MR. VAN WINKLE: The actual makeup of that activity  
13 that you're looking at.

14 MR. CHAMBLISS: Let me just add one additional piece  
15 of information so that we have something of a framework. The  
16 panel will have a total of 28 applications to review with a  
17 requested amount of \$65.5 million. There's one continuation  
18 request; there are 23 continuation and new activity requests;  
19 there are 24 additional applications expected from this set of  
20 regions in July.

21 Twelve of the regions that you will be reviewing  
22 have had -- twelve of the twenty-eight -- have had new coordi-  
23 nators since the phase-out was announced. There have been  
24 limited site visits. However, there have been Staff visits to  
25 nineteen of the regions in question. Two have had review

1 certifications; six have had management surveys; and twelve  
2 others have had technical assistance visits.

3 So there is a body of intelligence residing in the  
4 Staff as to how the regions are functioning and operating. I  
5 thought you would like to have that just as a backdrop.

6 MR. VAN WINKLE: Can I add just one thing?

7 MR. CHAMBLISS: Yes.

8 MR. VAN WINKLE: Dr. Vaun, I think what we're seek-  
9 ing here is the development of a level of funding and not a  
10 funding level -- level of approval, if you will, not funding  
11 level, and the funding level actually will be determined some-  
12 where within that level of approval.

13 If you come in, let's say, with a level of approval  
14 on one program at \$2 million, the actual funding level will be  
15 made up to that figure, it won't exceed it, and it may be less  
16 than that.

17 DR. SLATER: Could I --

18 MR. CHAMBLISS: Dr. Slater.

19 DR. SLATER: May I make a point? I, like you, have  
20 been trying to get a grasp on this in comparison to the old  
21 days and, furthermore, in the light of what Mr. Rubel is talk-  
22 ing about, and I have the same concern that you have, that  
23 while not really examining these projects which are presented  
24 in variable detail from one region to another, I'm attempting  
25 to make some kind of an assessment, really, to give you, in a

1 sense, professional backup as to what kind of funding these  
2 regions should have.

3 Coming through to my mind all the time is the fact  
4 that since we're apparently going through such major changes  
5 in the next few years in which RMP will be recast in some way  
6 or the other that what we're here to do, really, is to just  
7 look for the most obvious problems or errors which you as  
8 Staff have to correct in order to justify the expenditure of  
9 these funds and that we're not going to vary, really, very  
10 much from the figures you have here, because the most  
11 important role we have to play now in this interim period is  
12 to stabilize those staffs out there in order that one has a  
13 group of people that are well-trained and indoctrinated to  
14 move ahead in some fashion in the years ahead.

15 So I must say I don't have too much difficulty  
16 making assessments. I'm having to rely so much on what  
17 they've already decided to do there, that I think we're  
18 really here just to provide professional extramural moral  
19 support more than anything else -- obviously, there are going  
20 to be some holes in that, but, generally speaking, that's how  
21 I read it.

22 MR. CHAMBLISS: I assure you we need that, too, but  
23 we do need your professional judgment.

24 DR. SLATER: I agree.

25 MR. CHAMBLISS: And we need your views and we would

1 like you to work on the exception principle. If there are  
2 matters that are exceptions of policy issues, then we would  
3 like to have your judgment on them.

4 DR. SLATER: I'm not trying to be soft, but what I  
5 am concerned about is that with the stability of the staff and  
6 the projects and all they mean out there is perhaps the most  
7 important element in the survival of the whole pattern of  
8 activity that was started eight or ten years ago.

9 MR. CHAMBLISS: Mr. Thompson.

10 MR. THOMPSON: On the interface with kidney, EM --  
11 emergency medical services, and PSRO, did the Staff go through  
12 and edit any of these in any way, identify those projects that  
13 are obviously in conflict with kidney, emergency, and PSRO?

14 MR. CHAMBLISS: We have in fact gone through all the  
15 requested project activities and have seen -- attempted to  
16 determine if there was a conflict with the policies of another  
17 program. We have also had discussions with the key staffs of  
18 the kidney program, the emergency medical services program,  
19 and they will give us some assistance in these reviews where  
20 we find conflicts.

21 A number of these activities, the regions have been  
22 into actually before some of the legislation was passed --  
23 quality assurance, which borders very closely to PSRO, and so  
24 on -- and those activities are being continued.

25 However, in the case of EMS, you should know that it

1 is a program decision and a matter of statute that the RMPs  
2 or no other program will enter into EMS activities so as to  
3 build a system of emergency medical care.

4 Our regions have had facets of a system and, there-  
5 fore, with the understanding that we have between EMS and RMP,  
6 those activities are permissible for funding under this set of  
7 applications, so their basis -- they are not designed to  
8 produce total systems.

9 MR. THOMPSON: But maybe the problem is that if you  
10 put money into those nobody will ever be able to design a  
11 total system because those pieces will be out, you can't pick  
12 them up.

13 MR. CHAMBLISS: Well, at the local level the CHP  
14 agencies have been coordinating to see how the RMP proposal  
15 fits into the total need at the local level, so there has been  
16 a degree of coordination and cooperation there to make sure  
17 that the pieces that we support have some relevance to what  
18 else is going on.

19 MR. THOMPSON: But I detect something in the appli-  
20 cations I read, which, although it is not in direct conflict  
21 with the PSRO organization, it is obviously addressed to the  
22 tactic that hospitals, if they have any brains, have suddenly  
23 got to realize that they've got to get their own quality  
24 assurance program, optioning (phonetic) subbing it out to a  
25 PSRO or do it themselves, and some of these projects are

1 asking for money to let hospitals build up their own quality  
2 assurance programs so they can eventually do this for PSRO.

3 I object to it for two reasons. One is they should  
4 have been paying attention to quality a long time ago -- all  
5 of a sudden they shouldn't have discovered the wheel. But  
6 this isn't related to PSRO --

7 MR. CHAMBLISS: Indeed it is. As a matter of policy,  
8 Council policy, we have stated many times that the RMPs could  
9 not become involved in PSRO development per se; they could not  
10 use their funds for the operational aspects of a PSRO.

11 DR. MCPHEDRAN: They could be involved in develop-  
12 ment?

13 MR. CHAMBLISS: They could not be involved in the  
14 actual development, but that if there were studies, data  
15 collection or peripheral activities related to quality  
16 assurance, that they could be involved in that using RMP funds.

17 MR. VAN WINKLE: I'd like to add one comment. As  
18 far as the Staff comments you find in here, they have flagged  
19 items for your attention, items that they felt were of concern  
20 that they wanted to be sure that you looked at.

21 Now, they haven't made any recommendation on those  
22 to the committee. They've left that up to the committee.

23 And in looking at the criteria that you're going  
24 through as far as leadership, RAG, and all of these items, I  
25 want to assure you that the Staff have looked at all of those

(sic)

1 items, too, and if you see no comment, it doesn't mean that  
2 they haven't looked at them and are satisfied with what they  
3 see, but if you have any question, we'll be glad to have the  
4 Staff respond to it.

5 MR. CHAMBLISS: Mr. Posta.

6 MR. POSTA: I would like to make a comment concern-  
7 ing, for instance, EMS activities. Many of our states are  
8 making applications to HSA for various EMS activities. Dead-  
9 lines in certain areas have been April 15th.

10 We have other opportunities in area research for EMS  
11 that are going to be funded by another bureau and we have,  
12 from a Staff standpoint, made it clear that whatever we --  
13 meaning RMP, DRMP -- will be funding will be double checked  
14 with the other agencies to avoid duplication in these type of  
15 efforts.

16 MRS. WYCKOFF: Is that what you mean when you list --  
17 well, four EMS projects under concerns, that you're going to  
18 check them with these other to see if they should have applied  
19 somewhere else?

20 MR. POSTA: Right. And to see also if they're  
21 flagged whether or not the amounts of money requested in this  
22 application is, in essence, double that of what has been  
23 approved for the first six months of the year. So we do it  
24 both ways.

25 We keynote an expansion of an activity moneywise as

1 well as --

2 MRS. WYCKOFF: I see.

3 MR. VAN WINKLE: Continuations here aren't of  
4 concern in terms of the new legislation. Continuations are  
5 not of concern insofar as the new legislation. Only new start-  
6 ups.

7 MR. CHAMBLISS: All right. Are there other  
8 questions? If not, I think we should begin our review and our  
9 listing shows that the first regional medical program to be  
10 reviewed is Alabama.

11 The review is by Dr. Vaun and Mrs. Salazar, and the  
12 Staff person, who is already here at the head table, is Mr.  
13 Joe Jewell.

14 Will the first reviewer make his or her presentation?  
15  
16  
17  
18  
19  
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21  
22  
23  
24  
25



## ALABAMA REGIONAL MEDICAL PROGRAM

MRS. SALAZAR: Alabama has always led this parade --

MR. CHAMBLISS: Use the microphone.

MRS. SALAZAR: -- of the reviews, and I'm afraid I fell into that trap and I may get carried away, but I hope not.

The present funding of the Alabama RMP is \$687,000 in the third year of a triennial status, with the year ending April 30th, for a total of four operational years.

The activities that were reported in the application are related to phase-out pursuits, rescinding of phase-out, reactivation, retooling, in response to the off-again/on-again syndrome that has bedeviled the regions all across the country this past year.

In view of this, the Alabama application, to me, is somewhat astounding from a number of standpoints.

First, after the phase-out orders in February of 1973 only two projects were approved for partial support and only four which were funded through contracts were continued beyond June 30, 1973.

Two: the Regional Advisory Council elected to remain intact -- the RAG is called RAC there -- it retained its working committees, and, indeed, throughout such troublesome times of adversity it grew in strength and wisdom, guiding and supporting the RMP efforts throughout the region. The RAC has met four times, reviewed proposals, set priorities, implemented new

1 by-laws, counseling and opening avenues of communication in  
2 their respective geographic areas of the region.

3 Vacancies that have occurred on the staff have been  
4 filled very promptly and attendance at all meetings has  
5 averaged better than 66 percent.

6 There is a nine-member executive board of the RAC.  
7 It has met six times, average attendance at 75 percent. The  
8 chairman is a member of the State Health -- the State Board of  
9 Health Department.

10 The third astounding feature of this application, to  
11 me, has to do with the ability of the region to seek and  
12 obtain local support for twelve out of sixteen of their con-  
13 tinuation programs, twenty-one out of the thirty new proposals.  
14 Spoken or stated another way, in addition to the \$2,648,000  
15 they are requesting, \$1,922,000 -- almost \$2 million -- will  
16 be supplied by state, local, and other federal monies.

17 Or still another way, 73 percent of this application  
18 will generate other grant-related support, resulting in a  
19 total of \$4,500,000 for the Alabama RMP -- is that correct,  
20 Joe?

21 MR. JEWELL: That's correct.

22 MRS. SALAZAR: The Review Committee and the EMS Com-  
23 mittee have remained active, with the latter forming the  
24 nucleus of the State Advisory Committee to the Governor and  
25 the State Board of Health.

1           The membership of the RAC is adequately represented  
2 by providers and consumers from each of the 10 CHP B agencies  
3 and it includes the Director of the State CHP A Agency and a  
4 representative complement of health educators and providers,  
5 officials, and the like -- there's a mayor, too, as I recall.

6           The University of Alabama in the Birmingham Medical  
7 Center serves as the grantee and the present Executive  
8 Director of the Alabama RMP is on leave of absence from the  
9 university at 100 percent of time. Maximum resource support  
10 from the university is accorded the Regional Medical Program.

11           The present Director has had extensive experience  
12 with the Alabama RMP, having served on its first Regional  
13 Advisory Committee in 1967. She has been a member of various  
14 committees for about three years, has served as a part-time  
15 professional Associate Director. She has also been a member  
16 of the faculty of the School of Medicine for over 25 years,  
17 and for the past twelve years as Assistant and Associate Dean  
18 for Continuing Medical Education. She is active in medical  
19 affairs throughout the state..

20           The Deputy Director has been with the program since  
21 October 1970 and the Assistant Director for Operations has  
22 been employed by the Alabama RMP for seven years.

23           The position of Associate Director for Health Care  
24 Services, which will provide liaison with health providers  
25 throughout the region, is open. Recruitment is underway.

1           This unit is pursuing PSRO efforts and will provide  
2 an appropriate channel for emerging national health insurance  
3 information.

4           An Assistant Director for Multimedia Activities and  
5 an evaluator round out the professional staff and bring the  
6 total to its approximate prephase-out status.

7           There's a sense of optimism and enthusiasm that  
8 comes through in this application. It communicates a feeling  
9 of confidence in the competency and the wisdom and the motiva-  
10 tion of the staff.

11           The region appears to me to be on target in meeting  
12 its goals and objectives as revised in 1971 to meet the chang-  
13 ing national and local priorities.

14           It is quite apparent that enormous staff energy went  
15 into creating four of the initial six B Agencies in the state  
16 and it is still wielding a great influence on the emergence of  
17 the other four.

18           The Director of the CHP A Agency is a member of RAC  
19 and several members of the Area Health Councils are also RAC  
20 members. B Agency members frequently attend RAC meetings.  
21 There is excellent communication among all groups.

22           The endorsement of the Alabama Advisory Council for  
23 CHP A Agency is quite guarded, and there are some stated  
24 reservations concerning the duplication in sponsoring  
25 agencies, but for the most part these are fairly superficial.

1           As far back as 1967 the Alabama Regional Medical  
2 Program proposed in its first planning grant the development  
3 of six community-based health education centers to serve  
4 regional needs for health manpower education, service, and  
5 continuing education for all health professionals in the  
6 region. Eleven programs are now ongoing, covering all geo-  
7 graphic areas of the state, and one is emerging in the  
8 resource-poor southeast section.

9           There is an exciting program that is entitled  
10 "Project HELP" which emerged from a tripartite agreement among  
11 University of Alabama, Birmingham-Auburn, and the State Health  
12 Department for health education of the public. It utilizes  
13 the services of the Agriculture Extension Service at Auburn  
14 University and county agents and councils in every county of  
15 the state. This program will receive future funding through  
16 state education funds.

17           The present application, as I said, generates a  
18 feeling of optimism in the reader. Cooperative arrangements  
19 have been achieved. Staff of both CHP A and Bs are actively  
20 involved in RMP affairs. Projects, both proposed and ongoing,  
21 are timely, relevant, and appear to be viable. They are par-  
22 ticularly applicable to the region's health needs, but also in  
23 line with national emphases, such as PSRO and quality and cost  
24 controls of the health delivery system. These are all spoken  
25 to.

1 For the July submission the region is preparing  
2 additional projects in neonatology and one to develop a rural  
3 community health task force.

4 It is significant, I think, to note that the  
5 Regional Advisory Council incorporates in its committee  
6 structure the CHP B planning agencies. These areawide  
7 advisory bodies formulate policy and approve plans pertinent  
8 to health issues, not only project proposals from Alabama RMP  
9 but others requesting federal and state funds that affect  
10 their geographical areas.

11 From the very limited information to be gleaned from  
12 the report on the HRA-T4, I believe it's called, which is the  
13 Equal Employment Opportunity breakout and my previous  
14 knowledge of Alabama, it does appear to me that the Alabama  
15 Region has made progress in its Equal Employment Opportunity  
16 for minorities, but, I believe, still has a long way to go in  
17 achieving adequate representation of these minorities on their  
18 committees, particularly in the professional and clerical  
19 staff, as well as membership of planning groups and committees  
20 at the community level.

21 I'll cite you one example: the Regional Advisory  
22 Council membership is fifty-eight, only four of whom are  
23 blacks; the total professional staff is sixty-three, with  
24 eight blacks.

25 I will withhold my recommendations, Mr. Chairman,

1 until the other review.

2 MR. CHAMBLISS: Thank you.

3 I will now call upon the second reviewer, Dr. Vaun.

4 DR. VAUN: I'm not going to address attention exten-  
5 sively to the background because I think Mrs. Salazar has  
6 covered that well, and in a discussion that the two of us had  
7 initially, we agreed that she would address the background and  
8 I would talk somewhat about the projects.

9 I will start exactly opposite. I will address first  
10 and foremost my recommended level of funding, and then tell  
11 you how I arrived at that in analyzing the project.

12 I have recommended that their request of \$2,648,439  
13 be reduced to \$2,028,389 -- this may be backwards, but this is  
14 my approach to this one with the background you've gotten on  
15 Alabama.

16 I think they've done a good job. I think the  
17 projects that they've submitted are congruent with their  
18 stated objectives, and I saw one thing that came glaringly  
19 through in the Alabama application, and that is that they gave  
20 me a feel for priorities, both from the CHP point of view and  
21 from the RMP point of view, and I hope this doesn't act to  
22 their detriment because it was really a splendid job and it's  
23 part of the way I arrived at the reduction.

24 Also I arrived at the reduction on the basis of  
25 some experience with like projects and observations about the

1 successes of like projects.

2 For the core operation of the Multimedia learning  
3 skills, the only reduction in core was \$10,000 from that  
4 specific aspect of their project and not from project staff  
5 itself.

6 From the continuation projects -- and I really won't  
7 go into the details unless you want me to -- I have arrived  
8 at a level of funding reduction of \$107,753. From their  
9 \$565,005, I have come down to \$447,252, and there is only one  
10 project that I really didn't feel warranted funding at all and  
11 that was the No. 82, which is entitled "Audio-Visual Assist-  
12 ance in Educating Hypertensives."

13 I don't know, I feel that there's so much of this  
14 around now that spending \$7,000 on it in another area just  
15 doesn't seem like it was worth the effort.

16 The other \$100,000 came from reduction of funding of  
17 several of the projects. As I say, I'd be delighted to submit  
18 my recommendations to Staff or go over them here, whichever  
19 you wish.

20 MR. VAN WINKLE: I think it will probably depend on  
21 what the final recommendation is.

22 DR. VAUN: Why don't I go through the rest of them?

23 MR. VAN WINKLE: All right.

24 DR. VAUN: From their new projects, they submitted  
25 \$1,422,440; I would recommend a reduction of \$492,297 to bring



1 their new application award to \$930,143.

2 I was a little concerned again, although the pro-  
3 jects are congruent with their stated objectives -- I think  
4 \$11,000 for trophoblastic disease left me a little cool at  
5 this stage of our development; immunofluorescence for renal  
6 biopsies in the State of Alabama also left me a little  
7 concerned at this point; a rather sizeable sum of money for  
8 cervical cancer screening, I reduced substantially.

9 And then the PSRO which was \$151,000, and a few odd  
10 dollars, I thought should be substantially reduced by  
11 \$100,000. I just didn't feel this was appropriate.

12 So you have my recommendation in the light of Mrs.  
13 Salazar's background, and I wonder if that couldn't set the  
14 pattern. Don't you think it would be wasteful for both  
15 reviewers to spend a great deal of time presenting the back-  
16 ground? Couldn't we arrive at some agreement and one person  
17 take one task and the other person take another task and,  
18 hopefully, come together on it?

19 MR. CHAMBLISS: Certainly I would await the judgment  
20 of this committee on that point. I think it will tend to  
21 expedite things.

22 MR. THOMPSON: So moved.

23 DR. WHITE: I take exception to it and object, in  
24 the sense that many of us have done work already -- admittedly  
25 scanty -- but it might be somewhat difficult for us to recast

1 ourselves in roles which we hadn't been expecting.

2 DR. VAUN: In the light of consultation amongst the  
3 two reviewers --

4 DR. WHITE: If time permits.

5 DR. VAUN: -- maybe one would have spent more time  
6 on one thing than the other, they could agree on a presenta-  
7 tion.

8 DR. WHITE: If the two --

9 DR. SLATER: Mr. Chairman, I think it's quite easy  
10 to draw up background. Anybody can do that. But I think if  
11 there has been a fair amount of time spent in looking at the  
12 projects and considering them in the terms of the criteria you  
13 want, I think the individual reviewers have to go into this.  
14 There won't be that much duplication except as to background  
15 history. That seems redundant.

16 MR. CHAMBLISS: I seem to get a sense from the com-  
17 mittee that you would prefer to hold to the original approach.

18 DR. WHITE: I think everybody has to play his own  
19 role, and if you don't like the way I do it, you can holler at  
20 me.

21 MRS. WYCKOFF: I tried to follow this thing, which  
22 is quite different --

23 MR. CHAMBLISS: You are seemingly suggesting that  
24 we have the clock before us and we can always call time.

25 All right. Can we get a motion, then?

1 DR. VAUN: Mrs. Salazar hasn't made her recommenda-  
2 tion yet. She was going to withhold her recommendation.

3 MRS. SALAZAR: I defer to you as the principal  
4 reviewer.

5 DR. VAUN: Again, Bob, I'm new to this. Do I make  
6 the motion, or does somebody else?

7 MR. CHAMBLISS: You can make the motion if you  
8 choose, Doctor. You've already given us a level of funding  
9 that you have recommended and the rationale for that level.  
10 If you will put that in the form of a motion, the chair will  
11 entertain it.

12 DR. VAUN: I will move that the request of the  
13 Alabama Regional Medical Program be reduced from their  
14 requested amount of \$2,648,439 to \$2,028,389.

15 MR. CHAMBLISS: There's a motion on the floor that  
16 the recommended level of funding for the Alabama Regional  
17 Medical Program be placed at \$2,020,389 --

18 DR. VAUN: \$2,028,389.

19 MR. CHAMBLISS: \$2,028,389.

20 Is there a second?

21 MR. TOOMEY: I second it.

22 MR. CHAMBLISS: It has properly been made and  
23 seconded.

24 Is there any discussion on the motion, please?

25 Dr. Miller.

1 DR. MILLER: To what extent do we need to pay atten-  
2 tion to these motions for dollar levels in terms of the  
3 relative relationships of the various RMPs on this list? This  
4 motion places Alabama at a level that -- does it or does it  
5 not -- it exceeds the targeted available funds item, and with-  
6 out any consideration to the probability of what their state-  
7 ment was, an estimate of \$1.1 million application to be sub-  
8 mitted in July.

9 Are you going to count them out, almost surely,  
10 from much of anything on July 1st by this level at this time?

11 MR. VAN WINKLE: Dr. Miller, again, this is just an  
12 approval level. That's what's being recommended, an approval  
13 level. It does not necessarily mean that when it's actually  
14 funded that's what it's going to come out to be.

15 DR. MILLER: Could I ask, then, another question?  
16 What happens if this committee ends up with an approval level  
17 of \$114 million this time; then you decide who gets what,  
18 right?

19 MR. VAN WINKLE: I suspect Council will --

20 MR. CHAMBLISS: Council will then make its recom-  
21 mendations based on the findings of this committee.

22 DR. WHITE: I think that's quite appropriate. The  
23 fact that someone here has seen fit to suggest that Alabama  
24 deserves more would be taken into consideration even though  
25 they may not get that amount -- they might get more in

1 proportion than some other region.

2 MR. CHAMBLISS: That's quite true.

3 DR. WHITE: It's simply a guideline.

4 DR. SLATER: I'm just wondering how to deal with  
5 this, too. I wondered how, as Dr. Vaun has, to deal with  
6 dollar amounts, and I guess what I'm searching for are guide-  
7 lines. I've wondered whether or not we can't find the same  
8 problems that you have and indicate that our guidance is that  
9 within the framework of whatever cutbacks you have to make  
10 they shall not -- that they will have to redefine their distri-  
11 bution of funds to exclude the coverage rather than try and  
12 set a dollar level at this stage of the game.

13 In other words, I'd rather find fault with the  
14 thing, with the specific project, if we get into that degree  
15 of detailing, and then leave them with whatever funding level  
16 is ultimately going to be made possible, but within the guide-  
17 lines that they're not to spend money on those particular  
18 aspects.

19 MR. CHAMBLISS: That is correct, Doctor.

20 DR. SLATER: That gets us away from dealing with odd  
21 dollars, and I don't know whether that satisfies your thinking.

22 DR. VAUN: I'm not sure I understand it.

23 DR. SLATER: Rather than assigning dollar cutbacks  
24 as you have, identify the concerns that you have and give  
25 guidance to the Staff and the recommendation to the Council

1 that within the framework of whatever dollar cutbacks --  
2 they're asking for a hundred and thirty-six -- there probably  
3 is going to be some cutback, but in whatever framework, the  
4 money they receive shall not be spent on those particular  
5 projects. They have to define how they --

6 MR. CHAMBLISS: Well, I think he's simply been  
7 generous in giving us the dollar amounts and where, and we  
8 will -- the Staff will certainly take that into account as  
9 this goes through the review process.

10 MR. VAN WINKLE: And we would like Dr. Vaun's  
11 written figures -- details.

12 If you have them, we'd certainly appreciate them.

13 DR. VAUN: Maybe I'd better get clarification of  
14 that. Does that mean that if I submit the details that this  
15 is a mandatory translation to them where they cannot spend the  
16 funds?

17 That's what you were saying.

18 MR. CHAMBLISS: It does not. You have simply, based  
19 on your professional judgment, indicated those areas of  
20 concern, and they will be passed on through the review process  
21 and finally acted upon.

22 DR. VAUN: But it will be up to the region to decide  
23 finally?

24 MR. CHAMBLISS: Yes.

25 DR. VAUN: Fine.

1 DR. SLATER: Your indication of dollar amount is  
2 simply a reflection of your extent of concern.

3 DR. VAUN: Gut feeling.

4 MR. CHAMBLISS: Is there further discussion?

5 I'll call the question.

6 Those in favor of the motion, may I have the usual  
7 signal of voting?

8 (Ayes respond.)

9 MR. CHAMBLISS: And those opposed?

10 (No response.)

11 MR. CHAMBLISS: The motion, then, is carried, and  
12 we have finished our first review.

## ARKANSAS REGIONAL MEDICAL PROGRAM

MR. CHAMBLISS: In our next region we have only one reviewer here at the moment. That region is Arkansas. And we will ask Dr. Carpenter if he will carry the entire load for that region.

Dr. Carpenter.

DR. CARPENTER: Thank you.

I don't have anything like the kind of background on this region that Mrs. Salazar did. My view is that the region has maintained the mechanism of the regional program adequately. The advisory committee remains intact; the review system remains intact; and that what we have is an application prepared by a reduced staff in an appropriately reasonable fashion, but in a depressive time which has forced them to, in the first place, be responsive to a large number of federal initiatives, some of which I don't believe were at their emotional heart.

Secondly, they had to respond, obviously, very rapidly and they, in the process, were forced to give up much of the matter of pressing for very detailed program objectives and there's essentially nothing in the application about evaluation either of the past program or of the -- and no suggested specific evaluation of most of the projects.

And, so, one has -- as I read the application, I have the feeling of a regional program which is a bit at sea;



1 has no real continuing thrust that can organize Arkansas in  
2 any significant way, though it does have enough thrust to  
3 contribute here and there in a kind of stopgap way, which I  
4 think most regions are going to have to be content with.

5 I believe that if I were in Arkansas I would spend  
6 the next year trying to document -- trying to develop a highly  
7 professional staff and document what its effect can be in  
8 terms of a detailed project plan.

9 I have in view the July submission. You can see  
10 from your computer printout here that the present funding  
11 level is \$1.4 million; that -- as that somewhere, if we go  
12 through with their projected application, in July we'll be at  
13 a level -- which I'm having trouble reading -- of only 15 per-  
14 cent higher than what might be expected. On the other hand,  
15 it would be twice what they're now spending.

16 And I just don't believe that they've had an oppor-  
17 tunity to organize a coherent program that's twice as large as  
18 the one they're presently involved in.

19 So my inclination would be to fund them at about the  
20 same level now and if the July application shows progress in  
21 terms of more detailed planning, then I think there's an  
22 opportunity to provide them with what will, I suspect, be a  
23 large enough amount of money for them for the next year.

24 So I'd recommend a funding level of \$1,450,000.

25 MR. CHAMBLISS: At the current annualized level --

1 MR. POSTA: Excuse me, Doctor. That current annual-  
2 ized level projected over a year for Arkansas is \$1,848,000,  
3 the first column.

4 DR. CARPENTER: My first column shows a million four.

5 MRS. WYCKOFF: So does mine.

6 DR. WHITE: Do does mine.

7 MR. POSTA: I guess it's the 17th edition.

8 MR. CHAMBLISS: We're working from the May 21st  
9 edition.

10 MR. POSTA: I'm sorry about that.

11 MR. CHAMBLISS: Thanks for that presentation.

12 I would like to ask if Mr. Posta will provide, in  
13 the absence of the second reviewer, the committee with any  
14 additional information that he chooses on Arkansas.

15 Mike?

16 MR. POSTA: I have been associated as Operations  
17 Officer to Arkansas since 1970. The Mid-Continent Operations  
18 Branch considered Arkansas to be one of the better programs  
19 in the Mid-Continent Operations Branch, primarily because of  
20 the coordinator who has just resigned in February.

21 I think that Dr. Carpenter's comments were quite  
22 relevant because Dr. Silverblatt has left the State of  
23 Arkansas. There is a question of leadership.

24 However, Mr. Roger Warner has been the evaluator --  
25 the monitor and evaluation chief of that particular section --

1 and has done a good job in this regard and is serving in an  
2 acting capacity now.

3 The Search Committee is in process of selecting  
4 another coordinator. Mr. Warner is one candidate.

5 Seven of their top professional people have been on  
6 board for about seven years.

7 Now, last year when they came in -- meaning the last  
8 Council meeting in November of '73 -- the region responded to  
9 the five initiatives which DRMP had sent out to all of the  
10 RMPs; that is, "We want to do more in planning; we want to do  
11 more in quality care; we'd like to get something going in  
12 kidney, EMS, and hypertension."

13 Most of their application -- or their thrust during  
14 that period of time was in these five areas, and in this par-  
15 ticular application they have what they call an "umbrella  
16 concept" within the core staff of ten particular areas where  
17 they have maintained those five original ones that we've men-  
18 tioned and brought in position extenders more of a program  
19 force, unified health planning and new legislative concepts  
20 more in the area of hypertension and a couple of others that I  
21 can't recall.

22 Seventeen of the activities are new; seven are con-  
23 tinuing.

24 I might refer you to your yellow sheet in the book.  
25 I think you all probably have that. It more or less reflects

1 what Dr. Carpenter just mentioned with reference to staff.  
2 They have currently on board 16.6 full-time people. They do  
3 propose 29.6 in order to do the job that they've set out.

4 I think there's been no problems whatsoever with the  
5 CHP A and B agencies. Arkansas was one of the first regions  
6 to have a complete blanketed state with eight CHP funded  
7 agencies.

8 The ARMP and the CHPs, along with what we call an  
9 "Estes" (phonetic) program, the Experimental Health Delivery  
10 System package, have been in operation in Arkansas for about  
11 four years. They have been funded with about \$3.4 million of  
12 EMS activities from HSA.

13 In this particular application they do have an  
14 umbrella concept since the core staff did develop the EMS  
15 proposal that was approved by the then-HRA agency.

16 I could go on, but I think I'd better stop.

17 MRS. WYCKOFF: What do you mean by "an umbrella  
18 concept"? I see this in a number of these, and I wonder what  
19 does that consist of?

20 MR. POSTA: Well, within the total program staff  
21 budget, they have said, "We would like to administratively  
22 break up our entire program staff into ten areas," and they  
23 break out their budget accordingly, and those ten that I men-  
24 tioned in hypertension -- they have one on arthritis that I  
25 didn't mention -- each of these people on staff would be

1 working in these particular activities.

2 Within the application, which does request \$890,000  
3 in this total program staff budget, you have about 13 percent  
4 of the over-all request in what we used to call a develop-  
5 mental component or, as they call it, contingency funds -- or  
6 as some of us would call water.

7 But I might say in all fairness to Arkansas that  
8 that is a mechanism of funding, and I dare say that all of the  
9 applications you see have certain developmental component  
10 funds listed.

11 MR. CHAMBLISS: All right.

12 I wonder, at the end of this presentation, if  
13 there's a motion for Arkansas, or are there further matters to  
14 be discussed? Are there further questions?

15 DR. WHITE: Their request is for a million eight,  
16 and that's only \$400,000 more than they are getting at the  
17 present time.

18 DR. CARPENTER: Yes, and they're going to come in  
19 for some more in July.

20 I think it's very hard to set the funding level.  
21 For me, it was very difficult. If you try to go by -- you  
22 look at the projects and try to see which one would amount to  
23 something. I just don't have any confidence in anything from  
24 what they've described, and I, obviously, don't think we ought  
25 to make it impossible for them to start any projects. I think

1 their core needs to be protected, which I -- and, so, I sort  
2 of added a few projects to core.

3 DR. SLATER: The question I'm asking is whether you  
4 feel that they need to re-present what they have apparently  
5 done ineffectively for the July deadline so that they in fact  
6 are going to be coming back for the total amount that they  
7 were shooting for?

8 I'm not quite sure what the guidelines are that are  
9 associated with your suggestion for a continuation of funding  
10 at the present rate.

11 DR. CARPENTER: I was wondering about that, too.

12 DR. SLATER: Are they just to be given the money and  
13 then permitted to cut back where they see fit? How does this  
14 help improve their function?

15 I feel the same way you do; I'm at a loss as to how  
16 to react to them.

17 MR. VAN WINKLE: It would be too late, though, I  
18 think, to amend their July 1 proposal because their RAGs are  
19 meeting at the present time on that proposal -- I think most  
20 of them are, aren't they, Mike?

21 MR. POSTA: Yes. They expect about \$800,000 new  
22 activities to be submitted in that July 1.

23 DR. CARPENTER: Let me comment on that. I think  
24 they do have RAG approval on these projects, and I -- it's  
25 obviously suggesting an enormous amount of work in an already

1 overburdened staff, but if I was to be convinced that they  
2 could spend more money effectively, I would need additional  
3 information about their -- the goals and the evaluation  
4 systems for the projects that they intend, and I would think  
5 it might be interesting to think whether we want to suggest  
6 that some region provide that kind of information in view of  
7 the difficulty of the rush (phonetic) of the projects.

8 MR. VAN WINKLE: All I was looking at is that  
9 Council will be meeting and we cannot relay any information  
10 back to them until after Council meets and their July 1 appli-  
11 cation would probably almost be in the mail to us by that time.

12 DR. CARPENTER: But presumably -- and this is what  
13 the key issue is -- in July if you are not going to do a  
14 project review and you are going to have only an application  
15 that describes projects --

16 MR. VAN WINKLE: It'll be a full-blown map --

17 DR. CARPENTER: Well, you see, that gives you --

18 MR. VAN WINKLE: It'll have to stand on its own.

19 DR. CARPENTER: Then that, standing on its own,  
20 could say, "Hey, look at all the progress we've made since  
21 last time in our project plan."

22 DR. WHITE: May I ask a question, Mr. Chambliss?

23 MR. CHAMBLISS: Dr. White.

24 DR. WHITE: This was a highly regarded region at  
25 one time; is that correct?

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2 could spend more money effectively, I would need additional  
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23 MR. CHAMBLISS: Dr. White.

24 DR. WHITE: This was a highly regarded region at  
25 one time; is that correct?



1 MR. CHAMBLISS: It has been a highly regarded region.

2 DR. WHITE: The question now, Bob, is that there has  
3 been a change of leadership and some disassembling of things?

4 DR. CARPENTER: You know, it's hard to tell whether  
5 there's been a change in leadership or just, no matter how  
6 good your leadership is, this is an impossible situation, and  
7 it might be possible to say -- well, look at this -- I don't  
8 know if you can -- but as I look at the staff, they're being  
9 asked to do some very difficult things in terms of, you know,  
10 the details of the sickle cell project, for instance, and  
11 they're not able to do it, and I don't know whether that --  
12 maybe in the past they would have gotten the expertise they  
13 need from their voluntary groups. For some reason or another,  
14 they don't seem to have it now.

15 I can't tell whether it's the leadership or the  
16 time element.

17 DR. SLATER: Your real concern here is not, I  
18 gather, on a project basis whereby you feel that one wants to  
19 cut back there, but some sense that the program isn't as  
20 strong, that the staff leadership isn't as strong, and it  
21 doesn't satisfy these criteria as well as you would like and,  
22 therefore, it should be generally kept at the present level?

23 DR. CARPENTER: Yes; I doubt that the staff can  
24 enforce high-quality projects of the type suggested.

25 DR. WHITE: That's a reasonable concern.

1 MR. POSTA: I feel very awkward in defending the  
2 region. I really do. I don't think that's my role as Branch  
3 Chief, on top of that.

4 DR. SLATER: May I speak to that? I think it's very  
5 important -- if the Staff have direct contact with the people  
6 there and they have a sense of history that we certainly can't  
7 pick up from one reading --

8 MR. POSTA: I assure you this is not the best  
9 application that Arkansas has ever submitted, and that's true  
10 because 15 days after they got instructions, the coordinator  
11 had long departed.

12 However, they do have what I consider a good, small  
13 staff. Arkansas has never had a big staff. We're talking  
14 about a state that's forty-ninth in the country as far as  
15 average income is concerned. They have limited providers.

16 I think that -- just as an example in this particu-  
17 lar application, for the amount of other sources of support  
18 which is included in your conglomerate budget, they have state  
19 funds, local funds, and other federal support of \$415,000;  
20 mainly through the RMP, the EMS application was approved and  
21 plans put into the CHP A agencies were likewise approved.

22 They, along with the VA, were instrumental in draft-  
23 ing the proposal whereby Arkansas has a state Estes program.  
24 These folks have been working closely together. The Univer-  
25 sity personnel is involved and definitely involved with these

1 particular projects that are in the application, including the  
2 particular function, such as quality care. They have the  
3 nucleus of the program in the form of a contract now going on  
4 which has set the stage for the other eleven bigger or larger  
5 hospitals in the state to follow that pattern.

6 The hypertension program which was a thrust from  
7 us, as of last year they have carried the ball with that and  
(sic) 8 have hypertensive programs going on in each of the states.

9 They have drastically improved as far as the  
10 minority concerns their Council and review committees have  
11 had in the past.

12 Their turnover of the Regional Advisory Group is  
13 almost nil, and I feel that the ARMP, the Arkansas RMP, is  
14 much of a stronger agency when you look around at the CHP and  
15 its leadership there and the Estes program -- in particular,  
16 in the EMS portion that is being funded under Estes. They're  
17 looking to ARMP for that leadership and guidance to carry that  
18 program in the State of Arkansas.

19 Now, that's not to say how much money they've come  
20 in and gotten for cancer -- or have received from the cancer  
21 program or the heart program or others.

22 Now, I'm responding only because of what was said  
23 earlier with the previous region, and you're coming to a  
24 decision here. I agree that the token figure of 140 percent  
25 is something to shoot for after the May 1 application is

1 received, and I really don't think your recommendation is that  
2 far off, but I felt that I needed to defend this region just  
3 a little bit more, because we feel, at least at this level,  
4 that they haven't done that bad a job.

5 MR. THOMPSON: You see, this comment is now pushing  
6 us down to looking at specific projects. This is what worries  
7 me.

8 MRS. WYCKOFF: And we can't do it. There's not  
9 enough information for us to do it that way.

10 MR. CHAMBLISS: We do not propose to look at speci-  
11 fic projects, but simply the program and the objectives of the  
12 program at this particular state.

13 I would say, based on the presentation from the  
14 presenter and Mr. Posta -- I would ask -- I perceive the  
15 recommendation that Dr. Carpenter has made with regard to the  
16 level of funding. I have heard a number of items of rationale  
17 as to why he arrives at that point, and I'm wondering if I  
18 could get a motion on the floor for your recommendation, Dr.  
19 Carpenter.

20 DR. CARPENTER: Well, in view of some of the dis-  
21 cussion, let me move that we approve \$1.5 million for Arkansas.

22 MR. CHAMBLISS: It has been moved and seconded --

23 MR. VAN WINKLE: No second yet.

24 MR. CHAMBLISS: It has been moved that the level of  
25 a million five be recommended for Arkansas.

1 Is there a second to the motion?

2 DR. VAUN: Second it.

3 MR. CHAMBLISS: It has been seconded by Dr. Vaun.

4 Is there discussion on the motion?

5 DR. WHITE: I can sympathize with Bob in trying to  
6 come up with a figure that's more than he wanted but less than  
7 they asked for, but I don't know how we come to that ration-  
8 ally. Is there some other alternative to this? Is there some  
9 way of saying they deserve to be considered for an increase in  
10 monies beyond that which they're currently getting? We would  
11 not like to see them get more than the -- what do they call  
12 it? -- targeted funds, and preferably less.

13 MR. THOMPSON: They didn't ask for the target --  
14 they only asked for 80 percent of the target.

15 DR. CARPENTER: But they'll be up to 115 percent by  
16 the time it's all over.

17 MRS. WYCKOFF: They want \$782,000 new. That's a lot  
18 of new.

19 DR. SLATER: May I ask a question on this? On the  
20 next round that we're going to be sitting on, are the criteria  
21 going to be different than this round, or are we really going  
22 to be looking at projects in the old way?

23 MR. CHAMBLISS: The criteria will be the same.

24 DR. MCPHEDRAN: We will not be looking at projects?

25 MR. CHAMBLISS: We will just engage in the project

1 review.

2 DR. SLATER: Since this is on the floor, and having  
3 known Arkansas in the past, I have to give the benefit of the  
4 doubt to the staff in Arkansas under these situations. I  
5 think they've been through the mill and if there is a proposal  
6 that comes in that looks as if they're a little bit at sea, I  
7 don't know what else to do except say, "That's the way our  
8 country operates right now," and I'm inclined to move the  
9 money out of here so they can stay alive in their present  
10 state of health or at least their desired state of health, and  
11 I'd like to speak in favor of giving them what they ask for.

12 MR. CHAMBLISS: Any further discussion here?

13 DR. CARPENTER: I have obviously thought of that,  
14 too, as an approach we can take. I have in the back of my mind,  
15 I guess, something which is going to surface repeatedly, and  
16 it might as well surface now.

17 I think that local planning efforts have been slip-  
18 shod and we're now moving toward a time when we're going to  
19 try to redo the mechanism for local planning, and I believe  
20 that one of the messages that has to get back, one of the  
21 matters which deserves our consideration, is that you just  
22 can't reward low quality planning, and I don't see that -- you  
23 know, for instance, as this region begins to choose who its  
24 leaders will be in the health planning business, I think they  
25 need to choose very talented people, and I'm not anxious to

1 lead them astray.

2 MR. CHAMBLISS: Is there any further discussion on  
3 the motion?

4 MRS. SALAZAR: In an attempt to sort of meet halfway  
5 between these two points of view, I would hope that the  
6 message that goes back to this region is not punitive in any  
7 way. Certainly the staff must be having a pretty hard time  
8 with their strong leadership having disintegrated, and I think  
9 they need to be encouraged at this time rather than punished.

10 MRS. WYCKOFF: What about the kidney and the EMS and  
11 that sort of thing there? Did you discount those as things  
12 that should be supplied from other sources?

13 DR. CARPENTER: Well, frankly, I didn't. I don't --  
14 it seems to me that the health planning leadership in an area  
15 might well invest some monies in assisting that area to meet  
16 very specific goals of categorical federal programs, so with  
17 that philosophy, then, I didn't get -- and from what I heard  
18 about our guidelines, I gathered that we could permit some of  
19 this. I didn't really -- I can't say I discounted those.

20 MRS. WYCKOFF: What about this arthritis money?

21 MR. THOMPSON: That's separate. There's a special  
22 group of people out there (indicating).

23 DR. CARPENTER: Is that a core -- I think that's  
24 part of their core activity to assist the region to develop an  
25 application for arthritis funds, and develop the regional

1 system in support of that application.

2 DR. SLATER: I wonder if there's some other alterna-  
3 tives available here. We've in the past been able to send  
4 messages back. For instance, staff guidance. We've been able  
5 to lay out visits if we're concerned -- site visits if we're  
6 concerned about providing allocates (phonetic) of money. We  
7 have been able to pass things on -- for instance, hold it over  
8 until the next round subject to review by an elite group.

9 Are we under sufficient pressure here to respond to  
10 this one-time allocation? It's a survival matter, and we just  
11 use our best judgment here?

12 MR. CHAMBLISS: Certainly we're called upon to use  
13 our best judgment, but the region will get advice as this  
14 whole round of review terminates, and the concerns being  
15 expressed here now will be incorporated into the advice letter  
16 going to the region.

17 DR. CARPENTER: I have a question here. When their  
18 July application comes in, will it be a request for a certain  
19 dollar amount of supplemental funds or will it be a request for  
20 a new funding level?

21 MR. CHAMBLISS: It will be for both. You will note  
22 in your column "July 1 Estimate" that the region anticipates  
23 that it will request a sum approximating \$800,000.

24 MR. THOMPSON: Additionally.

25 MR. CHAMBLISS: That's simply a request. That does



1 not mean that that sum will be awarded, because you know the  
2 over-all limitations that we have on total funding. All of  
3 this will be fitted into the amount of the available dollars  
4 that we have once the final decisions are made by the court.

5 DR. MILLER: That \$800,000 is going to be for a  
6 series of projects, new projects, right?

7 MR. CHAMBLISS: Right.

8 DR. MILLER: On what basis are we going to make a  
9 decision about awarding Arkansas \$800,000 for a bundle of new  
10 projects?

11 MR. CHAMBLISS: That is only an anticipated figure.  
12 That is what --

13 DR. MILLER: I don't care whether it's \$100 or --

14 DR. WHITE: It's going to be on the same amount of  
15 concrete evidence that we have today.

16 MRS. WYCKOFF: Exactly.

17 DR. SLATER: It seems to me that we're going through  
18 a problem whereby a traditional review committee is having a  
19 hard time learning how to operate like a council, and this is  
20 in fact what we're being asked to do. We're being given a  
21 list of projects we are not able to technically analyze, but  
22 we're asked to look at their conherence within the framework of  
23 the history of the program and the objectives of RMP. And it  
24 seems to me that's what the Council used to do, and it may  
25 well be that in the future, whatever comes out of the

1 legislation, some other kind of system will have to be put  
2 together, but I would guess that we're not going to be able to  
3 operate comfortably like a traditional review committee and  
4 we are having to look much more at policy and staff security  
5 and so on.

6 MR. CHAMBLISS: We share your discomfiture.

7 DR. SLATER: I don't know how else to make these  
8 decisions.

9 MR. CHAMBLISS: Dr. Vaun?

10 DR. VAUN: As the seconder of the motion, I'd like  
11 to reaffirm my second of the motion on the basis of the dis-  
12 cussion I've just heard. I don't see that this is in any way  
13 a hindrance to the group.

14 I think it would be dangerous to give them more  
15 money than the leadership can use at this point, and they have  
16 an opportunity to come back again, and if there's going to be  
17 a total and complete presentation, if they get a few messages  
18 on this round, there's no reason why the discussion can't be  
19 different on the next.

20 I don't think this is a punishment or a harm to them.  
21 I think it's a rational decision on the basis of their leader-  
22 ship at this point.

23 MRS. WYCKOFF: Call for the question.

24 MR. CHAMBLISS: I would simply ask that those in  
25 favor of the motion let it be known by the usual sign.

1 (Ayes respond.)

2 MR. CHAMBLISS: Those opposed?

3 (Opposed respond.)

4 MR. CHAMBLISS: There are two opposed, Dr. Slater  
5 and Mr. Thompson.

6 The motion is carried.

7 Did you have further --

8 MR. POSTA: I wanted to know what is the official  
9 motion?

10 MR. CHAMBLISS: The official motion is that it is  
11 recommended that the level of funding for the Arkansas  
12 Regional Medical Program be placed at \$1,500,000, with the  
13 concerns expressed by the members of the Review Committee  
14 going to the region.

15 DR. CARPENTER: Particularly that they support that  
16 core.

17 MR. CHAMBLISS: Shall we move then to our next  
18 region, Bi-State?

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## BI-STATE REGIONAL MEDICAL PROGRAM

MR. CHAMBLISS: The reviewers are Mr. Toomey and Dr. McPhedran, and Mr. Frank Zizlavsky will be the Staff person here to give the necessary support.

Mr. Toomey.

MR. TOOMEY: I utilized the review --

THE REPORTER: I'm sorry, sir, I can't hear you.

MR. TOOMEY: -- for the basis of this discussion.

In reading the application I think the first thing that struck me -- was the microphone -- was the fact that the Regional Advisory Group disbanded and turned over the responsibility for the program to a 15-man executive committee. That 15-man executive committee has functioned. However, as time went on, very recently the program coordinator himself, Dr. Stoneman, resigned, and in the material that was sent I had, in reading it, a tremendous feeling of frustration on the part of the material that was written.

All of the program staff, however, seemed in terms of their experience to be an experienced staff. I could look the figures up, but it seems to me at the present time they have somewhere in the neighborhood of eleven program staff; whereas, their organizational program would call for about nineteen.

In looking at the past performance and the accomplishment of the Bi-State RMP, it seemed initially in tune

1 with the heart disease, cancer, and stroke programs, although  
2 it was affiliated with both Washington University and St.  
3 Louis University and these two universities were the granting  
4 agencies.

5 Later in the program the major thrust was in emer-  
6 gency medical services.

7 In looking at the even more recent programs, they  
8 have not substantially addressed the problems of accessibility  
9 and availability of care with the exception of the emergency  
10 medical services, nor have they addressed themselves to the  
11 needs of the minority groups, nor to health delivery systems.  
12 In fact, they are in a very, very particularly difficult kind  
13 of situation because they're attempting to provide a program  
14 for the rural Southern Illinois and the urban St. Louis area,  
15 and I'm sure that the conflicts in terms of the needs of both  
16 these areas are expressed in terms of the variety of programs.

17 At the present time they are requesting EMS con-  
18 tinuation grants, assistance to local planning, including some  
19 health manpower planning, quality assurance, manpower recruit-  
20 ment for the disadvantaged, and projects related to cancer and  
21 kidney disease.

22 Now, with the exception of the EMS, the projects  
23 that they propose do not in fact fall within a document which  
24 was in this proposal which was called, "The Health Needs of  
25 Bi-State RMP Region as Identified by Joint RMP and CHP

1 Planning Conference."

2 In February RMP and CHP met together and they  
3 selected three or four areas that they felt were necessary for  
4 the development of programs within the Bi-State area, a need  
5 for improvement of emergency medical services -- and that one,  
6 of course, they have worked on.

7 Secondly, need to improve accessibility to quality  
8 health care.

9 And the third was need to improve the availability  
10 of trained health manpower for the entire region.

11 And the fourth was need to coordinate health care  
12 delivery planning.

13 Skipping the feasibility for a moment, as far as the  
14 funding is concerned my comment here would be that the projects  
15 probably could be accomplished, but they do not seem to be  
16 compatible with the needs expressed in the joint RMP-CHP memo.

17 In terms of their relationship with comprehensive  
18 health planning, despite the memo that is in the proposal from  
19 RMP, my feeling in reading the comments from CHP -- well, I  
20 noted them as being polite but restrained, and very restrain-  
21 ed. I think I read into it, certainly, that there was not a  
22 tremendously happy relationship with that relationship.

23 As for the funding -- you can read this with me --  
24 I did not have it and I am interested in seeing it -- but at  
25 the present time the present level of spending annualized is

1 \$870,000 -- almost \$871,000. The targeted available funds,  
2 \$1,256,000. The May 1 request which I am presently discussing  
3 is \$1,129,000, but there is a July 1 estimate of \$410,000  
4 which places them at a figure in excess of the targeted avail-  
5 able.

6 On the basis of my own review of this, reading this  
7 material, frankly -- and the feeling that I got from reading  
8 the projects and reading the comments and relationships with  
9 CHP, it would seem to me to be the unsuitability of the  
10 projects in terms of the direction in which I felt RMP was  
11 attempting to move itself.

12 I recommended only \$800,000 in funding for this  
13 current recommendation.

14 MR. CHAMBLISS: Thank you.

15 We will now call upon our second reviewer, Dr.  
16 McPhedran.

17 DR. MCPHEDRAN: Mr. Toomey and I both were on what  
18 I guess was the latest site visit, formal site visit, to Bi-  
19 State, and the program -- this regional medical program we  
20 thought at that time had had a lot of difficulties with  
21 organization and there was some delay, as I recall, in their  
22 getting triennial approval, and I think that was true of  
23 several other regional medical programs, but we were always  
24 concerned about leadership in this program.

25 They had had a great many problems with their

1 relationships with the medical schools and it was perhaps a  
2 blessing in disguise when the medical schools withdrew, but I  
3 don't really think that the program leadership appears to have  
4 entirely gotten -- once they got rid of what was really an  
5 incubus, that is, their relationships with the medical  
6 schools, I don't really think that they got any sort of  
7 coherent direction of their own.

8           And I'm surprised to see that the Regional Advisory  
9 Group seems to have relinquished its responsibility -- I agree  
10 with Mr. Toomey's assessment of that. I thought that the  
11 Regional Advisory Group itself was capable of providing  
12 stronger leadership than that.

13           In reviewing the projects, I looked at the two new  
14 ones sort of as a touchstone for what direction they wanted to  
15 take rather than, I thought, technically reviewing them.

16           I think that the RAG or what was left of the RAG  
17 when they met in February with CHP, I think that they felt  
18 that the rug was pulled out from under them when no new EMS  
19 projects could be begun and what they have actually requested  
20 in the way of new projects are perhaps a dim reflection of  
21 what they would like to have.

22           Of those two projects, though, one of them does  
23 address minority recruitment and it has been such an important  
24 lack in this program before that I think note should be made  
25 of the fact that they seem to have come up with a project that,



1 in the bare bones that are given here, looks reasonable.

2 The other new project, which is a study of what's  
3 happened to manpower trained in a consortium that they partly  
4 sponsored, is something which I find myself not much in  
5 sympathy. It seems to me that the study -- I don't see why it  
6 requires this separate funding.

7 So that, rather than use this as a part of technical  
8 project review, I think that I would like to present it as a  
9 kind of example of what I think are the difficulties that  
10 they're having in getting a program direction.

11 Similar things could be said about some of the con-  
12 tinuation projects, but I was interested to note that the  
13 requests for quality assurance -- two of the requests for  
14 quality assurance relate to programs in out-patient practices,  
15 and I don't know whether that comes under the same kind of  
16 scrutiny as PSRO in hospitals -- Mr. Thompson shakes his head  
17 and says not -- because this is --

18 MR. THOMPSON: Right now legislation restricts it.

19 DR. MCPHEDRAN: The restriction relates only to  
20 hospital-based activity, hospital and nursing home activities.  
21 Well, that's what I thought, but I wanted to be sure about  
22 that.

23 MR. THOMPSON: With the option, and you know damn  
24 well they ain't going in that direction.

25 DR. MCPHEDRAN: But the purpose of these projects

1 for continuing support seems to me laudable, although I must  
2 say I didn't like what I saw as a technical matter in one of  
3 them. Nevertheless, I felt that their purposes were laudable.

4 I don't disagree with Mr. Toomey's funding level  
5 because I find such difficulty in coming up with one of my  
6 own. It's very hard to know. I think that, for example, the  
7 request for core staff, which is about \$550,000, as I recall,  
8 for direct and indirect costs -- I assume that that's based on  
9 an expectation that they would have their eight plus five  
10 staff, a total of thirteen staff. Since that is at least half  
11 of what we -- five-eighths of what we would be talking about,  
12 I don't really know whether they can get along and do anything  
13 worthwhile without increasing the core staff, but I'm reluc-  
14 tant to accede to the request to increase it by that amount  
15 because I'm not really sure that they can use the staffing.

16 And Mr. Zizlavsky has been there recently, I think,  
17 on technical matters, and maybe he could address himself to  
18 that question.

19 MR. CHAMBLISS: Mr. Zee, will you fill in there?

20 MR. ZIZLAVSKY: There's about three or four areas  
21 I'd like to comment on, and I might as well comment on the  
22 program staff area right now.

23 That \$550,000 figure for program staff is really  
24 gobbled up by indirect costs from these two universities.  
25 That's Point 1.

1           These five additional staff -- four of these staff  
2 are secretaries. They may be a little heavy in the secre-  
3 tarial area -- in the secretarial-clerical area by having  
4 seven secretaries for eight or nine professionals, so that may  
5 be a little too much.

6           The basic other program staff request is for a  
7 deputy coordinator and what they would call a programs opera-  
8 tion -- regional outreach person. I think these two are  
9 legitimate requests.

10           A comment about the RAG responsibility and the  
11 decrease from 75 members down to 15 members. Going back into  
12 our history, not to drag this out, but May 1973 was a "go/no  
13 go" type of month. Everybody was down. The results from  
14 RMPS came out in terms of recommendation for funding on the  
15 phase-out plans. Bi-State's program -- final recommendations  
16 for phase-out on this program were pretty skimpy.

17           By June 30th they probably had five or six total  
18 staff on board. I'm not asking for any sympathy from the  
19 reviewers, but it was at this time in May that the Regional  
20 Advisory Group thought RMP was really going under, and this  
21 was the main area where they delegated their responsibility  
22 to the executive committee.

23           Subsequently they have come back and they are start-  
24 ing to build right now in terms of increasing the RAG. They  
25 had not made that decision yet because of the future problem

1 in terms of health resource planning. Why put types of  
2 people on Regional Advisory Groups which might not be the  
3 future type of people?

4 Mr. Toomey is correct that in several areas they  
5 have not addressed accessibility and availability. They have  
6 improved in the area of minority representation. During the  
7 phase-in period they have been able to hire one minority  
8 person on program staff and they're leaning heavily on this  
9 person to really get into the St. Louis area, which really in  
10 the past they have not done an effective job.

11 I would have to go along with the recommendation for  
12 \$800,000 considering the factor that the July request is a  
13 \$410,000 request. They are under review for 31 projects  
14 presently, which there isn't any information in this applica-  
15 tion.

16 My best estimates in talking to the program involve  
17 that they decrease the 31 projects down to 24 projects, and  
18 this is the \$410,000 estimate coming up.

19 MR. TOOMEY: May I ask Zee a question?

20 Was my feeling right about the relationship between  
21 the CHP agencies and the RMP agencies? I got a feeling of  
22 some conflict.

23 MR. ZIZLAVSKY: The only area of conflict is dealing  
24 in the area of EMS. There was a subtle arrangement that when  
25 the EMS activities started up and the eight contracts were

1 awarded from HSMA (phonetic) at the time, the St. Louis area  
2 came in with a rather large contract. Simultaneously it was  
3 submitted to RMP and we recommended a \$200,000 recommendation  
4 and they finally received \$100,000, and they were one leg up  
5 on EMS planning for the St. Louis surrounding area.

6 This present project director, Dr. Wheeler, also  
7 has almost a million dollar project request in to the Kansas  
8 City Regional Office, which is their respective regional  
9 office, for new EMS legislation. We had a phone call yesterday  
10 from the regional office, and so we're on top of this situ-  
11 ation.

12 In getting very specific, the ARCH, which is the  
13 Alliance for Regional Comprehensive Planning, in the St. Louis  
14 area is an eight-county CHP B agency, they wanted to get into  
15 the area of EMS planning, but the RMP was funded in this area  
16 for planning. The National Advisory Council limited their  
17 activities to planning and training and there was an agreement  
18 between the RMP and the CHP that the RMP do the work.

19 The conflict now comes out in this application  
20 because no signals were given from the Kansas City Regional  
21 Office. RMP can no longer get into this activity. These are  
22 new monies.

23 I think you're going to see that this is just a  
24 symptom of what's happening nationally. Hopefully, we'll  
25 keep our -- we're on top of it, though.

1 MR. CHAMBLISS: Dr. Vaun.

2 DR. VAUN: Could you elaborate just a bit on this  
3 large amount of money that's being gobbled up indirectly by  
4 the two universities -- just a little bit?

5 MR. ZIZLAVSKY: Well, maybe "gobbled up" was too  
6 strong.

7 MR. THOMPSON: Ripped off?

8 MR. ZIZLAVSKY: Pardon?

9 DR. VAUN: "Ripped off," he said.

10 MR. ZIZLAVSKY: As you casually look at the indirect  
11 costs rates established for St. Louis and Washington Univer-  
12 sity, you have something like 80 percent rate for Washington  
13 University and 68 percent for St. Louis University.

14 I attended their March -- no, their April 1974  
15 Regional Advisory Group meeting when they were discussing  
16 their money problems, and everybody was concerned how to get  
17 more money, and I suggested to them that one of the areas they  
18 might consider was to reduce their indirect costs rates as  
19 some of the Regional Medical Programs have done, and --

20 MRS. WYCKOFF: They haven't done it nationally, then,  
21 by putting a ceiling; it's all negotiated?

22 MR. ZIZLAVSKY: It's all negotiated, yeah. Larry  
23 Pullen may want to comment on the technicalities of how these--  
24 I don't know --

25 MR. CHAMBLISS: Well, suffice it to say that it is a

1 negotiated rate and there would be very little that we could  
2 do at this point. I simply bring that to the attention of the  
3 committee.

4 MR. THOMPSON: Most universities have off-campus  
5 rates --

6 MR. CHAMBLISS: Mr. Thompson makes the point that  
7 most universities have off-campus rates. That's nowhere near  
8 this. Some do, yes -- most do, but in the case of this rate,  
9 it has been negotiated and we would be at a loss to make a  
10 change there.

11 The chair would entertain a motion on Bi-State.

12 MR. TOOMEY: I'll so move.

13 DR. McPHEDRAN: I second Mr. Toomey's motion -- I  
14 assume it was the --

15 MR. CHAMBLISS: It has been moved and seconded that  
16 the recommended level for Bi-State be \$800,000.

17 Is there discussion?

18 DR. WHITE: Could I ask -- this is the ceiling now,  
19 \$800,000. Suppose the staff comes to looking at this whole  
20 thing and they devise some kind of formula whereby everybody  
21 gets X percent of what they ask for or what we said they  
22 should get? These people may end up with substantially less  
23 money than they have this year. Is this what you want?

24 MRS. WYCKOFF: What does this do to the continuation  
25 projects that are listed at \$500,000 there? Are some of

1 those capable of being terminated or phased out?

2 MR. ZIZLAVSKY: There's a total of 17 projects.  
3 Fifteen are continuations. There are only two new projects.

4 MRS. WYCKOFF: What about the fifteen? Are most of  
5 those --

6 MR. ZIZLAVSKY: I'm trying to get -- in terms of  
7 being continually supported by outside sources of funding?

8 MRS. WYCKOFF: I wondered if they could be shifted  
9 over to something else quickly, you know, if they're dependent  
10 on continuations --

11 MR. VAN WINKLE: Your staff and continuations come  
12 up to over a million.

13 DR. MCPHEDRAN: I'd like to say something that, in a  
14 way, is in response to what Dr. White said. We had an in-  
15 formal conversation earlier in which we were talking about  
16 what happens when this \$115 million is to be distributed on  
17 relatively short notice and after so much phase-out has  
18 occurred, and of the two possibilities -- one, that it might  
19 not all be used and, two, that it might all be used but used  
20 in a way that would not necessarily reflect favorably on DRMP  
21 or the Regional Medical Programs -- I guess that I would  
22 really rather see the former.

23 I think I'd rather have us be in that position, so  
24 that's why, I guess, I favor these low funding levels, because  
25 I don't really feel that this program, this Bi-State Regional



1 Medical Program, can usefully employ a whole lot of money, and  
2 I think I'd rather see some of it just not distributed. I  
3 can hardly imagine that that will happen, but if I had to  
4 choose, I think that's the way I'd choose to do it, so that's  
5 why I think I support Mr. Toomey.

6 MR. TOOMEY: I'm like Dr. Slater. It's a little bit  
7 difficult to be precise and to be totally objective about  
8 these things.

9 As Dr. McPhedran said, we visited there -- I guess  
10 it was two years ago -- and in the course of two years there's  
11 much that slips your mind, but I'm certainly reminded of the  
12 fact that Southern Illinois, in the rural sections, has some  
13 very, very great needs and also great opportunities for some  
14 good planning because Southern Illinois University is tremen-  
15 dously interested in what goes on in those rural communities.

16 This is covered by Bi-State RMP, and there was  
17 rather an impassioned -- I guess in a sense an impassioned  
18 discussion by one of the Southern Illinois representatives at  
19 the meeting that we attended, and I don't see anything really  
20 that relates to the rural needs of Southern Illinois.

21 And then there is little or no doubt that in both  
22 East St. Louis and St. Louis that there are major problems of  
23 planning and health delivery, concerns related to accessibil-  
24 ity, availability, sponsorship of programs, and I had the feel-  
25 ing both at that time and now in this presentation that the

1 staff was just not focused in to see what could be done, even  
2 to study and to analyze and review and work toward those  
3 areas, and it may be, having been there and having undergone  
4 the kind of disillusionment, in a sense, that you would feel --  
5 and it's within this very subjective kind of feeling that I  
6 made the motion.

7 A VOICE: Call for the question.

8 MR. CHAMBLISS: I heard that the question has been  
9 called.

10 Is there further discussion?

11 MRS. WYCKOFF: This means it's less than they're  
12 getting now; is that correct?

13 MR. CHAMBLISS: The recommendation is that Bi-State  
14 be funded at the level of \$800,000.

15 DR. SLATER: May I ask a question? Would you recom-  
16 mend that they be phased out? I'm wondering why we're setting  
17 \$800,000. What we're saying is --

18 MR. TOOMEY: I don't think they ought to be phased  
19 out. I think that Bi-State as an organization should be  
20 divided into at least two parts. It would mean the construc-  
21 tion of another unit, but I think that, as far as I'm concern-  
22 ed, this would make sense.

23 DR. SLATER: Then I think some kind of rationale for  
24 this that's constructive in the sense -- in the sense that you  
25 just put it -- if you go back with a budget cut superimposed

1 on top of a phased-out program that's already existing --

2 MR. CHAMBLISS: Staff will take note of the rationale  
3 and the concerns that you've expressed here.

4 I'll call the question, then. Those in favor, let  
5 it be known by the usual sign.

6 (Ayes respond.)

7 MR. CHAMBLISS: And those opposed?

8 (No response.)

9 MR. CHAMBLISS: Then the motion is carried.

10 I would simply ask -- we're reaching the dinner  
11 hour -- the lunch hour, rather -- I will ask before we break  
12 for lunch that those reviewers take just a moment to complete  
13 their review sheets, and we'd appreciate it.

14 And then I'd like to get a consensus from the com-  
15 mittee as to when we should return. It is now ten of 1:00.  
16 I would say -- I would suggest if we could be back by 1:30,  
17 it would give this committee a chance to move forward.

18 I would simply let you know that we have accomplish-  
19 ed one fourth of today's workload, and I would certainly sug-  
20 gest that you return so that we may complete the twelve  
21 regions that we've set aside for this day's work.

22 I would now say that lunch is now being served.

23 (Whereupon, at 12:50 p. m., the committee recessed,  
24 to resume at 1:30 p. m. of the same day.)  
25

1  
2 MR. CHAMBLISS: If we could reconvene the Panel,  
3 I would like to put you on notice about some adjustments that  
4 we would like to make.

5 The first adjustment that we would call to your  
6 attention is that we have a new Recorder; Miss McClure is  
7 no longer with us and Mr. Dillingham is now our official  
8 Recorder.

9 Secondly, I would have you note that Doctor White  
10 has to be away from the Review Committee for an hour or so,  
11 and he has asked if we would move Georgia up just below  
12 Colorado-Wyoming, and that would give him an opportunity to  
13 go away and return later on in the afternoon. His co-reviewer  
14 has been notified.

15 I would like you to note also that we would like  
16 to move Wisconsin up in the place of Iowa, and hopefully we  
17 would be able to get Wisconsin today.

18 MR. THOMPSON: We don't have to stop, do we, in case  
19 we go beyond that target?

20 MR. CHAMBLISS: Oh, no; we can go as long as the  
21 Committee wishes, and I would encourage the Committee to have  
22 a late dinner if it so wishes.

23 DOCTOR SLATER: Do you think there is any possibili-  
24 ty of finishing by later tomorrow afternoon?

25 MR. CHAMBLISS: We would endeavor to do so, and

1 with your help, we can.

2 I have a sense of where the Committee would like  
3 to go in terms of the timeframe and the workload. Are there  
4 other suggestions here?

5 MR. TOOMEY: Let's finish by tomorrow afternoon.

6 DOCTOR SLATER: That means getting the whole group  
7 together again by what -- 3:30?

8 MR. CHAMBLISS: I would like you to note that on  
9 Friday the two panels must reassemble.

10 DOCTOR SLATER: We are suggesting that for 3:30  
11 tomorrow afternoon.

12 MR. CHABMLISS: We will have to see how the other  
13 panel is moving.

14 MR. THOMPSON: I can't be here Friday myself.

15 MR. CHAMBLISS: There has to be some coalescence  
16 of the various recommendations from the two panels, some  
17 coordination.

18 I would then call next for review the application  
19 of Colorado-Wyoming, and please note that Doctor White and  
20 Mrs. Wyckoff are the reviewers, and Miss Mary Murphy is the  
21 staff person.

22 Doctor White?  
23  
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## REGIONAL MEDICAL PROGRAM REVIEW

## COLORADO-WYOMING

DOCTOR WHITE: As a preamble, I might mention that I am a lumper rather than a sorter, so I have looked at this in a rather global manner, rather than looking at projects.

I have the fortunate perspective of having made two site visits to Colorado-Wyoming in the past, and know something about it from personal experience.

I know Doctor Nicholas, who is the present coordinator of the Region. Tom was Chairman of the RAG for a couple of years, and then decided to take on the job of coordinating the program, and has done a commendable and worthy job.

Tom is a fellow who has been known around the Region for many years; in addition to his talents as a physician, he runs a ski-resort, a small private plane enterprise, because he practiced in Buffalo, Wyoming, and this required commuting by airplane in order to go anywhere.

So he is well-regarded, well-known, and ambitious, an energetic, relatively young man. He is active in the area, he is knowledgeable in the area and he is accepted in the area.

The staff, according to the proposal presented to us at the present time, has been retained, in large part. This Region remained optimistic, even through the period of trial and tribulation. Most of them remained on the staff; some of

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1 the names I recognize as having been there two or more years  
2 ago, and they are planning to add even one or two more to the  
3 staff to deal with this Health Resources Planning and Develop-  
4 ment, which seems to be the direction that they're told to  
5 go in conjunction with the Hill-Burton, CHP and others.

6 There is an adequate description in the application  
7 as presented, in which they describe the staff and the indi-  
8 vidual qualifications, and so far as I can tell, all seem to  
9 have the appropriate backgrounds, experiences and degrees.  
10 And I believe there has been Washington staff visits out there  
11 to assure that they have good management practices, and follow  
12 the guidelines that have been laid down.

13 The Regional Advisory Group has continued to be very  
14 active. It has completed, in this period of time, a review  
15 of all past funded projects, since 1968. Now, I've forgotten  
16 exactly how many of these projects there were altogether; I  
17 think more than 20 -- obviously more than 20.

18 18 of these are now self-sufficient, either being  
19 run by someone else or generating their own support, and six  
20 they feel will become self-sufficient when RMP expires.

21 The Regional Advisory Group has been expanded in  
22 numbers to deal with the geographic dispersion that is  
23 required in Colorado-Wyoming, in the sense that they can't get  
24 together easily, and also expanded to deal with certain new  
25 objectives. They have brought on talents which have to do with

1 developing health resources and things of that sort.

2 They have continued to meet quaterly, as scheduled,  
3 and almost every individual member of the Regional Advisory  
4 Group is said to have participated in other committee func-  
5 tions, and to have made site visits, particularly in reference  
6 to this review of past projects.

7 It has reconsidered its goals, and has determined  
8 that the Regional Medical Program of Colorado-Wyoming is a  
9 viable one and will continue, in some form or another, even  
10 after funding subsidies.

11 Its past performance, I think, is excellent, as  
12 witnessed by the fact that a significant number of its pro-  
13 jects undertaken in the past are now self-sufficient and con-  
14 tinuing. It has become an accepted and utilized resource;  
15 for example, it was designated by the Governor of the State  
16 to be that agency which would undertake planning for the  
17 Emergency Medical Services for the State of Colorado, and I  
18 think in Wyoming as well. And it will continue to function  
19 in this regard.

20 It has -- in our past visits, and both Mrs. Wyckoff  
21 and myself have been there -- I think we have recognized that  
22 their goals and objectives are consonant with those laid down  
23 by the Office here in Washington.

24 So far as I can tell, without looking at the projects  
25 in great detail, and basing my judgment on the fact that I



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1 trust these people, I believe that what they are proposing to  
2 do this year will indeed be feasible within a year's time, in  
3 large part, and will have some hope of continuing under some-  
4 one else's aegis at the termination of the support from  
5 Washington.

6 The activities proposed consist of seven activities  
7 addressed to the problems of availability, accessibility of  
8 care; one addresses the need for more primary care types of  
9 individuals, and it is worthy of note that the Regional  
10 Medical Program in both Wyoming and Colorado was instrumental  
11 in getting legislation passed to permit utilization of these  
12 other professionals in rendering health care.

13 It has two new and one old objective, which served  
14 the regionalizationalization concept; this is important to  
15 this area because this is such a widespread geographic area,  
16 with dispersed population centers and very sparse population  
17 centers as well.

18 The only -- there were some proposals which I was  
19 not sure were appropriate under the material that we received  
20 from Washington. They are proposing a Bone Pathology Center,  
21 which I assume has to do with cancer in large part, and it  
22 seems to me I read something -- and Mike, you can correct me  
23 on this -- that some of these things were to be taken over by  
24 the National Cancer Institute, were they not, in some way or  
25 another?

1 It also wants to continue a Cancer Registry, which  
2 I think is more appropriately under the support of the Cancer  
3 Institute, and radiation time-sharing studies.

4 Even in the past I had some concern that they were  
5 emphasizing pediatric dialysis centers inordinately at the  
6 expense of certain other activities, and they are proposing  
7 even now to establish a pediatric nephrology center, to the  
8 tune of \$83,510.

9 I don't believe their EMS activities conflict with  
10 the policy, in the sense that they are continuations, more or  
11 less, of what was going on in the past, and they will not be  
12 operational programs, but mainly development and planning.

13 So far as I can tell from the letters of endorsement,  
14 their relationships with Comprehensive Health Planning are  
15 amicable, and indeed, they dovetail very closely in some of  
16 the more remote areas; Grand Junction is one which comes to  
17 mind, for example.

18 The letters were generally supportive, neither  
19 vindictive nor overly filled with praise, but I think they  
20 indicate that there is a good relationship between Comprehen-  
21 sive Health Planning and the Regional Medical Program and that  
22 in all probability, there will be joint development of programs  
23 for these health resources facilities.

24 The other comment I would have is that the whole  
25 tenor of the application is one of reasonable optimism -- not

1 that Regional Medical Programs in its present form will be  
2 continued, ad infinitum, but that they have at least estab-  
3 lished that they have a viable role in the State of Colorado  
4 and that the State Health Department, the schools -- whatever  
5 other funding agencies come along, will utilize this talent  
6 that is already there and not let it disband and disperse and  
7 be lost.

8 I did not come to any firm figure in terms of  
9 recommending support. I have a certain uneasy feeling of dis-  
10 quietude in the sense that I find it difficult to really under-  
11 stand how any Regional, no matter how good it is, can ask for  
12 a highly substantial increase in its sums, and in such short  
13 period of time adequately reviewed their pertinence to their  
14 needs.

15 Now, I can't say that for sure, because I did not  
16 look at each of their projects in great detail, but just on  
17 that general principle, I would think that, and it would be  
18 my recommendation, that Colorado-Wyoming be considered for  
19 the targeted amount, and I say that in terms of what I just  
20 discussed and in terms of knowing that they are going to be  
21 coming in in July asking for another quarter-million dollars  
22 and that in all probability they are not going to get what  
23 they asked for in any event.

24 That would be my recommendation, that they be  
25 allowed up to \$1,587,644, which is the targeted available funds

1 seen, with the option that they can apply for more <sup>75</sup> in July,  
2 which they expressed an intent to do.

3 MR. CHAMBLISS: Thanks for your recommendation,  
4 Doctor White.

5 We will now call upon Mrs. Wyckoff.

6 MRS. WYCKOFF: I made a very long report, and  
7 Doctor White has said most of it, so I don't want to take up  
8 more of your time with this.

9 I feel that the characteristics of this Region,  
10 which is a very far-flung one, which -- it is the same dis-  
11 tance from St. Louis to Washington as it is across this  
12 Region -- that is quite a large Region, and their interest in  
13 regionalization and in reaching out, and in their use of  
14 things such as the Emergency Medical Services, and their  
15 attempts to strengthen the services to this extremely rural  
16 area, are very worthwhile and very well-designed.

17 DOCTOR WHITE: Doctor Nicholas is a real mountain-  
18 man, who understands the mountain psychology.

19 MR. CHAMBLISS: He is from Buffalo.

20 MRS. WHYCKOFF: He knows how to work with this Board,  
21 and he has kept their enthusiasm up. I think they are very  
22 fortunate in getting a man who not only was a rural person  
23 who understood the difficulties in the rural districts, but  
24 he also came into Washington on business, he was sent on site  
25 visits by the RMP and learned a great deal about the whole

1 complex works, so that he is a sophisticated man, and yet  
2 he is a man who has knowledge of the small rural community's  
3 mind.

4 I think he has done a very successful job in that  
5 Region, through a traumatic experience, and I believe they  
6 have done the best we could possibly expect from them.

7 I agree with Doctor White's recommendation for the  
8 funding, and I would urge that we give them what they ask for  
9 at this time, even though I think perhaps the question he  
10 raised about the cancer projects may have some validity and  
11 that those possibly can be transferred.

12 I would like to turn in this long-winded written  
13 affair so that it does not take up your time, but it has com-  
14 ments on a number of the projects. Is that acceptable?

15 MR. CHAMBLISS: I am sure the staff would be most  
16 appreciative of your notes, and they will take into account  
17 your concerns, Mrs. Wyckoff.

18 MRS. WYCKOFF: I have some grave questions in here  
19 about the relationship of CHP and RMP in terms of their  
20 funding, and the agency that is going to pass judgment on --  
21 the agency that funds it now and how you work out these  
22 relationships in a satisfactory way, but I assume that with  
23 the new legislation, all this may become academic.

24 So I would like to second Doctor White's motion that  
25 it be funded at the requested amount. I think they are capable

1 of spending the money --

2 DOCTOR WHITE: I suggested the targeted amount.

3 MRS. WYCKOFF: The targeted amount.

4 MR. CHAMBLISS: The matter before the Committee now  
5 is simply a suggestion, and I would certainly entertain a  
6 motion.

7 MRS. WYCKOFF: All right. I'll make a motion to  
8 that effect.

9 DOCTOR WHITE: I'll second that.

10 MR. CHAMBLISS: It has been so moved:

11 "That the level of funding for Colorado-Wyoming  
12 RMP be set at \$1,587,644, which is the equivalent of  
13 the targeted amount for that Region."

14 The Committee has expressed its concerns with regard  
15 to the cancer activities and --

16 DOCTOR WHITE: Kidney.

17 MR. CHABMLISS: And the kidney activities as embraced  
18 in the motion.

19 That has been properly moved and seconded. Is  
20 there discussion?

21 In the absence of discussion, I'll call the question.  
22 All those in favor?

23 (Chorus of "Aye.")

24 Those opposed?

25 VOICE: No.

1 MR. CHAMBLISS: The motion is carried, with one  
2 negative vote in the person of Doctor Miller.

3 It is so ordered.

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1 MR. CHAMBLISS: I would simply like alert the  
2 Committee to stand guard for some momentary changes in the  
3 order here.

4 I have pointed out one, that Doctor White will have  
5 to leave, and we will take Georgia next so as to permit his  
6 temporary departure from the Committee, and then I would call  
7 to your attention the fact that our staff support for Illinois,  
8 Mrs. Kyttle, has to be out of the room, and I might say that  
9 she is one of the persons who has transferred from RMP. She  
10 has to be out of the room momentarily also, and she will  
11 return around 4:00.

12 We would then substitute Indiana in place of  
13 Illinois. We would make a change in Inter-Mountain and Iowa,  
14 and pick up at Kansas, Louisiana, and move down from that  
15 point, so there are a few changes that I would ask the  
16 Committee to take cognizance of.

17 We will now call upon Doctor White again, and  
18 Doctor Carpenter for a review of the application of the  
19 Georgia Regional Medical Program, and they will be supported  
20 by Mr. Jewell, from staff.



## REGIONAL MEDICAL PROGRAM REVIEW

## GEORGIA

DOCTOR WHITE: I'll follow the same general format, but in reality, comments are very akin to those made previously and only the names need changing, in a sense.

Georgia is in a triennial status. It's been awarded that in the past in recognition of its quality; again I have the advantage of having made two previous site visits to that Region, and have come to know J. Gordon Barrow professionally reasonably well during those two visits.

I think one can say, without too many reservations, that Doctor Barrow is one of the better Regional Coordinators. He is the original and only one in this particular area; even prior to his activities in the Regional Medical Program, he was very active in similar sorts of activities in the State of Georgia.

He has the appropriate accent, and is well-accepted by one and all in that area, and he has done a commendable job in establishing a very close relationship with the Georgia Medical Association -- or Society; I've forgotten which it's called -- so that they are the sponsoring fiscal agency.

There has never been this conflict of interest which seems to have arisen in certain regions between established medical organizations and the medical programs.

He has indeed cemented relationship, both in Atlanta,

1 and clearly out in the regions of Georgia.

2 At least on my previous site visits, it was my  
3 feeling that the people in that area who attended the visits,  
4 have come to recognize that the Regional Medical Program of  
5 Georgia was indeed a resource upon which a wide variety of  
6 people could call for help, ranging from patients to health  
7 professionals.

8 The staff, again, consists of thirteen key and  
9 stable people who have been there an average of five years  
10 and three months, and again, are well-qualified in terms of  
11 their backgrounds and degrees for positions that they hold.

12 They are organized well into administrative and  
13 operational groups with defined responsibilities and areas of  
14 operation.

15 The Regional Advisory Group has continued to be  
16 active; it meets regularly. In their words, it did not wither,  
17 it developed alternate plans, not just for the phase-out, but  
18 for its continuation beyond the time when support would  
19 wither. It even conducted a "retreat" which was apparently  
20 well-attended by most of the members of the Regional Advisory  
21 Group, in which they examined the alternative plans for  
22 survival with or without Washington's support.

23 Again, it is clear that the individual members of  
24 the Regional Advisory Group not only participate in the  
25 deliberations of the meetings, but participate in terms of

WHD-16

1 serving on committees, making site visits and interchanging  
2 with Comprehensive Health Programs throughout the state.

3 Its past performance has sometimes been misunder-  
4 stood. It also has this regionalization, or "umbrella" sort  
5 of concept, and in the past we have kind of thought at times  
6 that they were continuing an old activity under a new name,  
7 but in reality they were continuing a new activity under an  
8 old name, is what it amounted to.

9 And they have gone out and they have used community  
10 hospitals as a source or a center from which to spread out,  
11 creating a net of educational care facilities, investigation  
12 and the like, and the only question I saw in the whole appli-  
13 cation was whether or not they should broaden out and no longer  
14 use just -hospitals as a center, a focal point, but perhaps  
15 that there are other kinds of health agencies that could also  
16 serve this function as well, but that was a comment.

17 They have indeed established well-defined catchment  
18 areas and regions which subserve their projects and programs  
19 and activities, and by virtue of this they also have a close  
20 relationship with the area Comprehensive Health Planning  
21 agencies.

22 It has an Emergency Medical Services project which  
23 is largely that concerned with planning and coordination. Its  
24 continuation by others at the present time is not clearly  
25 specified. There is no hard money, or firm commitment by any

1 other agency or organization which indicates that it will con-  
2 tinue, but presumably something might arise on the scene.

3 Its objectives and priorities have been well speci-  
4 fied in the past, and are unchanged at the present time; they  
5 still have to do with availability and accessibility and  
6 development of new types of manpower and utilization and net-  
7 works of specialized services.

8 It also is undertaking a fairly extensive program  
9 for planning and developing health resources, and I guess  
10 this raises a question in my mind, particularly after hearing  
11 Doctor Paul's comments this morning, that although these  
12 Regions have been encouraged to do this, what is going to  
13 happen if they expend a lot of money, a lot of time and a lot  
14 of effort meeting, getting together, saying "This is what the  
15 health resources facility should be for the State of Georgia,"  
16 and in the meantime Congress is passing a law which is dia-  
17 metrically opposed to this sort of thing?

18 Is this something that we should attend to? Should  
19 we say: "No, let's not be doing that until we see, when the  
20 dust settles, where we're going to go." Or should we hope  
21 that by virtue of their doing something now they'll have some  
22 future influence on Congress? I don't know.

23 Their relationship with Comprehensive Health  
24 Planning, I believe to be good. They exchange memberships on  
25 the respective committees and Regional Advisory Groups and

1 boards; they have funded one another for certain types of  
2 activities, there are certain adequate letters of support  
3 from the Comprehensive Health Planning agencies, without  
4 serious adverse comment.

5 I think it is important to notice also that they  
6 have not -- even though they were told they might expect  
7 140 percent, they have not chosen to ask for it, and they  
8 have also indicated that they felt they would not be asking  
9 for any money in July.

10 They have given considered thought to what it is  
11 they would like to do and they want to get underway at the  
12 present time, and it is going to take less money than they  
13 thought they may possibly be awarded.

14 It seems to me this does reflect some thinking, some  
15 merit. This is a Region of merit, a Region of past perform-  
16 ance, and I would feel they are entitled to what they  
17 requested, or any fair proportion thereof that is finally  
18 evolved.

19 MR. CHAMBLISS: All right; our next reviewer for  
20 Georgia is Doctor Carpenter.

21 DOCTOR CARPENTER: Well, it is always a pleasure  
22 to follow Phil, because he makes it so easy.

23 I would just -- this application was an enormous  
24 relief to me. I thought in some areas that maybe I was wrong  
25 about Regional Medical Programs, and I found that if I was, at

1 least Gordon Barrow in Georgia agreed with me.

2 So I can hardly say enough good things about the  
3 Region.

4 You know, for instance, they don't charge indirect  
5 cost rates, except on a few -- I don't know: 76-46 -- less  
6 than \$100,000 in the total program of nearly three-plus  
7 million dollars -- less than \$100,000 of indirect costs.

8 They have their own goals; they are leading the  
9 development of the health-care system in Georgia, I believe,  
10 as much as any organization I have ever seen lead in such a  
11 complex environment as the state, among its health care pro-  
12 viders and interested consumers.

13 They have their own goals and they are pursuing  
14 them actively, but they take full advantage of Federal prior-  
15 ities, and move in new areas with amazing speed.

16 They have responded to the minority problem very  
17 well; there are -- there are a large percentage of minority  
18 people, particularly in the projects. They --

19 I am tempted to read two paragraphs out of the pro-  
20 jects, because they contrast so much with the Arkansas descrip-  
21 tions and some of the other ones I have seen -- not really  
22 trying to single out Arkansas, but to make the point that  
23 these people do have specific goals, they do indicate in their  
24 project descriptions their understanding of the pitfalls in  
25 developing. You know, no matter what you try to do, there are

1 always problems, and they indicate, I believe, that they are  
2 aware of the importance of the problems.

3 And I could go on and on, but I would agree with  
4 Phil's funding recommendation, and I would make a motion then  
5 that we approve support of the level requested.

6 DOCTOR WHITE: I'll second that.

7 MR. CHAMBLISS: There is a motion that:

8 "That the funding level for the Georgia  
9 Regional Medical Program be set at \$3,629,757, which  
10 is the total amount requested by the Region."

11 MR. VAN WINKLE: And you might note that they don't  
12 propose to come in July 1.

13 MR. CHAMBLISS: Now that you have heard the motion,  
14 is there discussion? Mr. Thompson?

15 MR. THOMPSON: Some people may not know that they  
16 have had probably the most successful EMCRO program, which was  
17 an Experimental Medical Care Review Organization, and they  
18 have been designated, I think so far, as the only statewide  
19 PSRO, which also indicates the kinds of togetherness that  
20 somehow this state manages to put together.

21 MR. CHAMBLISS: All right; further discussion on  
22 Georgia?

23 Then I'll call the question. All those in favor of  
24 the motion, please say "Aye."

25 (Chorus of "Aye.")

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And those opposed?

(No response)

There is no opposition, and I would simply say to the staff, as they convey to the Council, the observations -- the recommendation made about the Region in addition to the level of funding support recommended.

I would ask Doctor White, in that he will be leaving shortly, if he would be kind enough to prepare the review sheets, and we would very much appreciate that, and you likewise, Doctor Carpenter. Thank you.

DOCTOR WHITE: The question arose: do you want these signed? Should they be signed?

MR. CHAMBLISS: We have no aversion to them being signed; it is not required, but if you like. We can be much more specific in our observations.

DOCTOR WHITE: You know it comes from one of two people anyway.

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1 MR. CHAMBLISS: I would indulge the Committee and  
2 Doctor White for one further observation here, and that is  
3 that Doctor White is also scheduled to review today the appli-  
4 cation for Louisiana.

5 Would you be disposed at the moment to continue,  
6 Doctor? Or would your time not permit?

7 I only call upon you on that momentarily. It is  
8 not required, however.

9 DOCTOR WHITE: Well, my hesitancy reflects the  
10 fact that I don't see Doctor Perry here.

11 MR. VAN WINKLE: Doctor Perry will not be on the  
12 Panel.

13 DOCTOR WHITE: Therefore, I am the only person who  
14 is going to have any say-so about Louisiana, I guess.

15 MR. CHAMBLISS: You will have support from staff,  
16 however, in the person of Mr. Zivlavsky.

17 DOCTOR WHITE: It would make me more comfortable to  
18 do it at a later time.

19 MR. CHAMBLISS: Indeed so; no problem at all.

20 I would then call the attention of the Committee to  
21 the application from the Indiana Regional Medical Program.  
22 The reviewers there are Doctor Slater and Doctor Thompson.

23 I have skipped Florida. I would -- if the Committee  
24 will indulge my mistake, I will change that and revert back to  
25 Florida, and then come to Louisiana. I would thereupon call

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upon Doctor Miller, who will be supported by Mr. Van Winkle,  
from staff.

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## FLORIDA

DOCTOR MILLER: I probably have a little bit different point about many of these things than many other members of this Committee, having directed a Regional Medical Program for seven years, and I tend to be a little critical, which I hope you'll bear with me, and I won't feel offended if you vote down my views more liberally than I make judgments.

Florida, our Regional Medical Program has been an outstanding RMP; for a long time it has the second highest current level of annualized funding, according to our list, under California.

It is an ambitious RMP; it has always has an ambitious program. It is well organized, with good leadership, good program staff, excellent Regional Advisory Group, excellent past performance and accomplishments -- I could go on and give details of these things, but there is not much point. They are all very good.

Their objectives and priorities are not quite so succinctly specified or controlled, but nevertheless do address the program activities, address all the key issues that we focus on.

I can't find anything really wrong with any component of their application, which is large, for three million dollars; the staff's only question for Reviewers' attention was the

1 MAST program, which is an EMS component, but staff didn't  
2 feel that there was any problem here.

3 So the proposal, the operational activities and all,  
4 are indeed congruent with the Region's explicit priorities  
5 and suggested areas of emphasis, and they get along well with  
6 CHP, and the CHP relationships are good.

7 So then you get down to the problem which I  
8 addressed in all of these five that I reviewed in detail,  
9 under a couple of basic principles.

10 The first one was that virtually all the RMP's  
11 should be given complete support for their core staff and for  
12 continuation of program activities that they have gotten  
13 started and that have been going all right.

14 But then -- provided the budgets are not doubled  
15 or tripled, that is.

16 But then the problem of new projects and the feasi-  
17 bility of getting them completed in a successful way, with a  
18 meaningful impact, with recognition as an RMP activity, in  
19 one year, seems to me to be quite a big question.

20 The staff did not summarize, in the Florida program  
21 here the answer to the question:

22 "Are continuation projects budgets raised too  
23 much for the next year, out of proportion to what they  
24 have been this present year?"

25 And I would like to ask staff if that is true, because a

1 number of these projects have rather large budgets, much the  
2 same, however, as you have just reviewed in the Georgia  
3 program, with rather tremendous individual budgets for some  
4 of the program activities.

5 And in Florida, in the Florida RMP, the numbers of  
6 -- lost my page here, but there are something like -- 35  
7 projects, of which 25 are new, I believe. 22 are new, and not  
8 previously funded, and if one goes into those projects, there  
9 are a number of them that are certainly very questionable as  
10 to whether they can be successfully and very conscientiously  
11 completed in one year, activities that would be worth the  
12 rather large budget requested.

13 The bilingual communications system of translation  
14 from English to Spanish, of \$121,000, without any real indica-  
15 tion that it is going to be continued by anybody else.

16 A number of these. Visitor assessment of visitor's  
17 needs for health care of visitors to Florida, with a budget  
18 of \$189,000, a Florida perinatal program, which is an obviously  
19 needed thing, but with a budget of \$212,000 and no real indica-  
20 tion exactly as to whether they would be continued, except to  
21 say that efforts would be initiated to try to find out if they  
22 can be continued. One would hope so, for \$212,000.

23 Improving health care assessment quality assurance,  
24 which is an excellent plan, in community hospitals. Anybody  
25 who has worked in one of those things, in those endeavors,

1 which we did, knows that there is a very limited amount you  
2 can accomplish in one twelve-month period and a budget of  
3 \$212,000.

4 A program to start a mid-wifery project, which is  
5 obviously very much needed in many places in this country  
6 but it is one mid-wife with a budget of \$87,000.

7 An Indian health care program for acute critical  
8 illness in Indians; we started developing one of those in  
9 Minnesota, figuring it would take at least three years to get  
10 it going.

11 So, I find myself being critical of dealing out  
12 rather tremendous amounts of money, even to what I regard as  
13 one of the best RMP's in the country, to activities like this  
14 that have relatively high budgets and, I think, somewhat  
15 questionable potential for comparable achievement.

16 Now, if the RMP was likely to be funded for another  
17 three-year period, every one of these things would be good,  
18 and they would be ahead. We'll come to Missouri later, and  
19 I think the situation is similar there. They would be ahead  
20 of the game, because they would have started things, moved  
21 very rapidly in their very large endeavors, and then moved  
22 right ahead then with some critical key issues and have a  
23 year's head start on a lot of other programs that then will  
24 start three-year projects of such things.

25 So in terms of that, obviously one should okay

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1 their funding.

2 They also plan to come in for another application  
3 in July, for another one and a half million dollars.

4 So they're not modest. They are good, but not  
5 modest. Applying for a total of four and a half million.

6 I fail to be able to differentiate the charge to  
7 us of reviewing these things without considering these cost-  
8 benefit aspects of particularly new-project activities, and  
9 consequently -- well, my first recommendation after studying  
10 all this was that they be cut by a million and a half.

11 I guess, in view of what has gone on this morning,  
12 I would say that was an unusual recommendation, and therefore  
13 I would -- well, I would like to hear Staff's reactions,  
14 since the other Review Committee member is not here.

15 MR. VAN WINKLE: In terms of the continuing support,  
16 Doctor Miller, I can only go on their past record, which has  
17 been excellent. That has been one of their main objectives  
18 in their cost-sharing of funds, and I just noticed the one  
19 statement in here that since July of '71, \$3.7 million have  
20 been invested by the Florida RMP, and that was augmented then  
21 by \$5.2 million of other funds that they were able to drum  
22 up, and then after completion of the FRMP support, they con-  
23 tinued a number of those projects with other funding in the  
24 amount of another one and a half million.

25 So they have had a very good record of continuation

1 after their phase-out.

2 Now, I noticed, too, some of the large increases  
3 in budgets, and did check this out, Doctor Miller, and parti-  
4 cularly on their continuations; their budgets were jumping  
5 very high.

6 DOCTOR MILLER: Oh, yes; maybe twofold.

7 MR. VAN WINKLE: And what I found out is that we  
8 were comparing against four-month budget; the previous budget  
9 that you were looking at was only for a four-month period.

10 DOCTOR MILLER: I did not have the previous --  
11 they are not in here, the previous budgets.

12 MR. VAN WINKLE: No, but I went back to check, and  
13 it looked like a horrible jump, but then when I annualized  
14 that against this, and as an example, I just pulled one out  
15 here.

16 They had started out only in two counties, and it  
17 was a pilot study; they now are moving out into all 67 count-  
18 ies of the state.

19 The one on the next page, for example, was a pre-  
20 test pilot program in three hospitals. They are now moving  
21 that computerized system that they developed into a state-  
22 wide program now.

23 And as I went through each of these, I found that --  
24 you know, that type of justification. The one on the commun-  
25 ity organ-donor program, that started only in Dade County; it



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1 is now moving out into four surrounding counties around Dade,  
2 and it will increase the capability.

3 And I think one other thing I would like to mention  
4 about Florida, along with the other good things you say, is  
5 that they also do not have an indirect cost rating.

6 DOCTOR MILLER: No. They are a separate corpora-  
7 tion which has its costs all direct.

8 MR. VAN WINKLE: I am not sure what other -- I  
9 really can't say anything as to the continuations, other than  
10 the fact that their past record has been excellent.

11 DOCTOR SLATER: May I ask a question which bears  
12 on the indirect versus direct charges?

13 Are the direct usually less than the indirect  
14 charges being made by universities or other institutions?

15 MR. CHAMBLISS: Yes, they are.

16 DOCTOR SLATER: Considerably less?

17 We seem to be very concerned about the indirect  
18 costs that are charged to the program. I am just trying to  
19 get a fix on the difference in amounts, or a percentage, let's  
20 say.

21 MR. VAN WINKLE: Well, let's assume that you had a  
22 two-million dollar grant to a program. You might have another  
23 80 percent of that added on to that, that we have to put out  
24 in terms of indirect costs.

25 DOCTOR SLATER: Right, but if you build the direct

1 costs into the two million dollars, what would that total  
2 package come to?

3 DOCTOR MILLER: I can answer that partly.

4 It depends a lot on how the big institution handles  
5 its accounting for indirect costs. If the big institution,  
6 now, like a big university -- we ran through this in  
7 Minnesota, because a part of ours was a university component  
8 and may have indirect costs -- now, if the university figures  
9 its indirect costs across the board, with all departments,  
10 which includes all laboratories and research units and so  
11 forth, and they got all the costs of all those research units  
12 built into the total indirect cost rate, then a desk operation  
13 like RMP is charged an exorbitant amount of indirect costs.

14 If however they have two levels -- and they fre-  
15 quently do -- and they cost-account indirect costs on the basis  
16 of the kind of work we are doing, then it is -- it may not,  
17 depending on how efficient the big organization is -- their  
18 indirect costs may not come out any bigger than if you do a  
19 direct cost.

20 MR. VAN WINKLE: Doctor Miller, you were talking  
21 about this Region looking ahead, and that is precisely what  
22 they are doing during phase-out. They did not stop.

23 They said: "No way are we phasing out;" they never  
24 at any time believed they were going to phase-out and they  
25 continued their program, and when the June 15th turnaround

1 came, they were way down the road. That is precisely<sup>98</sup> the way  
2 they are going to look at it right now.

3 DOCTOR MILLER: I expect that is precisely what they  
4 are working on right now.

5 MR. VAN WINKLE: They intend to be whatever organiza-  
6 tion that is that responds to the new legislation. That is  
7 their intent, whether it has anything to do with this appli-  
8 cation or not -- but I do know that is their intent.

9 MR. CHAMBLISS: I might simply suggest to Doctor  
10 Slater, if I may, that as we move from the world of founda-  
11 tions to the world of institutions, this issue will become a  
12 very keen one, about indirect costs.

13 DOCTOR SLATER: I'm sure it is.

14 MR. CHAMBLISS: It is one that has been rather per-  
15 plexing for many of us.

16 DOCTOR SLATER: Foundation spending is very simple,  
17 by simply saying:

18 "We never pay anybody more than 15 percent, if  
19 that; we can't do it."

20 MR. CHAMBLISS: I wonder if the Reviewer, Doctor  
21 Miller, is now -- are there further questions? I would enter-  
22 tain -- I would like to have a recommendation, and I see  
23 Doctor Vaun's hand.

24 Doctor Vaun, did you have a question?

25 DOCTOR VAUN: Yes. Winnie, you raised the question

98-A

1 about the possibility of these projects after a year, or the  
2 possibility of accomplishing the objectives and goals within  
3 a year.

4 I wonder, if in the stage of transition now, that  
5 is a legitimate question? Not considering Florida's past  
6 performance, but I wonder if that is a real question on our  
7 part in this panel? I would just like some reaction to that.

8 To me, it sounds like you are questioning the  
9 whole management ability of that program when you ask that  
10 question. In other words, if they didn't think that there  
11 was either a reasonable chance of follow-through with funding  
12 from other sources, or a reasonable chance that they would  
13 accomplish their objectives, than how can you say in one  
14 breath that it is a reasonably well-managed program, and yet  
15 you have sizable questions about the money?

16 DOCTOR MILLER: When RMP's first started, the RMP  
17 was a source of "soft gold" from the Federal Government. I  
18 went through this, in the process of getting people to change,  
19 because these are the kinds of budgets we had in all our  
20 applications. They were huge.

21 Now, it is quite obvious -- if you haven't heard it,  
22 but it has been expressed very widely -- RMP is now another  
23 source of soft gold for one year, only. All the frozen money  
24 has been released, and RMP now has more money in one year than  
25 they had before.

1 Now, I don't -- maybe you don't -- I'm not sure  
2 that it is politically desirable to try to react against  
3 that at this circumstance.

4 MR. VAN WINKLE: Doctor Miller, I am familiar with  
5 the review process. I have been at some of their meetings,  
6 and it is probably one of the toughest groups I have ever  
7 encountered.

8 As I mentioned to you this morning, at the last RAG  
9 meeting I attended, they became so personal I almost wondered  
10 if there was going to be a little bloodshed.

11 Staff are involved with the development of that pro-  
12 gram from Day One, and long before many of those proposals  
13 ever come to the first committee in the review process, Staff  
14 has already been at work on their budgets.

15 They have two different review groups that have a  
16 go at those, and again, you can get reductions in any one or  
17 all three of those three review groups. I sat through one on  
18 a Saturday, and then on the Sunday I thought all the slashes  
19 had been made, and then went to the Council meeting on a  
20 Sunday and found out that it was not resolved at all.

21 DOCTOR MILLER: Yes. The letter says that it had  
22 over 100 projects applications that they reviewed.

23 DOCTOR CARPENTER: How many did they accept?

24 DOCTOR MILLER: 35.

25 MR. THOMPSON: May we arrive at some kind of money

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1 here?

2 MR. CHAMBLISS: The Chair would entertain a motion  
3 based on the presentation.

4 MR. THOMPSON: I'm not going to let him off the  
5 -- off the hook; he hasn't made a recommendation.

6 DOCTOR MILLER: All right.

7 They are planning on coming in with a million and  
8 a half more application. Their target total is \$3.2 million,  
9 they are applying for three million now. Their current fund-  
10 ing level is \$2.3 million.

11 I would recommend a funding level of \$2.7 million.

12 MR. CHAMBLISS: The recommendation is a funding  
13 level of \$2.7 million for Florida. Is that in the form of a  
14 motion, Doctor?

15 DOCTOR MILLER: If you wish.

16 MR. CHAMBLISS: ✓And is there a second?

17 MR. THOMPSON: I will second it.

18 MR. CHAMBLISS: It has been moved and seconded:

19 "That the funding level for Florida be estab-  
20 lished at \$2.7 million."

21 Is there any discussion?

22 (No response.)

23 If there is no discussion, are you ready for the  
24 question? Those in favor?

25 (Chorus of "Aye.")

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Opppsed?

(No response)

The motion is carried, and it is so recommended, at  
\$2.7 million.

I would say that the Committee is moving along  
rather well, and that we will go to the next Regional Review,  
and that is Indiana.

- - -

## REGIONAL MEDICAL PROGRAM REVIEW

## INDIANA

MR. CHAMBLISS: Indiana will be presented by Doctor Slater and Mr. Thompson, supported by Mr. Jewell.

DOCTOR SLATER: All right, sir, I'll begin with Indiana.

The budget request, as you have seen on Line 43 of the print-out there, they are annualized now at \$1,057,000, and they are requesting \$1,221,000 against a targeted fund of \$1,430,000, so they are considering about 84 to 85 percent of what they are targeted for, but coming back in July for another \$400,000, which would bring them up to about 112 percent of their current.

I looked at the proposal and tried to sort it out in the sense of the guidelines that you gave us, and let me introduce this by saying that I found it very difficult to come to grips with what they are doing.

When I looked at the specific projects that they have been involved in in the past, and what they have been able to accomplish, I am impressed that something is going on out there, and I do believe they can't write a proposal very well, or write a report. I found repetition and lack of clarity, and so I think that I am going to reflect that.

I would say that this is a traditional type of RMP program in contrast to the one I'll report on later in Illinois.



1 Program leadership is satisfactory.

2 Program staff -- every one of the current staff  
3 have been in RMP for over four years and they have experience.

4 The non-medical professional people, with the excep-  
5 tion of the Dean, who has been associated with the school and  
6 the program support for some time, are now instituting them-  
7 selves to the level of 33, with good representation in  
8 Indianapolis and the regional areas.

9 At the 37 level, they had 30 people from Indianapolis  
10 and seven from the regions. They are now going to try, in  
11 their new level of 33, develop a better balance for minority  
12 and geographic representation.

13 They have the usual types of committee -- Executive,  
14 Review, Evaluation and so on, which I thought was satisfac-  
15 tory.

16 They outlined that they have two major thrusts; they  
17 attempt to develop guidelines on standards and criteria on two  
18 main types of activity.

19 One, the identification of hospitals to provide  
20 better capability there, with particular reference to state  
21 emergency medical services, and secondly, they are interested  
22 in enhancing a whole series of specific programs which have to  
23 do with quality of medical care, access and the like.

24 These are identified as renal dialysis, kidney-  
25 transplant, radiation therapy, angiography and the like.

1 Now, as far as past performance is concerned,  
2 they describe themselves as really spearheading regionaliza-  
3 tion and improved cost-effectiveness by acting as coordina-  
4 tors, planners and developers, and I wrote a quote here:

5 "They are interested in more quality of health  
6 care available to more people at less cost."

7 That, I thought, was a nice, general "motherhood" statement.

8 Within that framework they really have been working  
9 closely with CHP, and have been attempting to extend sub-  
10 regional RMP development that is tied in with the existing B  
11 agency development in Indiana.

12 Examples of what they have done in the past, very  
13 briefly, are that they have developed a data base to reveal  
14 health deficits. I am not quite sure what that means, because  
15 there wasn't enough information.

16 They have organized sub-regional CHP provider-  
17 consumer groups in six areas, five or more on the Board.

18 They have promoted programs to meet these above  
19 needs. For instance, physician-extender and continuing educa-  
20 tion programs, they have been involved in legislation on  
21 statewide emergency medical services, a couple of neighborhood  
22 health centers in the urban areas, state stroke-therapy  
23 services, consultation in organized coronary-care units -- I  
24 could go on.

25 All of the above, with the exception of a little bit

1 of continuing RMP staff and money input, have been initiated  
2 and are on-going and phased over to other support. They are  
3 not totally independent; where the line is drawn, I am not  
4 sure, but they have made a major effort to act as a catalyst  
5 and move programs they started out onto other funding lines.

6 At the moment, they also have some limited demon-  
7 strations; hypertension screening and care programs in dis-  
8 advantaged urban areas. They are looking at what they call  
9 the "assurance of quality of care." I wish they had just  
10 said they were setting up a perinatal upgrading program,  
11 instead of all the generalizations.

12 They have a kidney disease program which includes  
13 immunologic studies. This is a hope to define ways by which  
14 you can prevent organ rejection. I was concerned about this  
15 because I think it should be funded by -- it is a basic  
16 science study and should be funded by some other method.

17 Now, the objectives and priorities -- after all  
18 these years of effort they had a mail poll recently among  
19 25 RAG members and 65 non-RAG members, and they carefully  
20 itemized what they came up with, and honestly, it is what you  
21 put together as a first-run ten years ago.

22 Continuing medical education, needs of under-served  
23 areas, emergency medical services, hypertension, innovative  
24 health-care strategy -- it's all over the map. But it's  
25 traditional, in the sense of what many RMP's consider to be

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the umbrella approach of improving the quality of medical care.

At the moment they are moving ahead with the hope of having two major thrusts. They described this as expansion of the program staff -- and I need some help from Staff on that if John hasn't got a better understanding of it. -- and regionalization.

Within that framework they then present a proposal which moves along lines that include emergency medical services, for which they already were able to achieve 1974 legislation, which only provided them \$75,000 for the state, so they are asking for another \$95,000 to enhance that program until they can get better funding from the state.

They are also wanting to have help for health-resources planning in cooperation with the six CHP existing B agencies.

On page 25, they outline, in three or four lines each, 13 new activities for which they have planned a July application, which amounts to \$400,000.

In the present proposal they are asking for \$616,000 -- I believe it is -- for new program staff, and what I don't understand from their proposal, and maybe the Staff person here knows, is whether or not the \$616,000 of new money for program staff is to program that \$400,000 of 13 new projects. I don't know whether they are interrelated or not.

The specific projects range across the board. They

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1 want a kidney-transplant exchange information system -- only  
2 \$8,776, and what this means really is to computerize in their  
3 Southeastern Regional Organ Procurement Program the 8,000  
4 tissue types scattered among the population of people who  
5 they can count on to contribute organs.

6 I would gather that that would pay for a computer  
7 clerk, or something. It is a tremendous program to buy for  
8 \$8,776.

9 The second point was care for hypertension patients  
10 in Marion County, which -- for \$141,000. That is a specific  
11 center model they want -- they want to fund the equipment and  
12 overhead on a center in which screening, clinical care --  
13 screening, clinic, diagnosis and treatment, including nurse-  
14 practitioner follow-up of these patients, can be gotten off  
15 the ground. They want to be able to acquire data, study,  
16 study the compliance rate of these people in this deprived  
17 area.

18 They are looking for the development of a statewide  
19 "tele-medical" system, which is really a telephone-answering  
20 service, for \$41,000.

21 They are looking for the development of -- as I  
22 mentioned earlier -- quality assurance, which is really improv-  
23 ing perinatal infant death, in Marion County, where they have  
24 again inner-city high-mortality rate. They are attempting to  
25 put together six hospitals to do mortality reviews, with the

1 idea of upgrading the performance of the doctors as well as  
2 patient compliance; that to be done for \$23,766.

3 Those are worthwhile projects -- most of them are  
4 very worthwhile.

5 Looking at the feasibility of all of this, I found  
6 it a little difficult to assess. I assumed -- I gave it a  
7 "satisfactory." I can't tell on the basis of the way the  
8 program is written, even in the terms of past performance.

9 The relationship with the Comprehensive Health  
10 Planning, I would say, is very close, insofar as the evidence  
11 shows.

12 Overall assessment of this, I gave average, or C-  
13 minus, largely based on their inability to present it very  
14 well. Again, I come back to the fact that they are overly  
15 general and euphemistic, lacking specificity in the writeup,  
16 but on the basis of what they have already done, it looks as  
17 if they are capable of performing reasonably well.

18 John Thompson and I looked at what might be pulled  
19 on this, and I think we feel the Emergency Medical Services  
20 is open to question with regard to that \$95,000. I question  
21 whether or not we should be funding the kidney disease immuno-  
22 logical rejection studies; you mentioned the dialysis -- kidney  
23 dialysis program as well.

24 I need specific information on what the \$616,000  
25 for program staff is aimed at. I somehow just could not decipher

1 that. So I will leave my final comment up in the air, except  
2 that I do believe that despite the fact that they are only  
3 asking for 84 percent of the targeted funds, they still may  
4 be asking for too much at this time, with this type of appli-  
5 cation.

6 MR. CHAMBLISS: All right. Our next presenter, Mr.  
7 Thompson.

8 MR. THOMPSON: I am very much in agreement with  
9 Bob's evaluation. It is very difficult to understand what  
10 the goals and objectives of this particular program are,  
11 because they are stated in such general terms, you know,  
12 like regionalization -- that's a goal.

13 The nearest thing we can get -- and the only reason  
14 I can pick this up is because it was underlined -- is the  
15 development of innovative programs in health-care delivery to  
16 -- with special emphasis on under-served geographic popula-  
17 tions and medical areas, and on public and professional edu-  
18 cation about health-care matters that will assure quality and  
19 cost-effectiveness of service.

20 If those are their goals and objectives, none of  
21 the particular programs that we are asked to review have any-  
22 thing to do with those goals and objectives.

23 The second -- I'm not quite as obviously optimistic  
24 about the relationship with CHP, because every reference to  
25 CHP -- and I would like to have Staff input -- is very care-

WHD-45

1 fully phrased.

2 For example: "Communications have never been so good  
3 as they now are with CHP."

4 Well, I have been in areas where, if you said  
5 "hello" and somebody said "hello" back, between the two people  
6 communications had never been so good! Because before they  
7 wouldn't even talk to each other.

8 I can't operationalize that kind of a phrase.

9 The staff is over 72 percent of the total request --  
10 over 72 percent of the total request is for core-staff, and  
11 the reason I am concerned about the EMS component is that it  
12 specifically states -- in one of the few specifics in the  
13 whole thing -- that, and I quote:

14 "The general objective of this project is to  
15 develop an areawide EMS system adequate for the needs  
16 of those counties constituting Region 7."

17 So that is obvious that they are building an EMS system, and  
18 whether this system is in conflict with that or EMS or not,  
19 I think we ought to define.

20 I am certainly not turned on by that "Dial-a-Disease"  
21 project which they have, where you dial in someplace, and  
22 they slam on an Ely Lilly cassette, I think, that tells you  
23 all about the problems of the man over 40, and about --

24 (Discussion off the record)

25 MR. THOMPSON: But, to continue, I would rate it as



WHD-46

1 poorly as Bob did, and certainly not give them the amount of  
2 money they asked for.

3 But on the other hand, if we want to maintain the  
4 capacity for this outfit to do something, and 72 percent of  
5 the whole project is staff, you can't cut it too much, so I  
6 recommend a cut of \$100,000, from what they request, to bring  
7 it down to --

8 DOCTOR SLATER: To come back on to that staff, the  
9 staff request, the other support services that are involved  
10 with staff, come to not \$616,000, but \$882,000, and that is  
11 really to improve the Emergency Medical Services system  
12 development, Family Practice program development, integration  
13 of Comprehensive Health Planning and IRMP activities, hospital  
14 access studies.

15 A lot of this has to do with data collection and  
16 planning. They see themselves as the planners for Indiana,  
17 as far as I can make out, including the CRMP. The CHP group  
18 -- excuse me, and I guess I need clarification as to whether  
19 or not this is real.

20 MR. CHAMBLISS: I would ask -- we are cognizant of  
21 your recommendation in terms of the funding level, but I  
22 would ask, are there any inputs as it relates to CHP for that  
23 state -- for that Region?

24 MR. JEWELL: Which question should I answer first?

25 MR. CHAMBLISS: Answer the Committee's question

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1 first.

2 MR. JEWELL: On CHP, Mr. Chambliss, this is a con-  
3 tinuation application, and about two months ago I was out  
4 there to their wedding of RMP and CHP, so we were wondering  
5 what the children were going to look like. But they had the  
6 A agencies, and all their B agencies are funded, and I was  
7 surprised at the quality of men that I met up they -- and  
8 --they were all men.

9 This was a two-day meeting, where they got in a  
10 room, in a motel, and laid it out -- what they had not told  
11 each other, what they wanted to tell each other -- so I can  
12 only attest to the viability of the statements in their cover  
13 letter, that what I witnessed there on one visit was a very  
14 useful, viable discussion, and I am not really that much inter-  
15 ested in meetings.

16 Doctor Slater, on your request for program staff,  
17 sir, there is \$616,000 that they are pulling out, and it will  
18 be funded under the program-staff component, sir.

19 It will not buy new people, and this is for RFP's,  
20 if you will, sir, to address these priorities that they have  
21 listed on the last page of the application. EMS, Health-  
22 Resource Planning Criteria and Standards, Arthritis Study,  
23 Cancer Control --

24 DOCTOR SLATER: The 13 new projects?

25 MR. JEWELL: Well, they are contracts; yes, sir, but

HD-48

1 that would just be funded out of the program staff component.  
2 There are -- their actual program staff request, money-wise,  
3 is about \$265,000.

4 DOCTOR SLATER: They are only going from 9 to 18,  
5 so I see. What this means, then, is that that money is to  
6 provide for contracts for people for work to be done in those  
7 13 areas. I see.

8 MR. JEWELL: Yes.

9 MR. THOMPSON: Are they going to have their contracts  
10 finished in time for July submission?

11 MR. JEWELL: No, sir; no, sir.

12 DOCTOR SLATER: They have another \$400,000.

13 MR. JEWELL: This is for the next year, Mr.  
14 Thompson. These are two separate groups. Their other hopes  
15 and submissions for the July submission are, I think, on page  
16 25.

17 DOCTOR SLATER: I was wrong about the program staff,  
18 John. The program staff is to improve the contract for more  
19 Emergency Medical Services, to help develop their system for  
20 the Family Practice Program Development Integration of  
21 Comprehensive Health Planning with the RMP.

22 That is what the \$616,000 in contracts is going to  
23 be for; is that correct?

24 MR. JEWELL: Yes, sir.

25 DOCTOR SLATER: Maybe it was here, but I didn't get

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1 that originally.

2 MR. THOMPSON: What are we going to recommend?

3 DOCTOR SLATER: Well, we will recommend \$100,000  
4 less, and with recommendations that this be applied to what --  
5 the immunologic?

6 MR. CHAMBLISS: We get a sense of your recommenda-  
7 tion; we will ask that that be placed in the form of a motion  
8 momentarily, but I would simply have the Committee note that  
9 there is a representative here from the HEW Region Office 10,  
10 which in Indiana is a part of that regional configuration.

11 I would simply call upon Mr. Wally, if he wishes, to  
12 make a statement regarding that program or regarding the CHP-  
13 RMP relationships, and he may do so at this time.

14 MR. WALLY: I am not that totally familiar with it,  
15 but I know that in Region 5 we are encouraging a merger. We  
16 are encouraging a merger, or as it was put before, a marriage  
17 between RMP's and CHP's in their approach to the whole compre-  
18 hensive health program.

19 So you may find that that sort of seems like ambi-  
20 valence on their part, but we are encouraging them.

21 I guess this is optimism on our part, that new legis-  
22 lation will encompass that kind of a framework.

23 DOCTOR SLATER: It may be too late, but I would  
24 quietly recommend that they get somebody else to do the writ-  
25 ing of these proposals, sharpen the focus and reorganize them

1 better.

2 MR. THOMPSON: To you there were three questions.

3 There was the CHP-RMP; there was the program of  
4 specifically-stated EMS programs, and the very scientifically  
5 based renal programs, specifically in the project itself.

6 Now, I think the Staff person can answer fairly  
7 well; they are doing RFP's or something, rather than increas-  
8 ing staff, to explore further programs, but we still are stuck  
9 with the problem that there seems to be very little relation-  
10 ship between the goals and objectives as stated on page 19  
11 of their report, and the programs we have been asked to  
12 review, which, in fairness to them, all have been continuation  
13 programs.

14 MR. CHAMBLISS: The Chair is open for a motion here.  
15 Will you so move the recommendation that you just made,  
16 Doctor Slater?

17 And that motion, as I gather it to be, is:

18 "That the Regional level of funding be recom-  
19 mended at \$1,121,159, and that due notice be given to  
20 the CHP relationships, the renal aspects of the applica-  
21 tion and the EMS."

22 MR. VAN WINKLE: What about the CHP relationships?

23 MR. CHAMBLISS: It has been moved and seconded, and  
24 is there discussion?

25 MR. VAN WINKLE: I want to be sure of this, because

1 we are going to have to take the message about it to them.

2 DOCTOR VAUN: Carrying through the theme of the  
3 illicit relationships, the reason I say that is that one of  
4 the ways to avoid CHP comment is to put \$600,000 in a slush  
5 fund.

6 MR. THOMPSON: Most of which is devoted to tasks  
7 that CHP ought to be looking at.

8 MR. CHABMLISS: Is there further discussion?

9 Question? All those in favor?

10 (Chorus of "Aye")

11 Those opposed?

12 DOCTOR VAUN: No.

13 MR. CHAMBLISS: Doctor Vaun is in opposition, and  
14 the "Aye's" have it; the motion is carried and Staff will take  
15 due note of your observations, Doctor Slater, regarding the  
16 over-generous non-specific writeup of the application.

17 DOCTOR SLATER: Which I rated as C-minus, by any  
18 elementary school standards. I am very unhappy with this;  
19 I am very unhappy with the amount we have given them, I don't  
20 know what to cut it back to, because it is almost impossible  
21 to make a judgment.

22 MR. THOMPSON: I think a critical question is  
23 whether the \$600,000 was a dowry or a bribe.

24 MR. CHAMBLISS: Those are two legal phenomena, and  
25 the Staff will take note of them.

1 DOCTOR WHITE: I won't cast a negative vote; I will  
2 just abstain.

3 MR. CHAMBLISS: I think those of you on the  
4 Committee who are interested in measurements would like to  
5 know that we are 66 percent through our workload for today,  
6 we are now 35 percent through our workload for this panel.

7 It is getting close to 3:00 o'clock, and those of  
8 you who would like coffee may have a chance; those of you  
9 who would not like to have coffee and would rather have it  
10 later on today? I am with you and we can proceed; it is left  
11 to you.

12 (Discussion off the record)

13 MR. CHAMBLISS: Would you like a break?

14 DOCTOR SLATER: Why don't we take a break and bring  
15 it back to the table?

16 (Whereupon a short recess was taken.)  
17  
18 - - -  
19  
20  
21  
22  
23  
24  
25

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1 MR. CHAMBLISS: All right; I would like to reassemble  
2 the Committee and lay out a suggestion for you, in terms of  
3 what we might be able to do today.

4 If we could consider the regions in this order, I  
5 think it might lay out for us a work-plan for the balance of  
6 the day:

7 Wisconsin, coming up first.

8 Kansas.

9 Michigan.

10 Mississippi.

11 Missouri, and perhaps

12 Illinois, and

13 Louisiana.

14 If we could make that accomplishment today, we would  
15 be well into tomorrow's work and that would mean we would have  
16 completed half of our regions.

17 I hear the words "let's go," and I am ready, and I  
18 hope you are.

19 I would then call upon Doctor Carpenter and Doctor  
20 Scherlis; I will call upon Doctor Carpenter, and Mrs. Parks  
21 as his Staff support, to now begin the presentation of the  
22 application from Wisconsin.

23

24

25



## REGIONAL MEDIAL PROGRAM REVIEW

## WISCONSIN

DOCTOR CARPENTER: Thank you, Mr. Chambliss.

This one is to some extent a rerun of what we have heard before. The Region has, as you have heard this morning, lost its distinguished coordinator, and so we have a Region with a very illustrious past history that now, I believe, judging from the rather poorly written application, is in a crisis of leadership, and so it is hard, first of all, to know whether -- again, whether it is just that the words did not get on paper, or whether the leadership really is going to be a problem.

I think I have no way to judge that it won't be a problem, and so you can see something about where I start.

The program staff and professional staff -- well, it is worth noting that they are asking for a 276 percent increase in their funding, and the program staff has fallen to eight professionals.

The Advisory Group is not -- it has met three times or so, but not accomplished anything that is too clear in terms of responding to the vicissitudes of the recent past.

I think past performance has been quite good. They have terminated 18 projects, and all but three of those are still operating in the state, in independent funding.

The objectives and priorities are very vaguely

1 stated; they seem to be little more than a description of  
2 Federal priorities.

3 Except for this evidence of past performance, there  
4 is no evaluation to speak of of what is going on now and the  
5 projects themselves have vague goals; frequently there are  
6 multiple projects in a single area, and no evidence of coor-  
7 dination.

8 For example, I think there are six or seven projects  
9 in the area of continuing education and the Continuing  
10 Education Committee of the Region has not met for the last  
11 year.

12 I think their CHP relationships, as far as I could  
13 make out, were reasonably good, although in one instance  
14 Comprehensive Health Planning responded with negative comments  
15 of a technical nature about one of their projects, and as I  
16 read the project description, I must say that I believe CHP  
17 was right.

18 And the Region did not take any note that I can see  
19 of the ideas coming from the Comprehensive Health Planning  
20 agency.

21 So I did not think there was any way this region  
22 could be considered above average, and I was -- in other times,  
23 you know, this Region would not have been an average region,  
24 and therefore, the 276 percent increase in funding did not  
25 seem very logical.

1           There were several things, many of which were brought  
2 to the attention of the Staff, on these yellow sheets here.  
3 You notice there are now eight full-time professionals on the  
4 staff, and it is proposed they hire an additional 15 people  
5 in the next year to a program which will presumably phase out  
6 at the end of that time, and although in the past there has  
7 been a close relationship to the Governor's Office in this  
8 state, nothing is made of that in the present application,  
9 and there is no reason for me to assume that those 15 people  
10 would have any kind of continuing employment, and unless the  
11 labor market is better in Wisconsin than it is in Detroit,  
12 they are in trouble, in trying to recruit that many people.

13           Nor am I certain that in the course of a year, even  
14 if they could find them, they could get them organized into  
15 a constructive program.

16           The Region has spent \$1,400,000 on Emergency  
17 Medical Services, and -- or at least they were awarded  
18 \$1,400,000 -- and I would assume they spent most of it, in  
19 the last -- they have \$118,000 to run them to June of '74,  
20 and they are requesting essentially another million more.

21           The program is very well described. This particular  
22 project is very well described; they think, you know, the goals  
23 have been set up for some time and they are good goals, to  
24 show that there has been quite a bit of thinking.

25           But I guess we have the problem now, with independent

1 funding available elsewhere, whether it is appropriate for us  
2 to spend that much money in very direct -- you know, by buying  
3 telemetry equipment, in the direct development of the EMS  
4 system.

5 On the other hand -- well, I am not sure; it may be  
6 that there is adequate staff in that area, so this one thing  
7 they might do particularly well. I can say no more about  
8 that.

9 There are \$430,000 in continuing education projects,  
10 plus \$100,000 for a discharged-summary review for the hos-  
11 pitals in the state, so it is \$530,000 in essence for that,  
12 and that in a place where the continuing education committee  
13 does not meet, and where there is no particular indication  
14 that, you know, it would be fine if they could say:

15 "We are going to look at the discharge summar-  
16 ies and try to identify some things that continuing  
17 education is needed for."

18 But there is no suggestion of any melding of -the idea of  
19 quality review in continuing education that I can think of,  
20 or that I can find.

21 There are a couple of research projects that snuck  
22 in: development of sero-diagnostic procedures for gonorrhea  
23 and quantitative cytotoxic assays, and they are exciting  
24 projects. The cytotoxic assay, though, they didn't even  
25 bother to describe it as a part of the Regional program, so

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1 there is another \$100,000 that troubles me.

2 There is \$156,000 in mental health programs, and I  
3 -- they are not such bad programs, actually -- are we allowed  
4 in that business?

5 MR. CHAMBLISS: That is an expressed concern of  
6 Staff, and we would certainly note your concern, because it  
7 does raise a substantive policy issue of funding.

8 Your question is very germane.

9 MR. VAN WINKLE: Those programs have traditionally  
10 been funded elsewhere.

11 DOCTOR CARPENTER: Well, you know, I suppose you  
12 can make a regionalization out of mental health as well as  
13 out of physical health, but we will leave that for the policy-  
14 makers.

15 I wonder if Staff would like to comment before I  
16 guess at a -- or before one of you all guess at a funding  
17 level?

18 MR. CHAMBLISS: Mr. Van Winkle, will you and Mrs.  
19 Parks?

20 MR. VAN WINKLE: I want to say one thing about EMS.

21 This was a proposal that had been submitted to us,  
22 to a select EMS Special Review Committee; it was approved  
23 for three years, and received two-year funding direct from  
24 here, in addition to their normal operating funds.

25 The reason we flagged it was not that it was any-

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1 thing new; it is a continuation, but we flagged it because --  
2 what did they get on their first award?

3 MRS. PARKS: I think it was about \$1.6 million or  
4 something, for a two-year period.

5 MR. VAN WINKLE: They are asking almost as much  
6 for the third year as they had for the full two years, and  
7 that seemed like a tremendous increase in funds to us. It  
8 looks like a doubling up in the last year.

9 MRS. PARKS: Well, this is why it was flagged,  
10 simply because it was a tremendous increase over what they  
11 have gotten.

12 DOCTOR CARPENTER: What do you know about the manage-  
13 ment system for the use of those funds? Is it these eight  
14 staff people, or do they have now a group of people who are  
15 established --

16 MR. VAN WINKLE: They are well-established, and  
17 Mike, from the Mid-Continent Branch, has visited that program,  
18 on an EMS basis, and I think the concurrence is that this is  
19 probably one of the better EMS programs that they have run  
20 into in the country.

21 MR. POSTA: Of all the supplemental funds that RMH  
22 put out -- we did visit 23 projects this past year, and they  
23 were without a doubt the top program.

24 MR. VAN WINKLE: But our question was -- the reason  
25 we brought it to you is that that seemed like a tremendous

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1 jump in funds, because that is about what they had for a two-  
2 year period, and now they are asking for almost that for  
3 the third year.

4 MR. CHAMBLISS: I would like the Committee to know  
5 that we are asking for your judgment here as to -- and your  
6 recommendations about the funding.

7 DOCTOR SLATER: Well, just a minor one, because it  
8 is such a small amount of money. Mrs. Salazar and I were  
9 consulting, wondering whether that Self-Administered Sex  
10 Therapy Program is -- violates the Federal guidelines for  
11 RMP's.

12 MR. CHAMBLISS: That is certainly one of the policy  
13 matters we will be handling.

14 MR. VAN WINKLE: We could not particularly tie that  
15 back in to their goals and objectives.

16 MR. THOMPSON: Who got the book?

17 MR. CHAMBLISS: That has been noted with great  
18 interest; that will be taken into consideration.

19 MR. THOMPSON: Who is the Principal Investigator?

20 MR. VAN WINKLE: Doctor Carpenter, I would like to  
21 add one thing.

22 We have Staff concerns here about the leadership  
23 of the program. I think you should know they quite recently  
24 came in for some rebudgeting of some dollars they had, and up  
25 to this point in time I don't believe we have approved that.

1 MRS. PARKS: We have not gotten the additional  
2 information.

3 MR. VAN WINKLE: We have told them to go back home  
4 and further justify the information that would even allow  
5 them to rebudget.

6 So we are concerned, and we think we have tried to  
7 express this.

8 MRS. PARKS: During the phase-out, Doctor Carpenter,  
9 they did lose just about all of their key professionals on  
10 their staff, and of course, as you mentioned, Doctor Hersbeck  
11 finally left, too.

12 At one point they were down to just about no one  
13 except the present Coordinator, and the management aspects of  
14 the program -- there was actually no one there at one point  
15 to handle the program.

16 They have hired accountants now, and though while it  
17 is kind of early to really evaluate his effectiveness, he  
18 seems to be getting in there and trying to get some of the  
19 problems straightened out.

20 MR. VAN WINKLE: He is one of the positive things we  
21 see.

22 MRS. PARKS: Right. And the request for additional  
23 staff -- frankly, I can not justify it because I am not clear  
24 on what all of these people will ultimately do and it just  
25 seems awfully ambitious to me.



DOCTOR SLATER: It sounds to me as if the judgment is going to have to be made substantively, rather than in any specific objective grounds that you have.

What I hear is that we don't now know how the staff will be used, and we are uncertain what -- whether or not they can really float that much by way of programming if they have the money.

I am talking about making a recommendation of \$2 million. They are at \$1.73 now; that leave about another \$500,000 to come back in for in July to get up to the 100 percent.

The 276 percent is just out of the question.

DOCTOR CARPENTER: Is that a motion?

DOCTOR SLATER: I am just asking if that is a sort of ballpark -- if we are both together.

DOCTOR CARPENTER: I couldn't decide between \$1.70 and \$2.0.

MR. CHAMBLISS: The Chair will entertain a motion here as to the level of funding recommendation.

DOCTOR MILLER: Could I ask a question first?

MR. CHAMBLISS: Yes, Doctor Miller.

DOCTOR MILLER: Is it true, and to what extent is it true, that the current level of annualized funding, as you have listed here, in most cases probably is the level that was the highest that Region ever had in the history of the Region?

1 MR. CHAMBLISS: Is that the case?

2 MR. PULLEN: Yes, sir.

3 DOCTOR MILLER: I think most of these are just  
4 about the top that the Regional Medical Program has ever  
5 had.

6 MR. PULLEN: I think it was more the 779.

7 MR. CHAMBLISS: Nonetheless, in this Region, if you  
8 add to it the Emergency Medical activity, you would find it  
9 a substantively higher level of funding of Regional program  
10 activities; I think this is about the level.

11 DOCTOR CARPENTER: Do you have an expenditure report  
12 for the July meeting?

13 What am I asking for? That would be too early, I  
14 guess? Yes; sorry.

15 DOCTOR SLATER: Recommendation for two million  
16 dollars?

17 DOCTOR CARPENTER: Yes.

18 MR. CHAMBLISS: I am advised by Mr. Pullen, of our  
19 Grants Management Staff, that the expenditure reports were due  
20 May 1st, and they are in the process. They are being pro-  
21 cessed now, so the answer is yes, we will have an expenditure  
22 report by July.

23 DOCTOR CARPENTER: If they are expending at the rate  
24 they say they are, in July, or as they say they might be, and  
25 we want to push the Emergency Medical Program at that time, we

1 would have another opportunity, or if we wanted to take the <sup>130</sup>  
2 lid off, then I would second what I understand to be a motion  
3 for two million dollars.

4 DOCTOR SLATER: Two million dollars.

5 MRS. PARKS: Two million?

6 MR. CHAMBLISS: The motion has been properly moved  
7 and seconded that:

8 "The level of funding to be recommended for  
9 the Wisconsin Regional Medical Program be set at two  
10 million dollars."

11 Is there further discussion?

12 Are you ready for the question?

13 DOCTOR CARPENTER: Yes, can I add a little, or at  
14 least think about adding something to the record?

15 In view of the problem of whether they can effect-  
16 ively use that money for the Emergency Medical Service, would  
17 it be practical to ask them for an interim funding report?  
18 This one here will only carry them into '73. I guess that  
19 would be July of '73, so if we could have a few months more  
20 information, I think it might help them.

21 MR. CHAMBLISS: Yes, we can request that, and Staff  
22 will do that.

23 Is there further discussion?

24 Call the question; all those in favor?

25 (Chorus of "Aye")

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1 Opposed?

2 (No response)

3 The motion is carried.

4 - - -

5 MR. CHAMBLISS: I would like now to turn your  
6 attention to the Kansas Regional Medical Program.

7 The presenters for Kansas will be Mrs. Wyckoff and  
8 Doctor Vaun, and Staff support will be in the person of Miss  
9 Mary Murphy.

## REGIONAL MEDICAL PROGRAM REVIEW

## KANSAS

MRS. WYCKOFF: This is a modest request from Kansas. I am going to follow your design that you have in the Review Sheet, and try to construct my report along those lines.

Program Leadership: the Coordinator, Doctor Brown, has been with the Kansas RMP for several years and knows how to work with the Kansas state and local organizations.

He understands the nature of Kansas and has its support. He has bent over backwards to get provider support in the early days, and has never fully recovered from that effort.

He has a good working RAG, which has met regularly every month. His Executive Committee functions regularly, as does his project review committee. They have good EMC representation.

The program staff. During the cut-back the staff was reduced, and if you will look at the little yellow sheet here you will see that he has, really, a very small staff of nine professionals, two clerical.

MR. CHAMBLISS: If you would kindly talk just a bit louder, please?

MRS. WYCKOFF: The remaining staff are skilled, having a minimum of 16 months RMP service. They have had to do double duty in project development and monitoring.

1           The Health Service education directors have helped  
2 to fill the vacuum created by the loss of coordinators.  
3 There is a close and cooperative effort work with the CHP.

4           There are no minority members on the staff as far  
5 as I can tell.

6           The RAG. The RAG has about three or four consumers  
7 among 22 persons, and appears to have only one minority mem-  
8 ber, though there are a very few on some of the subcommittees.

9           The RAG is hard-working and dedicated, and has an  
10 Executive Committee that keeps things moving in between  
11 Council meetings. Its Project Review Committee screens and  
12 evaluates and recommends all projects to the Council, and  
13 the Evaluation Committee monitors the projects.

14           The RAG shows itself capable of acting well under  
15 the stress of the present application. It has a liaison sub-  
16 committee relating to CHP,

17           However, this report is probably the most confused  
18 report that I have ever read, and if I seem confused, it is  
19 because I have been mired in it, trying to find what it is  
20 he's trying to say. So you will have to excuse the jerks  
21 when we jump back and forth between subjects.

22           I will stick, however, to the design we have here.

23           The past performance has addressed substantive prob-  
24 lems, in accessibility and availability, both in rural and  
25 urban ghetto areas. For example, under "Access," they have

1 the Model Cities Program, which of course was closed down  
2 by other factors than RMP.

3 The Ottawa County health clinics, the Dart City  
4 Indian Health Care Clinic, DeSoto Rural Health Clinic, Kansas  
5 City Rural Clinic; under their efforts toward efficiency and  
6 quality in professional performance, they have improved the  
7 Kansas Library Information system.

8 They have a rural circuit course for nurses that  
9 has been effective.

10 These are examples of what they have had; the cadre  
11 training for pharmacists, and under "New Skills" they have  
12 had several courses for clinical nursing and dental systems.

13 Under their "Past Efforts at Regionalization,"  
14 they have their Great Bend project. I had great pleasure in  
15 making a site visit to that once, and it is quite an experience,  
16 I assure you, puddle-jumping across those fields in a tiny  
17 little four-seater plane with Doctor Nicholas.

18 I realize how thoroughly rural a lot of Kansas is.

19 They had an extended coronary care unit, like most  
20 of the RMP's of that day, and nephrology training. They have  
21 been working to set up the -- the core staff has been working  
22 to set up four big health education service centers, and they  
23 are now coming in for a substantial amount of money for these.

24 They have helped with other Federal programs; they  
25

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1 have been called upon to help with the Emergency Medical  
2 Service, and they have successfully launched the big kidney  
3 program which is quite well known throughout the center of  
4 the country.

5 The measure of their work, I think, is seen by the  
6 fact that the major -- the 18 major programs that have been  
7 terminated have been continued with local support or with  
8 other support.

9 Their Circuit-Nursing Course, their Physician  
10 Placement program, their Kansas Library project, the Nurse-  
11 Clinician project, the basic education for medical clerks,  
12 and the formal regionalization of the kidney program, and  
13 method of treatment.

14 Under Point No. 5, "Objectives and Priorities,"  
15 they say their objectives have shifted from the emphasis on  
16 the information gap to direct concerns for the expansion of  
17 new services, Region-wide projects, or categorical disease  
18 and quality assurance.

19 Much work has gone into sub-regional area develop-  
20 ment of these manpower services, area education programs  
21 including public education.

22 They have had varying degrees of success in carrying  
23 out their short-term objectives in the following fields:

24 Health-care delivery, primary care:

- 25 1. More effective health manpower;



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2. Quality medical care assurance.

3. Disease control.

And it is not until you get under "Disease Control" that they mention anything to do with planning.

The new proposal falls into place as congruent with the major thrusts listed above.

The 13 projects for which they asked continuation funds are in line with their program objectives, and they have been carefully and favorably reviewed by CHP.

Four new projects are as follows:

Quality assurance of diabetic care: \$28,500.

They proposed to develop a model management system, protocols for the health-care team, education, assessments of patients, projects in training and utilization of the diabetic nurse-practitioner, the CHP --

The CHP comments:

"The issue of funding beyond the first year is not addressed, and efforts to obtain patient input and acceptance are not described. However, the major outcome expected appears to be in standards for use in peer review and in professional education systems at KUMC."

This will supplement the juvenile diabetes project now under way in Wichita, and sponsored by the Kansas Diabetes Association. These fit under their Objective 3 above: quality

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1 improvement.

2 The second one, the second new project that they  
3 are asking for is primary health care in DeSoto, a small  
4 rural community -- \$26,288.

5 The rural community has raised \$4,000 in this rural  
6 county of a population of about \$7,000 for a primary care  
7 clinic sponsored by the Cedar Valley Medical Association. It  
8 is now operating with a nurse-practitioner and a part-time  
9 physician.

10 CHP okays the project but raises the question about  
11 the development of criteria for disposing of grant-related  
12 income. This is one of their rural access objectives.

13 The third one is the Berkley Health Education pro-  
14 ject, which as I guess you know, is a 6th and 7th grade public  
15 education program -- a campaign against smoking.

16 The fourth one, the perinatal mortality project  
17 regionalization, is for \$305,000 and it is a very elaborate  
18 project, and they admit that this will take at least five  
19 years before this can become operational.

20 The RAG says that this has special merit, and I  
21 question very seriously how we are to interpret the term  
22 "feasibility" when they say that with five years -- that five  
23 years is the limit that they need.

24 Now, with CHP relationships, I would say they are  
25 very good, although they have not been funding CHP activities

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1 as much as some of the other RMP's.

2 I notice on the Staff summary that the concerns  
3 here -- No. 1, Project 70-A, Emergency Medical Training,  
4 Extension of Project 70 -- was initiated from program staff  
5 funds and is a continuation of the activity.

6 This seems a legitimate enough program, if we are  
7 permitted to fund this sort of thing.

8 The second, Project No. 51, where the funds went  
9 from \$24,000 -- or \$48,000 in one year to \$117,000 in one  
10 year, is a pretty big jump, and Project No. 52, which has  
11 gone from \$40,000 to \$112,000 is also a pretty big jump.

12 But from the little I am able to find in material,  
13 it seems as though they have been preparing to expand, and  
14 that they possibly can do this effectively with the increased  
15 funds, since they have built a network at the junior  
16 colleges, and they have laid the groundwork for the health  
17 services education work.

18 The one I raise the question about, however, is the  
19 \$305,000 perinatal project, and I would like to hear from  
20 Doctor Vaun about it.

21 MR. CHAMBLISS: Will you continue, Doctor Vaun?

22 DOCTOR VAUN: I think the Director comes through as  
23 a very strong and good leader for the project. I am impressed  
24 with him, I am impressed with the continuity of RAG at a  
25 very difficult time; I am impressed with the shift of object-

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1 ives, and more so with the addressing of projects to the  
2 rather mundane, everyday needs of people, like dental atten-  
3 tion, and diabetes, rather than tribioplastic tissues.

4 I am tremendously impressed with the scope of  
5 their projects relating to real health care needs.

6 I am further impressed with the continuation of  
7 fundings on projects that have been terminated. They have  
8 a good track record with that. I would hate to dock them  
9 anything, but as Mrs. Wyckoff has identified, I think they  
10 are overly ambitious in their perinatal projects, and I  
11 don't see coming through any special contribution on the part  
12 of the hospitals.

13 I think their faculty is terribly fat, with two  
14 part-time neonatologists; I didn't know there were that  
15 many in any one state, let alone that they were going to be  
16 faculty, and -- you know, again addressing themselves to the  
17 development of their own intramural audio-visual aids -- this  
18 just leaves me a little cold.

19 So I would recommend, subject to Mrs. Wyckoff's  
20 modification, a \$100,000 reduction from their request. The  
21 request was \$1,733,380; I would recommend \$1,633,380.

22 I do it with tongue in cheek, because it would  
23 appear that these people came in with a very reasonable  
24 request. They didn't ask for the Moon, like some of the pro-  
25 grams have, and I hate to dock them anything, in view of the

1 fact that they are not even up to what target might be, but  
2 I think the project, as I said, is overly ambitious, does not  
3 address certain items that I think are terribly important.

4 So I think I am going to recommend that they be  
5 docked \$100,000.

6 MR. VAN WINKLE: And do you want a message to get  
7 on that particular project?

8 DOCTOR VAUN: I think something should be said  
9 about it in light of what Mrs. Wyckoff commented about.

10 MRS. WYCKOFF: They are only asking for 77 percent  
11 of their target, and when they get -- if they get the whole  
12 \$300,000 that they are asking for in July, they will only  
13 get 91 percent of their target.

14 So theirs is a very modest request, actually. I am  
15 sorry that they have put so many eggs in one basket.

16 DOCTOR SLATER: Question. If there are funds left  
17 over after these two rounds, is it possible for these Regions  
18 to come in again for further supplementary funding?

19 MR. CHAMBLISS: No, there will not be, Doctor  
20 Slater.

21 DOCTOR SLATER: This is the end of the line, even  
22 if there is money left over?

23 MR. CHAMBLISS: They will not have a new opportunity  
24 to apply. The July 1 application date is the final date as  
25 things stand at the moment.

1 MRS. WYCKOFF: I would like to ask about this  
2 indirect cost information that is in this project. It ranges  
3 from 55 percent down to 8 percent, and I wondered if -- if  
4 it is perinatal, what would affect this?

5 MR. CHAMBLISS: I wonder if our Grants Management  
6 man would speak to that? I do recall Kansas having perhaps  
7 one of the very low indirect cost rates, sometime ago.

8 MR. VAN WINKLE: This is different institutions,  
9 is it not?

10 MRS. WYCKOFF: Yes, it is their whole list.

11 MR. CHAMBLISS: Staff is checking that now.

12 MR. VAN WINKLE: It is just the varying rates, I  
13 would guess, between whatever institutions receiving the  
14 funds--

15 MRS. WYCKOFF: I hope we are talking about the  
16 right one.

17 MR. CHAMBLISS: I would simply ask one question of  
18 the reviewers. Are there any comments to be made with regard  
19 to CHP-RMP relationships in this Region?

20 MR. VAUN: I think Mrs. Wyckoff mentioned that.  
21 From the report they appeared good.

22 MRS. WYCKOFF: Yes, their relationships are good.  
23 I do think they need a little prodding on the affirmative  
24 action program.

25 They have a very small staff, but I think they

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1 should pay attention to it on their Board -- on their RAG.

2 So, with that as a suggestion, I would like to move  
3 approval of the --

4 DOCTOR VAUN: \$100,000 reduction in their request.

5 MR. CHAMBLISS: Is that in the form of a motion?

6 MRS. WYCKOFF: \$100,000.

7 DOCTOR VAUN: \$1,633,380.00.

8 MR. CHAMBLISS: All right; that is a motion, I take  
9 it? Has it been seconded?

10 DOCTOR VAUN: I will second it for Mrs. Wyckoff.

11 MR. CHAMBLISS: It has been moved and seconded; is  
12 there discussion?

13 MISS MURPHY: I would like to make an addition.

14 MR. CHAMBLISS: We would like to have further input  
15 from the Staff. Miss Murphy?

16 MISS MURPHY: I would like to add that they did have  
17 a minority professional on the staff, and with the phase-out  
18 she left them. I think that is probably what has actually  
19 happened in a lot of areas.

20 DOCTOR MILLER: In response to a question by Doctor  
21 Slater, it is fair to say -- to tell the Committee that the  
22 RMP-DRMP staff does intend to award all the funds that are  
23 available, if the Review Committees approve that much and  
24 the National Council approves it.

25 MR. CHAMBLISS: Yes, they do indeed.

1 DOCTOR MILLER: The intent is to award all the  
2 money requested now -- between now and the next period.

3 MR. CHAMBLISS: If it is properly reviewed and  
4 recommended, yes, we will.

5 DOCTOR SLATER: Well, the question came up- this  
6 morning, on whether we might like to recommend withholding,  
7 rather than give it away to the programs.

8 DOCTOR MILLER: We might, but if we do it will just  
9 be on expended funds; it will not be awarded any other way.

10 MR. CHAMBLISS: All those in favor of the motion?

11 (Chorus of "Aye")

12 Those opposed?

13 The "Aye's" have it, the motion is carried, with  
14 a recommended level at \$1,633,380.

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1 MR. CHAMBLISS: Shall we now draw our attention  
2 to reviewing the application from the Michigan Regional  
3 Medical Program?

4 MR. TOOMEY: Did you rule on this Inter-Mountain?

5 MR. CHAMBLISS: The Inter-Mountain Region will be  
6 reviewed in lieu of Wisconsin in our final session. That is  
7 how we got Wisconsin early on, and Iowa was also one that  
8 we were holding over, and I thought I would review them in  
9 that order, until Doctor White returns.

10 MR. TOOMEY: Unless there are other reasons, I am  
11 here, Mrs. Salazar is here and Miss Murphy is here; why don't  
12 you get rid of Inter-Mountain?

13 MR. CHAMBLISS: All right. All the parties are  
14 here, and Inter-Mountain will be presented by Mr. Toomey and  
15 Mrs. Salazar, with Miss Murphy as the Staff person.  
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## REGIONAL MEDICAL PROGRAM REVIEW

## INTER-MOUNTAIN REGION

MR. TOOMEY: Once again, back several years ago, I had the opportunity to visit the Inter-Mountain Medical Program prior to awards, prior to Doctor Stuart's becoming Coordinator. I think it was Mr. Hagman who was the Coordinator back then when I visited.

The implication, in my opinion --

DOCTOR SLATER: Would you speak up, sir?

MR. TOOMEY: Program leadership is satisfactory, from all appearances. I have not met Doctor Stuart, but I understand that he is rather a contrast to the former program coordinator.

The former program coordinator had some difficulties with the administration of the University of Utah, and apparently from the material in the application, Doctor Stuart has been able to overcome those problems, and their relationships were on a very satisfactory basis.

The program staff seems adequate in size; their capability seems to be sufficient. When I was there a year and a half -- two years ago, they had some trouble with the evaluation program and apparently that program still exists, because one of the positions are still vacant, and the Deputy Director of the program is in charge of the evaluation at the moment.

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1            Their Regional Advisory Group, as far as I see,  
2 both in the application and from my personal contact, is  
3 rather outstanding. They are interested, they meet regularly;  
4 as a matter of fact, they had five meetings that were listed  
5 over the past year. Their Executive Committee meets -- has  
6 met at least three times.

7            The past performance and accomplishments of the  
8 Inter-Mountain RMP seem to be adequate. Their relationship  
9 with the Comprehensive Health Planning agency in the area  
10 they cover, which incidentally covers Utah, Montana -- or  
11 parts of Montana, Colorado, Wyoming and Nevada, and they  
12 have programs that have been extended into each of these  
13 areas.

14           They have established as their objectives and  
15 priorities programs related to rural health care needs, to  
16 strengthen -- the strengthening of the local health planning,  
17 to quality assurance -- projects related to quality assur-  
18 ance in primary health care, and the Emergency Medical  
19 Services.

20           Their proposals seem to conform at the present to  
21 these major thrusts that I just mentioned.

22           I think however, that it is important to note that  
23 there are 11 programs for which they are requesting continua-  
24 tion funding, and that there are 38 new programs for which  
25 -- that they are proposing in this present application.

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1           Because of the 11 and 38 -- that's 49 projects --  
2 it seems as though they have in fact bitten off rather much  
3 to do, and because of this they have requested considerable  
4 sums of money, and if you will look at line 15, the Inter-  
5 Mountain section, their current level of spending, annualized,  
6 is \$1,878,000. Their targeted available funds are \$3,597,000.

7           Their May 1 request is for \$3,849,000, which is 106  
8 percent of the targeted available funds, and the total of  
9 the July 1 estimate is another half-million dollars, which  
10 would bring them up to \$4,349,000, or 120 percent of the  
11 targeted available funds.

12           In terms of the yellow sheet that you have in your  
13 booklet, there is -- the very last line, I believe, the Inter-  
14 Mountain Regional Medical Program is considered a good pro-  
15 gram, but it is felt that the Region is over-funded.

16           I might say I heard this from several sources,  
17 from people who have been acquainted with the program, but I  
18 have to say, in defense of what has been done, that it has  
19 been a very aggressive, a very viable, a very concerned pro-  
20 gram, and it would seem to me that on the record of their  
21 past accomplishments, they would probably rate as certainly  
22 a good to excellent program.

23           I would agree, on this premise, that they should  
24 perhaps have a greater consideration given to the amount of  
25 money that they are requesting, more on the basis of the fact

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1 that they are requesting three -- and almost four times as  
2 many programs -- to be put into operation as what they  
3 currently have in operation, and from that basis it would  
4 seem to me questionable as to whether the total amount of  
5 dollars should be provided.

6 They have done one other thing, apparently within  
7 the past year, the implications of which I am really unable  
8 to evaluate at the moment, but because of the interest in  
9 RAG and apparently because of the extreme -- what I would  
10 consider to be their concern that they continue with an on-  
11 going operation, to pick up the main threads of an RMP pro-  
12 gram and develop a new organization called the "Health  
13 Development Services Corporation," and this was not in exist-  
14 ence when I was in Salt Lake City, previously.

15 I did not have the opportunity to talk with the  
16 staff about this, but it seemed, from very quickly reading  
17 this paper, which is an attachment in your booklet, that it  
18 seems they have created an organization structure which would  
19 allow for the work of the Regional Medical Program to be  
20 carried on, to secure funding from numbers of sources, and  
21 to provide for -- really through the sale of their services,  
22 to provide for the continued development of many of the needed  
23 programs in those areas.

24 This sort of Health Development and Services  
25 Corporation, which is a separate organization, has come back,

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1 now, to IRMP and requested funds for some of the projects  
2 that IRMP has approved in the amount of almost \$405,000.

3 So IRMP will be funding an organization which was  
4 created by IRMP to pick up the threads of the work of  
5 Regional Medical Programs in carrying it on, and it is a  
6 voluntary non-profit organization, and I don't mean then at  
7 all to imply that there is a thing wrong with it. I just  
8 think it is a very innovative and aggressive kind of move  
9 on the part of the people in that area to provide for them-  
10 selves a mechanism to continue their work.

11 The other thing to which I would call your atten-  
12 tion is the extent to which IRMP is -- and you will find  
13 this, again, in your yellow sheets -- they are providing  
14 assistance to the Idaho Comprehensive Health Planning agency,  
15 the Utah agency, the Montana agency, the Western Colorado A  
16 agency, comprehensive health planning, and in Nevada the  
17 Comprehensive Health Planning A agency, so that these planning  
18 agencies in the state, which make up a part of the Inter-  
19 Mountain section, are being specifically funded out of the  
20 RMP funds, and I haven't added it up but it makes rather a  
21 substantial sum of money.

22 In addition to which they have a number of projects  
23 related to the development of influence in the hospitals to  
24 act, I presume, in a more efficient and effective manner.  
25 Management consulting services, management engineering, and

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1 multi-hospital in-service training, and several others.

2 I would just comment in general on the fact that  
3 personally I am not sure that it is the responsibility of  
4 the Regional Medical Programs to specifically focus on the  
5 development of the hospitals to enhance their capabilities  
6 from a management standpoint. This is the question that I  
7 do have.

8 I don't have any question about their support that  
9 the A agencies, particularly in fact -- in light of the fact  
10 that it is one of the areas in which the IRMP says they are  
11 interest, to strengthen local health planning.

12 I don't know whether strengthening the A agency can  
13 be construed as local health planning, but I -- attempting  
14 to give consideration to planning needs in that area.

15 In net, when I look at the record they have, when  
16 I have the remembrance of my visit with the group in Salt Lake  
17 City -- their leadership, particularly, from the Regional  
18 Advisory Group, and the fact that their objectives and their  
19 priorities are in line with those that they have selected --  
20 or, let me put it this way: their project is pretty much in  
21 line with their objectives and priorities that they have  
22 selected, and it seems to me that we have a good to excellent  
23 Regional Medical Program which shows good strength, innovative  
24 ability, a desire to continue the work, to enhance the  
25 planning, to provide for better services in the area, and it

IHD-85

1 is only that I have some doubts as to some of the projects.

2 That is one facet, and I have some doubts as to the  
3 capabilities to initiate, desirably, 38 new projects, so that  
4 I would change the recommendation -- change the funding that  
5 they have requested, and I don't -- now, Mrs. Salazar, you  
6 want me to say what I think it should be, the neighborhood  
7 in which I think that funding should be?

8 MRS. SALAZAR: Yes.

9 MR. TOOMEY: I think it should be reduced somewhere  
10 in the neighborhood of two and a half million dollars, as  
11 opposed to the request they have, which is \$3.8 million.

12 MR. CHAMBLISS: All right. Will -- Mrs. Salazar,  
13 will you make your presentation?

14 MRS. SALAZAR: I have nothing to add. Some of the  
15 concerns that I have had about the application have been  
16 explained by Mr. Toomey, who has been in the Region since I  
17 have. His last visit pre-dates my numerous visits.

18 I do have one question that perhaps Staff could  
19 address themselves to, which deals with the Region's past  
20 history and mechanization, dealing with hardware.

21 That was one of the old problems that we used to  
22 discuss.

23 Secondly, in reading the last site visit report,  
24 which took place in January, I believe, of this year, there  
25 were some very serious issues raised as to minority groups



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1 participating in RAG's or Executive Committee, and staff.

2 And this, too, is an old program that has been with us for a  
3 long time.

4 MR. TOOMEY: I did not have time to read Mary's  
5 report on the last site visit.

6 MRS. SALAZAR: The third thing that I might ask is  
7 what will be the interface to assure that there will not be  
8 duplication of funds going into the new corporation and into  
9 the Inter-Mountain Region Medical Program? How do they co-  
10 ordinate the efforts? Are they two free-standing, and how  
11 do they relate?

12 MR. CHAMBLISS: If you raise a question about the  
13 corporation, I think the Committee might be interested in  
14 something of a report that our Grants Management branch has  
15 developed on the corporation, and I would ask Mr. Pullen  
16 if he would express those concerns to the Committee, please?

17 MR. PULLEN: These are some of the concerns  
18 expressed by the Grants Management Branch about the Health  
19 Services -- Health Development and Services proposed by the  
20 Inter-Mountain RMP.

21 It does not appear to have the final approval of  
22 the grantee to organize a staff. Such a corporation, with  
23 RMP employees. We are not aware of the use of RMP employees  
24 solely to staff an affiliated organization, as proposed, and  
25 we seriously question the proposal of the corporation as being

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1 necessary to fulfill IRMP requirements. The proposal appears  
2 to be broader in program and geographic scope than the RMP.

3 Since it exceeds that of the IRMP-BMS Alaska Project,  
4 I do not think it is appropriate for the developmental costs  
5 through employee support to be charged totally to the grant.

6 As previously advised, the RMP does not charge any  
7 organizational costs for this corporation to the grant funds.  
8 It is understood that this organization is designed to assume  
9 all of the normal functions of the RMP program staff after  
10 termination of grant support.

11 If the corporation is determined to be a free-stand-  
12 ing organization, then the incorporating costs should be  
13 spread among the various supporting agencies, not solely to  
14 the IRMP.

15 A statement from the grantee will be required to  
16 indicate that the development of such an organization with its  
17 grant funds is in keeping with the grantee policy, particular-  
18 ly considering the broad scope proposed.

19 This proposal would seem to be a mechanism to by-  
20 pass the changing of an RMP from a university to a free-stand-  
21 ing organization which the coordinators have been discouraged  
22 from finalizing prior to passage of legislation.

23 It could well be that if we are able to approve  
24 this technique, other RMP's may elect to go the same route  
25 with grant funds in anticipation of passage of new legislation.

1 MR. CHAMBLISS: I think that may answer some of  
2 your questions. It does express some concern emanating from  
3 the Staff regarding the corporation.

4 We admit that it does have innovative features,  
5 but whether there is a bit of prematurity here at the moment  
6 will be left for your judgment.

7 Mr. Posta would add further comments.

8 MR. TOOMEY: I don't know enough about it, becuse  
9 you know, I didn't get a chance to read this until just this  
10 morning.

11 MR. POSTA: This, I might say, Mr. Toomey, is  
12 relatively new as far as the other administrative problem  
13 issue that we have had to do business with for the last two  
14 weeks.

15 First of all, we have heard from the Region, too,  
16 which -- which assures us that this is a separate entity,  
17 as of July 1, the same as the Health Department or AID or  
18 any other institution. I think our concern as far as IRMP  
19 is concerned is how much RMP or grant funds have gone into  
20 this particular corporation since its birth in January of  
21 this year, through a charter with the Secretary of State of  
22 Utah.

23 The grantee has worked with the Attorney General;  
24 they do not think there is any hanky-panky going on. The  
25 grantee has written a letter to the RMP giving their views

1 on this particular corporation, and they definitely will  
2 dichotomize those costs going to the RMP and to this particu-  
3 lar corporation, which to date have amounted to about \$18,000.  
4 That is the latest on the corporation as of this morning.  
5 We just got this \$18,000 figure this morning.

6 MRS. WYCKOFF: How do they from the Health-Set  
7 corporations that have been formed all over the country that  
8 are non-profit and separate and funded by RMP?

9 MR. POSTA: I wish I could tell you; I can't.

10 I do know that our original -- I should say from  
11 the Mid-Continent operations concern all along has been: who  
12 are on the Board of Directors?

13 Are these folks a part of the IRMP? And if they  
14 are, this might be a conflict of interest, and they would  
15 have to make this decision.

16 This is what we are still working on, but I think  
17 it is a legal corporation the same as any other corporation  
18 asking for a charter in most of your states.

19 MR. TOOMEY: As I understand it, there is an  
20 overlapping of the Board membership between RAG and the  
21 Board of the Health Services Development Corporation, and  
22 there are employees of IRMP who are on the Board of this new  
23 corporation, employees.

24 MR. POSTA: Well, the Coordinator, possibly -- or  
25 probably.

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1 MR. TOOMEY: Well, in there it said there would  
2 be minority representation from the employees.

3 But the other thing it seems it is going to do is  
4 to essentially really act as a broker. It will go out and  
5 develop programs and then it will come back and attempt to  
6 convince IRMP to fund those programs; am I not right?

7 Between the money that is going through that organ-  
8 ization and the fact that there are 38 new applications,  
9 and there are questions about a number of them, I felt that  
10 two and a half million which is, I believe -- they are  
11 annualized now, out of that \$1,800,000, so this represents  
12 an increase over their annualization, but it is a million-  
13 three under what they are requesting.

14 MR. CHAMBLISS: Yes.

15 The first presenter, Mr. Toomey, came up with a  
16 recommendation, but as I recall, that has not been placed in  
17 the form of a motion.

18 MRS. SALAZAR: I would be glad to second, but I  
19 prefer to withhold a second until I hear some other comments  
20 on the other points that I raised.

21 MR. TOOMEY: You see, the point -- I think the thing  
22 that worries both of us right now is the fact that so many  
23 people -- well, a number -- two or three people -- have made  
24 the comment:

25 "This is an organization which already had

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1 already had a million-eight and seems to be overfunded,"  
2 and so now they come back in and their request just about  
3 doubles that, and you reduce it by a million-three and I  
4 think the question still is: is it overfunded, and I don't  
5 know how to answer that.

6 MRS. WYCKOFF: Are any of these project numbers  
7 money that goes into this organization? We can't tell from  
8 this which ones they are.

9 MRS. SALAZAR: Some project staff will be function-  
10 ing in this new organization, as I understand it on page 14,  
11 but they would gradually phase out as this thing becomes a  
12 free-standing agency.

13 But this is the part that bothers me, as to who is  
14 looking at that during that interim period when IRMP is over-  
15 lapping this organization.

16 MR. POSTA: As I understood that document, the  
17 Executive Committee of the Regional Advisory Group is the  
18 watchdog organization of this new corporation.

19 So far as Mr. Toomey has mentioned, \$18,000 --

20 MR. TOOMEY: And the projects that they talk about,  
21 the ones that are meaningful -- medical consultation for  
22 rural communities, that's a 99; rural medical technology  
23 systems, medical consultations, \$40,000. Rural medical tech-  
24 nology systems, which is Number 104, is for \$115,000.

25

1 Rural quality assurance, No. 105, is for \$126,000.

2 And rural medical practice and management, \$114,000.

3 That is No. 106.

4 The other one is modeling the Utah Health Care  
5 system, which is only \$7,100.

6 That is a level of about two and a half million;  
7 why don't I cut that back to two?

8 I move that we allocate two million dollars to the  
9 Inter-Mountain Region Medical Program.

10 MR. CHAMBLISS: There is a motion on the floor that  
11 the Inter-Mountain Regional Medical Program be set at a level  
12 of two million dollars.

13 Is there a second?

14 MRS. SALAZAR: This is across the board, Mr. Toomey,  
15 that you are talking about?

16 MRS. WYCKOFF: Now they are at one million-eight,  
17 so this -- it raises them \$200,000.

18 DOCTOR MILLER: They are at \$1.88 million.

19 DOCTOR SLATER: \$200,000 instead of two million.

20 DOCTOR MILLER: It raises them \$120,000, so you  
21 essentially are holding them to the same level of current  
22 funding.

23 MR. CHAMBLISS: Is there a second on the motion?

24 DOCTOR VAUN: I have a question, but I don't have  
25 a second.

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1 MR. CHAMBLISS: All right; maybe the motion will  
2 die for want of a second.

3 MR. THOMPSON: I will second the motion, just to get  
4 it on.

5 MR. CHAMBLISS: The motion has been made and secon-  
6 ded that the:

7 "That the level of funding for Inter-Mountain  
8 Region be set at two million dollars."

9 Is there discussion? Doctor Vaun?

10 DOCTOR VAUN: I still have not heard an answer to  
11 Mrs. Salazar's question. All I have is hearsay that they  
12 are over-funded. I mean, does anybody have any evidence that  
13 they have a Swiss bank account or that their projects are  
14 lousy? One or the other?

15 Otherwise, this is hearsay and I don't think we  
16 should use that to really cut the program fairly substantial  
17 amounts of money. Their performance has been good, I think,  
18 that is what we have to go on, and not the hearsay that they  
19 are overfunded.

20 MR. POSTA: Doctor Vaun, could I respond to that,  
21 please?

22 DOCTOR VAUN: Somebody had better, I think.

23 MR. POSTA: I think that the Council took a fall  
24 site visit to Inter-Mountain this last go-round, and was  
25 concerned primarily because of the turf problems that existed



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1 in Mountain States Regional Medical Programs, the Inter-  
2 Mountain Regional Medical Programs, and Colorado-Wyoming,  
3 and I wanted to be careful not to say that this problem is  
4 -- has been solely Inter-Mountain's.

5 But Inter-Mountain has had more turf problems that  
6 -- than all Regions in the country put together. They are  
7 even in Alaska now, doing an EMS project.

8 But that is to their -- you can pat them on the  
9 back with one hand, but other people, particularly Mountain  
10 States -- Colorado-Wyoming and the like, don't particularly  
11 care for-it.

12 So I think that what I am saying is as straight-  
13 forward as possible, that there are some people that feel  
14 that this Region has got too much money and they are getting  
15 in everybody's way in the surrounding territories.

16 Now, what we did demand in this particular applica-  
17 tion is to have the inter-Regional Coordinators group, which  
18 is composed of the three Coordinators of those three RMP's,  
19 together with the coordinators, get together and take a look  
20 at everything that has been accomplished, and everything that  
21 is requested, and everything contemplated on being rebudgeted  
22 -- they actually met on May 9th and have submitted a letter  
23 signed off by six people, that all but ten activities have  
24 been approved by all three Coordinators and RAG Chairmen.

25 They will meet again, and have mentioned two dates

ID-;95

1 that they will be meeting together final dollars will be  
2 distributed among the three Regional Medical Programs.

3 But I think, to zero in, Jesse, on your question  
4 concerning why do we think this is overfunding, it is coming  
5 from several different discussions with your group.

6 MR. THOMPSON: Well, if you have hard evidence --  
7 you know, when they say Inter-Mountain -- that's between  
8 any two mountains you can find.

9 MR. TOOMEY: You take a look at the support of  
10 the Nevada A agency, and I think they have only touched a  
11 little bit of Nevada, and here they are funding A agents  
12 for the whole darned state.

13 MRS. WYCKOFF: I just don't understand the policy  
14 of funding A agencies and then turning around and asking for  
15 their approval. There is something corrupt about that. They  
16 wouldn't dare not approve.

17 MR. CHAMBLISS: Is there any further discussion?  
18 Miss Murphy, I think Jesse had a question about the minori-  
19 ties, and we have always brought that up, and it seems every  
20 time we get a few on the staff --

21 MISS MURPHY: Then the phase-out came, and we lost  
22 several Orientals, but the day after our site visit, the  
23 Great White Father brought some Indian into the Inter-Mountain  
24 Regional Program from the Arizona area, and they hired him  
25 on the spot.

WHD-96

1 So they hired him on the spot, and he is responsible  
2 for all the Indian components that are in the projects. But  
3 they still insist that they have their quota of minority com-  
4 pared to the number of minorities in the Inter-Mountain  
5 Region.

6 About hardware, I went through rapidly; I counted  
7 about \$173,000 for all the projects. I don't have anything  
8 else to compare to.

9 MRS. WYCKOFF: Are there RMP projects where we are  
10 assisting the state legislatures with information on an  
11 organized basis?

12 MR. CHAMBLISS: That is a policy issue; we have  
13 discouraged this before, Mrs. Wyckoff. We have discouraged  
14 this before, in this Region, I might add.

15 MRS. WYCKOFF: There is a great increase in the  
16 amount of money for that, too.

17 MISS MURPHY: We discussed that at the site visit  
18 and CHP had asked for that program, and their concern in the  
19 comments was that they had not elicited the people that would  
20 attend, so they had turned the program, the seminar, completely  
21 over to CHP, and I think it was 110 or one of those Regions,  
22 and they are going to run it.

23 They are going to select the people right up there  
24 themselves.

25 MR. CHAMBLISS: It simply still has some connotations

VHD-97

1     though, that we might question, especially in dealing with  
2     the legislature.

3             MR. THOMPSON: Your primary purpose is to set up  
4     HMO's; to find out if the state legislature prevents commun-  
5     ity sponsored practices, then you have to go to the state to  
6     carry out your main objective.

7             MR. CHAMBLISS: We would agree there, but the ques-  
8     tion is, who should do it?

9             MR. THOMPSON: RMP.

10            MISS MURPHY: RMP is the only one with the money;  
11     the CHP doesn't have the money.

12            DOCTOR MILLER: Maybe I missed something here, but  
13     perhaps somebody could go over it again.

14            What is the purpose of this new organization? Was  
15     this new corporation formed to replace RMP when it finally  
16     dies out, or to be the future coordinator of CHP-RMP, Hill-  
17     Burton and so forth, if that evolves? Or is it a foundation-  
18     PSRO approach, or -- I didn't quite get what the purpose of  
19     it is.

20            MR. CHAMBLISS: Would you enlighten the Committee  
21     on that?

22            MISS MURPHY: I think possibly it is your certain --  
23     your second comment. I think they will be ahead as far as  
24     the unified health plan is concerned.

25            DOCTOR MILLER: Do they have some articles of

1 incorporation or by-laws that would really tell what they  
2 are supposed to do?

3 MISS MURPHY: We don't have the by-laws, but they  
4 are incorporated, and there is the whole document.

5 DOCTOR MILLER: One of the things you are telling  
6 us from the Staff standpoint is that one of the things you  
7 ought to figure out is how they are going to react to the  
8 future legislation, which has not yet been written, which is  
9 a favorite story of yours, and in the past, too, I think.

10 But anyway, how do you put all these programs  
11 together at the local level? If that is what this is, we  
12 ought to give them a bonus instead of cutting down their  
13 funds. Because that is one of the goals.

14 MISS MURPHY: When they formed this corporation,  
15 they did it with the understanding they could go to places  
16 like Robert Wood Johnson and try to get funding that they  
17 could not get through the University, because it is a state  
18 university, because that is part of the psychology.

19 MRS. SALAZAR: I guess one of the problems that I  
20 have with this is the fact that they did not move away from  
21 the university immediately.

22 MISS MURPHY: This is my complaint. They want the  
23 best of both worlds.

24 DOCTOR SLATER: The new organization is tied to the  
25 university, too?

D-99

1 MR. CHAMBLISS: Does this discussion, Mrs. Salazar,  
2 begin to clear up some of your questions regarding the cor-  
3 poration?

4 Shall I call for the question?

5 DOCTOR MC PHEDRAN: Before you do, I would like to  
6 ask Mrs. Salazar, now do you agree with Mr. Toomey's funding  
7 recommendation?

8 MR. CHAMBLISS: All right; and Mr. Toomey's recom-  
9 mendation is that the Region be funded at a level of two  
10 million dollars.

11 MR. VAN WINKLE: That has been seconded.

12 MR. CHAMBLISS: That has been seconded. Those in  
13 favor, may I have the usual sign?

14 (Chorus of "Aye")

15 Those opposed?

16 (No response.) ✓

17 The "Aye's" have it.

18 Now, may I call, please, just a short break for the  
19 convenience of our Recorder? Just a couple of minutes,  
20 please.

21 (Whereupon a short recess was taken.)

22 - - -  
23  
24  
25

WHD-100

## REGIONAL MEDICAL PROGRAM REVIEW

## MICHIGAN REGION

MR. CHAMBLISS: We would like to resume, after a momentary break; we will begin with Michigan, and as we begin with Michigan, we would like the record to show that Doctor Carpenter has in fact absented himself while this Region is under review.

The presenters here, Mr. Toomey and Doctor White, supported by Mrs. Parks.

Will you proceed?

MR. TOOMEY: I am of the opinion that the Michigan program was -- I am not of the opinion; I know -- it was difficult to read, difficult to understand, and I have feelings of inadequacy in talking very much about it, because I think that the proposal has a number of inadequacies.

Program leadership was difficult to determine for the kind and quality of program leadership; as a matter of fact, I am not even sure at the present time who is the program coordinator.

In a listing of staff, it listed Doctor Tupper, and in all of the signatures it had Doctor Graham-Welk as the individual, and -- so I have some concern -- not concern, but I just don't know.

The program staff; they have 12 people, four clerical, five professional and three in management.

WHD-101

1           The question you had on the review shsheet is the  
2           adequacy of the program staff to manage and monitor the  
3           operation of projects, undertake such activities as will con-  
4           tribute to local CHP plan development and related efforts,  
5           and my one note here is that I found it difficult to find  
6           an answer to that question.

7           The Regional Advisory Group seems to meet only as  
8           needed, and it was difficult to determine their participation  
9           except on a project review Committee basis.

10          The question related to past performance and accom-  
11          plishments; these items do not appear to be or have been  
12          consonant with the recent program thrusts, except for  
13          Emergency Medical Services, and more recently, today -- and  
14          this I did not know -- hypertension was encouraged because  
15          -- and a good thing it was, because the program is -- seems  
16          to have more than its share of hypertension projects in it.

17          Objectives and priorities at the present time relate  
18          to cancer, kidney, Emergency Services, hypertension, nursing  
19          homes, health manpower and development, and the proposal is,  
20          as written, it seems to me, to be questionable in terms of  
21          its appropriateness.

22          The funds they are requesting -- \$3,777,000, of  
23          which \$1,675,000, is a continuation project, and \$1,755,000  
24          for new projects; they have an estimated July request of  
25          \$800,000, and Michigan's target figure is \$2,000,000 -- their



HD-102

1 targeted available funds, is \$2,969,000 -- approximately  
2 three million dollars, and their request at the moment would  
3 total, -as I said, \$3,077,000 and when you add the \$800,000  
4 that they anticipate, it goes to better than four and a half  
5 million dollars, which is 154 percent of the targeted avail-  
6 able funds.

7 I think there are problems related to the Emergency  
8 Medical Services; they are permanently requesting \$750,000  
9 increase in the funds for Emergency Medical Services, to pro-  
10 vide a continuation of linkages and relationships between  
11 the Michigan RMP and the non-RMP programs.

12 I think overall, probably I would say that I was  
13 disappointed. I was disappointed in what seemed to be a  
14 lack of program leadership; I was disappointed in the infor-  
15 mation I could get out of it from the Regional Advisory Group.  
16 I had disappointments as I attempted to review the past per-  
17 formance and accomplishments and I felt they were not conson-  
18 ant with the objectives and the priorities, and I felt that  
19 their request for funds was very much out of line.

20 MR. CHAMBLISS: All right. Shall we turn to the  
21 second reviewer, Doctor White?

22 DOCTOR WHITE: I share Mr. Toomey's views, to some  
23 extent.

24 It was difficult to ferret out from this proposal  
25 who, if anyone, was leading the organization at the present

1 time.

2 As he mentioned, Doctor Tupper was indicated on --  
3 in the narrative; in one of the budget pages it stated this  
4 was a TBA slot; either Doctor Tupper was being magnanimous  
5 and loaning his services, or there was indeed a lack of an  
6 executive director.

7 They have a bit of a confusing , relationship, in  
8 that they have what they call an Executive Director who is  
9 -- whose responsibilities are the overall direction of the  
10 program, and then they have a Program Coordinator, which I  
11 feel fills the more traditional role of the RMP Director.

12 I am not quite sure that both are necessary, but on  
13 the other hand, I seem to recall that Michigan got good grades  
14 in the past. It was a fairly well-regarded Region at one  
15 time, at least, and I don't know what has happened in this  
16 transition, but obviously there is some question as to whether  
17 or not leadership is adequate, at the present time.

18 And also, I share Mr. Toomey's concern as to  
19 whether or not the Regional Advisory Group, although it has  
20 continued to meet quarterly at full strength, has participated  
21 at the same degree of enthusiasm and the same critical atti-  
22 tude as it has in the past.

23 It does state, however, that the Regional Advisory  
24 Group is meeting; the members of it meet with the Comprehensive  
25 Health Planning and Hill-Burton personnel to develop health

ID-104

1 services resource, and I raise the question again, as Doctor  
2 Miller did a moment or so ago: is this an appropriate thing?  
3 Are these people something which will come to naught by  
4 virtue of the fact that they can't get the Congress to do it  
5 anyway?

6 They do seem to have appropriate Regional Advisory  
7 Group representatives on Review and other Committees, and on  
8 paper, at least, it would indicate that they have a good,  
9 thorough review process. I question that for something that  
10 I will bring up later.

11 Their past performance I did not evaluate well; I  
12 could not tell exactly from their narrative how many of these  
13 have been picked up by others and how many were continuing.

14 Some of them seemed relevant, and I based that  
15 assumption on the fact that they were previously given eval-  
16 uations of good management and good hypothesis; therefore,  
17 one would assume that their continuing projects, having been  
18 approved under the old set-up were reasonable ones.

19 Their new ones, however, raised the question in my  
20 mind as to whether people haven't been too critical. They  
21 have something like 40 projects, in one guise or another,  
22 and I don't really get the idea from reading this that they  
23 have spent a great deal of time in developing these or in  
24 giving them adequate review, even though they may have gone  
25 through the holes that are appropriate. I wonder if some of

171  
1    them weren't just kind of hanging there in the wings and  
2    have never even been given a great deal of attention in the  
3    past, and now they say:

4                   "Boy, we'd better get these done while we've  
5                   got the chance."

6                   Many of their projects presumably could be accom-  
7    plished in short-term, but one at least has a short-term --  
8    two-year time schedule, which obviously precludes its being  
9    accomplished in a single year. This is another example, I  
10   think, that they have not looked at critically.

11                   They do have a relationship with Comprehensive  
12   Health Planning, and are participating in this blanket sort  
13   of of agency that is to take over.

14                   They indicate that they have a meeting scheduled  
15   in July, at which they will come to some further concrete  
16   conclusions about this.

17                   Some of the titles of the projects also raised  
18   the question in my mind as to relevance to Regional Medical  
19   Programs. Some of them seemed naive -- or I am, and that  
20   is possible; some of them seemed clinically oriented, like  
21   their clinical research projects, in a sense, rather than  
22   educational demonstration projects.

23                   I question, for example, what is their "buddy?"  
24   They have something here called a "buddy system," for the  
25   role of supporting a buddy in hypertension control. I don't

WHD-106

1 know if this simply is something like Alcoholics Anonymous --  
2 you call and say: "I'm having an attack; I need your help."

3 They have a great deal of emphasis on hypertension;  
4 they have one which I can't think really can be accomplished  
5 in a year's time. I'm not sure really one can evaluate  
6 hypertension in a variable population and come to any valid  
7 conclusions in a year's time; you can't even collect the data  
8 in a year's time.

9 A comprehensive relaxing therapy. Well, this smacks  
10 of accupuncture.

11 Well, these are the questions I have in my mind.

12 Number 1, their leadership is unclear.

13 Number 2, how critical were they in evaluating what  
14 is going on?

15 No. 3, 40 projects seem an impossibility. Some  
16 of them are obviously an impossibility by their own statements,  
17 and I think that their request for funding is ludicrous in  
18 terms of the amount of activity they could really undertake  
19 in a year's time and get something out of it.

20 As Mr. Toomey mentioned, they are asking for  
21 \$3,700,000, they are targeted for \$2,900,000; they are  
22 currently \$1,400,000, and they want to come in for \$800,000  
23 in July.

24 If you gave them two million now, you would be  
25 doing them a favor, and anything they get in July presumably

VHD-107

1 could be critically appraised.

2 MR. TOOMEY: The 40 projects they have listed as  
3 "Review and Comments" by CHP agencies, the projects entitled  
4 "Action taken" -- they are all asterisked as statewide pro-  
5 jects that referred to the Councils of the B agencies, but  
6 there were four of the 40 projects that were endorsed by  
7 these CHP agencies. The other 36 are either "no action  
8 taken," "pending" or -- no action or pending. They had four  
9 endorsements.

10 DOCTOR WHITE: I think Mr. Toomey pointed out, and  
11 Mrs. Parks certainly did a creditable job in bringing this  
12 to our attention, this expansion of funding for some of the  
13 operating projects, the doubling of the budgets for some  
14 things that seemed hardly valid.

15 I guess the one exception I might take is, if  
16 indeed they have a commitment, which they say they have,  
17 from state agency in Michigan, to continue the EMS service  
18 at the end of one more year.

19 MRS. PARKS: Right. This is what I understand.

20 DOCTOR WHITE: Then perhaps it is a valid investiga-  
21 tion.

22 MR. VAN WINKLE: Doctor White, on the matter of  
23 the Coordinator, this was a very strong program under Doctor  
24 Hustice, and then there was an interim period before Doctor  
25 Tupper came aboard, and the program slipped very badly.

WHD-108

1 Doctor Tupper turned that program all the way around and  
2 brought it right back up to the top.

3 Tupper left; he's living in Grand Rapids right now,  
4 and if you know the geography, that is some distance from  
5 where this is located. He is on a full-time job, and I think  
6 he is lending his name to this, and I think it is a private  
7 commitment on his part to give it some guidance.

8 MRS. PARKS: He is available?

9 MR. VAN WINKLE: He is available by phone and by  
10 request, but Doctor Graham-Welke was a former staff member  
11 whom they brought in who in fact is running the program from  
12 day to day, and Doctor Tupper has very little input at the  
13 present time, very little input, and I think your criticisms  
14 were well justified.

15 DOCTOR MILLER: Could I ask a question, both with  
16 regard to this EMS business, because there is some confusion  
17 in my mind certainly, about the limitations on EMS.

18 Now, here is one; we said -- our directions said  
19 that a program in RMD can continue a previously started EMS  
20 but can not mount a statewide EMS system.

21 Well, here is one that has gone from \$36,000 a year  
22 to \$750,000 and it is obviously developing a statewide system,  
23 or trying to in one year.

24 Is this directly opposed to the principle, or is it  
25 not? Because we have some others that are coming up where they

WHD-109

1 obviously got a statewide EMS system.

2 MR. CHAMBLISS: Will you comment, Mr. Van Winkle?

3 MR. VAN WINKLE: This is a continuation project.

4 DOCTOR MILLER: Yeah, but a continuation from  
5 \$35,000 to \$750,000? That is quite a continuation project.

6 MR. VAN WINKLE: We are aware of this, but they are  
7 saying that as far as it being affected by this new law that  
8 we can have no new starts, but we can continue to fund what  
9 has been funded.

10 But we strongly questioned this use.

11 DOCTOR MILLER: We question whether this can be  
12 ripened into a full-fledged \$700,000 system in one year with  
13 a -- with Regional Medical Program funds.

14 MR. VAN WINKLE: There is one other --

15 DOCTOR MILLER: I will tell you, practically it is  
16 ridiculous. I have had one of those things.

17 MR. VAN WINKLE: I would like to hear from some  
18 of those physicians about this automated peritoneal dialysis  
19 also.

20 The kidney program is going almost totally with  
21 home dialysis, using artificial kidney, and now all of a  
22 sudden, we are going off, apparently, in this year with auto-  
23 mated peritoneal, and I can't very well see people walking  
24 around the street carrying a bottle in their hand, and I  
25 don't know if it is a part of the Michigan State Renal Plan.



HD-110

1 There is no mention of it, and Michigan does have a very  
2 highly sophisticated renal program -- you know, a state pro-  
3 gram that is supposed to cover all of this.

4 DOCTOR SLATER: Presumably this has all been  
5 cleared by their professionals before it ever gets here.

6 DOCTOR MILLER: Peritoneal dialysis? I didn't  
7 think they did it any more.

8 MR. VAN WINKLE: I didn't think so either.

9 MR. CHAMBLISS: I think the Committee should know  
10 that both the EMS and the kidney activity will be commented  
11 on by the other agencies that are supporting those activities  
12 and we will have input from them.

13 DOCTOR SLATER: Can we put a contingency on this  
14 subject to clearance of the technical use of this, despite  
15 the fact that they have already approved it at their own -- ?

16 MR. VAN WINKLE: I think it raises two questions.  
17 If this came through their review process, and they are send-  
18 ing it in saying that it has been technically looked at and  
19 cleared, then I question the process.

20 DOCTOR WHITE: That is right. That is why I said  
21 on paper it looks good but obviously they have gone through  
22 the motions without having any enthusiasm about this.

23 MRS. WYCKOFF: Don't they still have to get an  
24 ad hoc panel of experts on kidney programs?

25 MR. CHAMBLISS: Are the reviewers prepared to make

HD-111

1 a recommendation on funding, in the light of the discussion  
2 that has taken place?

3 DOCTOR MC PHEDRAN: I just wanted to ask -- the  
4 other people that are likely to comment on EMS going from  
5 \$34,000 to \$750,000; they are not likely to take exception  
6 to that. They might have to bear the burden of expense  
7 otherwise.

8 I mean, I don't think that because we think that  
9 that is tantamount to a new projet -- we ought to be able to  
10 say that that is tantamount to a new project, and we can't  
11 imagine anything going from that low a figure to that high  
12 a figure without it being a new project, so I think we  
13 ought to be able to settle it here and not leave it for some-  
14 body else to take care of.

15 MR. CHAMBLISS: Then we would like your specific  
16 recommendations here as it relates to EMS.

17 MRS. WYCKOFF: Why don't we ask Doctor Dushan  
18 to comment on this thing? He is on the panel, and he is a  
19 pathologist.

20 MR. CHAMBLISS: Would the Committee seek that?

21 DOCTOR MILLER: There is a jurisdictional question,  
22 however, that I wish you would answer for us.

23 We are not empowered to make technical review --

24 MR. THOMPSON: I don't think we can; I think all  
25 we can do is cut the hell out of them.

1 DOCTOR MILLER: Therefore, if we are facing a  
2 technical question, that is beyond our jurisdiction.

3 MR. THOMPSON: No way.

4 DOCTOR WHITE: I take exception. We are not  
5 looking at the quality -- well, at the peritoneal dialysis,  
6 perhaps, but not at the EMS together.

7 DOCTOR MILLER: No. But about this kidney thing,  
8 this is a technical question.

9 DOCTOR SLATER: Let's ask another point.

10 Are they requesting funds for services, or simply  
11 planning, evaluation? We can't provide money for dialysis,  
12 can we?

13 MRS. PARKS: For the EMS?

14 MR. CHAMBLISS: For the kidney.

15 MR. VAN WINKLE: They are trying to determine the  
16 feasibility of it.

17 MR. THOMPSON: You ought to get some kidney people  
18 to look at that.

19 MR. VAN WINKLE: I related it back to process here.

20 MR. CHAMBLISS: We would simply like to have on  
21 record an expression of your reservations, if there are any,  
22 and then Staff will proceed further on that.

23 MRS. WYCKOFF: Couldn't we have the old process  
24 we used to have, of a special Committee on Kidney, to look  
25 at this for us and give us a report later, or give the report

1 later?

2 MR. CHAMBLISS: Yes, we will. That expertise now  
3 resides with Doctor Goodman, and we will call upon him to  
4 give us input as -- and an assessment of this particular  
5 activity.

6 DOCTOR SLATER: Well, let's leave it that unless  
7 we approve it, we don't think it should be included in the  
8 figure.

9 MR. CHAMBLISS: That is very clear.

10 MR. THOMPSON: The issue, I think, is whether we  
11 think it is a whole new project.

12 DOCTOR MILLER: Mister Chairman, could we get some  
13 understanding here with regard to future actions we are  
14 going to have to take tomorrow, that a continuation of an  
15 EMS project for RMP would be one that is proceeding at not  
16 a total statewide plan, unless it previously was approved,  
17 and would be of a magnitude of funding similar to what it has  
18 done previously, and that anything beyond that, moving in  
19 or beyond the jurisdiction of RMP's in EMS, would that be  
20 fair?

21 MR. CHAMBLISS: Not entirely; we have discussed  
22 this with EMS and they feel that unless there is a total  
23 system involved with all the components of the Emergency  
24 Medical Systems, that these activities would be proper for  
25 funding under RMP.

WHD-114

1 But we raised another question of magnitude in  
2 terms of funding, and I think that in and of itself would  
3 require interaction between these two programs, and a  
4 closer examination of the project, so as to take care of  
5 the concerns that you express.

6 We will do that; we will call in Mr. Stryker, and  
7 I believe -- Mr. Reardon, and Stryker, and get their assess-  
8 ment of this project.

9 The level of funding requested here is very high;  
10 they have gone, as you have indicated, from \$30,000 to  
11 \$700,000, and we in fact will bring them in and get their  
12 views here, and it will be taken into account as this recom-  
13 mendation goes forward.

14 MR. VAN WINKLE: All we have to look at is a Form  
15 here; we don't have, you know, the original application,  
16 but it certainly looks like a full statewide comprehensive  
17 EMS system.

18 MR. TOOMEY: Mister Chairman, my recommendation  
19 that I have here, on the presumption of the three-quarters of  
20 a million for EMS, and the amount of money that was involved  
21 in the hypertension, I was going to recommend two and a half  
22 million dollars until I heard this morning that hypertension  
23 projects are within the province -- and I hadn't counted  
24 them but I think there were 13 or 14 hypertension projects.

25 With this in mind, I would recommend funding at the

WHD-115

1 level of three million dollars.

2 MR. CHAMBLISS: You have heard the recommendation.

3 Is there a motion to that effect?

4 MR. TOOMEY: I so move.

5 DOCTOR SLATER: Seconded.

6 MR. CHAMBLISS: It has been moved and seconded  
7 that the level of funding for Michigan be set at three million  
8 dollars.

9 Is there discussion?

10 DOCTOR VAUN: Yes. I find that at serious conflict  
11 with the two million dollars that was recommended by your  
12 reviewer.

13 DOCTOR MILLER: I found a serious objection in this.

14 DOCTOR VAUN: He recommended two; you recommended  
15 three.

16 DOCTOR WHITE: I said we'd be generous if we gave  
17 them two million dollars.

18 MR. CHAMBLISS: All right; we have something of a  
19 dilemma here.

20 DOCTOR WHITE: That's all right; the motion is on  
21 the floor.

22 MR. VAN WINKLE: Was there a second?

23 MR. CHAMBLISS: Yes, there was a second. All those  
24 in favor?

25 DOCTOR SLATER: Aye.

WHD-115

1 level of three million dollars.

2 MR. CHAMBLISS: You have heard the recommendation.

3 Is there a motion to that effect?

4 MR. TOOMEY: I so move.

5 DOCTOR SLATER: Seconded.

6 MR. CHAMBLISS: It has been moved and seconded  
7 that the level of funding for Michigan be set at three million  
8 dollars.

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23 MR. CHAMBLISS: Yes, there was a second. All those  
24 in favor?

25 DOCTOR SLATER: Aye.

VHD-116

1 MR. CHAMBLISS: Opposed?

2 (Chorus of "No")

3 MR. CHAMBLISS: The motion did not carry in the  
4 matter of three million dollars.

5 That motion is lost.

6 DOCTOR SLATER: That is the only motion that's been  
7 lost all day.

8 DOCTOR MILLER: It shows we are disturbed.

9 MR. CHAMBLISS: The Chair is open, then, for another  
10 motion.

11 MR. TOOMEY: I will go back to my original recom-  
12 mendation for \$2,500,000.

13 MR. CHAMBLISS: There is a motion on the floor for  
14 a level of funding for \$2,500,000. Is there a second?

15 MR. THOMPSON: Second.

16 MR. CHAMBLISS: It has been moved and seconded.  
17 Are you ready for the question?

18 DOCTOR WHITE: I would like some discussion.

19 I would point out again the various number of pro-  
20 jects; whether they are meritorious or not is immaterial,  
21 one would think. I do not believe that they could have been  
22 given the critical appraisal they deserved within the time-  
23 span that is allowable, particularly if the leadership has  
24 faltered in the meantime; without infringing upon a territory  
25 which we are not allowed to get into, I would point out that



ID-117

1 point out that the specific objectives of the EMS program --  
2 the specific outlets they are seeking, setting of of standards  
3 for courses, the training of 1800 EMTA's -- I confess to be  
4 unfamiliar with what is involved with that, but it seems to  
5 me it is a big number within a single year. Perhaps not.

6 Perhaps the evaluation of this program as to its  
7 benefit to Michigan, I don't think you can evaluate it in a  
8 year's time; you can't even get it done, so I don't think you  
9 can evaluate it, in a coordinated statewide EMS component  
10 to be assumed by the Michigan Department of Public Health.

11 Now, I will retract a statement I made earlier, that  
12 if the State Department is going to take over, perhaps this  
13 is worthwhile, because as I read this now, it appears to me  
14 that perhaps the Michigan Department of Public Health is  
15 going to take over responsibility for training rather than  
16 for the establishment of existing programs.

17 Therefore, I doubt that \$750,000 is a wise invest-  
18 ment.

19 DOCTOR WHITE: I don't think we should settle this  
20 question without begging the question, I guess.

21 MR. TOOMEY: The funds requested are for program  
22 staff of approximately \$350 thousand and for the continuation  
23 projects of approximately \$1,675,000, which gives you, at  
24 two million dollars just to continue their project staff,  
25 their core staff and their program staff in the continuation

HD-118

1 projects. That two million dollars allows for no additional  
2 projects.

3 I mention that merely as a sidelight. If the  
4 concern is a further reduction from the two and a half to  
5 approximately two, as I said, this allows for continuation.

6 Now, I will once again admit that their \$600-700,000  
7 -- and I did the arithmetic very quickly -- in hypertension  
8 projects -- in some of them, for instance, hypertension pro-  
9 jects in the Detroit Department of Public Works, as an  
10 example, and then you mentioned, Doctor White, the buddy  
11 system of hypertension, whatever that is.

12 And then on top of that, you know, I am extremely  
13 skeptical of the -- in the application anyway, but I hate to  
14 cut them down to exactly where they are -- where we are now.

15 DOCTOR MILLER: Question, please.

16 MR. CHAMBLISS: Is there further discussion of the  
17 motion on the floor? It has been moved and seconded. Shall  
18 I call the question?

19 All those in favor of setting a level at \$2,500,000  
20 for Michigan, say "Aye."

21 (Chorus of "Aye")

22 Those opposed?

23 (Chorus of "No")

24 MR. VAN WINKLE: Almost all ought to have a show  
25 of hands.

WHD-119

1 MR. CHAMBLISS: I would ask for a show of hands,  
2 please. Those voting "Aye," may we see your hands?

3 (Show of hands)

4 MR. CHAMBLISS: Five in favor?

5 Those opposed?

6 (Show of hands)

7 MR. CHAMBLISS: The "Ayes" have it and the motion  
8 is carried.

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HD-120

## REGIONAL MEDIAL PROGRAM REVIEW

## MISSISSIPPI REGION

MR. CHAMBLISS: May we turn our attention then to Mississippi? The reviewers there are Doctor Vaun and Mr. Toomey, supported by Mr. Van Winkle, and I should make mention of the fact that the Committee has set as its goal the review of three additional Regions this afternoon, and there will be two left when Mississippi is completed.

DOCTOR SLATER: What are the others, sir?

MR. CHAMBLISS: Illinois and Louisiana.

DOCTOR VAUN: First, I should be -- should issue a disclaimer. My daughter happened to be looking through this; she looked at the pictures and I didn't, and she said: "Daddy, you needed a haircut for the picture."

Remembering the nature of the visit, however, I am sure there was no effort on Doctor Lampert's part to seduce me into giving him more money, and I will describe the nature of the visit, which has, I think, some bearing on the issue.

MR. CHAMBLISS: We will not consider that as a conflict.

DOCTOR VAUN: I think it was September 1972 when Doctor Joe Hess and his storm-troopers went down to straighten up the Mississippi Regional Medical Program. They were having a great deal of difficulty and they went down there to take them to task.

ID-121

1 I must admit retrospectively, as I look back on  
2 what we did when we were there, we might have been a little  
3 too critical for Mississippi not having evaluation of their  
4 projects, because in the subsequent years I haven't seen much  
5 evaluation of anything from anybody, let alone Mississippi.

6 But nonetheless, they were in trouble with leadership  
7 problems, and the question that kept coming across the table  
8 during the day was: it is very hard to tell where Ol' Miss  
9 ends and RMP begins, and that was a serious problem and there  
10 seemed to be a great deal of incest between the program and  
11 the Ol' Miss. I am indeed pleasantly surprised to see this  
12 summary of projects come out these years later, because  
13 whether it was us or whether something has happened down  
14 there, certainly this is a pretty good piece of work that  
15 has come out since then, and I am rather pleased with it.

16 I think it would suggest that there are some  
17 strengths there that we did not identify at that time, but  
18 Doctor Lampert has obviously done a pretty good job of his  
19 burden of sustaining staff through a pretty rough time.

20 It would appear that the CHP relationships are  
21 satisfactory. I think that here the projects address them-  
22 selves more now to the health care needs of Mississippi  
23 rather than to continuing this so-called soft money for the  
24 University of Mississippi when NIH was phasing out and other  
25 aspects of that nature.

VHD-122

1           Maybe it said the General was no longer there, but  
2 there was a retired General down there who was running at that  
3 time the University of Mississippi and also seemed to be, to  
4 a large part, with a certain lady, running the RMP.

5           Things have changed, and I think that though their  
6 request at this time is unrealistic, I think that the RMP of  
7 Mississippi deserves a few pats on the back.

8           I am recommending a reduction of funding which I  
9 will hold until Mr. Toomey has his licks, and then together  
10 we will recommend something to you.

11           MR. TOOMEY: Well, once again I am following the  
12 format; I felt the program leadership was strong and viable.  
13 I felt the program staff to be competent.

14           RAG meets, the Executive Committee meets, the  
15 Planning Committee meets, the Manpower and Education Committee  
16 met several times, Health Systems and Public Education.

17           Their past performance has been impressive; for  
18 instance, I don't want to go into these, but the first stroke  
19 and intensive care unit, care and training, the first chronic  
20 pulmonary disease unit, treatment and training program, the  
21 first on-going effort toward coordinating continuing health  
22 education, the first system for coronary care and training --  
23 and there really are a dozen of these "firsts," that indicate  
24 the impact of the Mississippi Region on -- the Regional Medical  
25 Program on the state of Mississippi, and frankly I felt it was

HD-123

1 quite impressive.

2           Additionally, they were extremely -- I felt --  
3 perceptive in establishing goals and they were quite precise  
4 in the establishment of objectives in order to support the  
5 accomplishment of those goals.

6           The proposals that they have are congruent and they  
7 certainly mesh well, generally speaking, with the proposals  
8 that were made.

9           I looked at the CHP comment, the state comprehensive  
10 plan came with an endorsement of 39 out of 59 projects that  
11 had been proposed. There were four responses from comprehen-  
12 sive health planning agencies, and the tone of these respon-  
13 ses were all extremely cooperative, extremely friendly, and  
14 seemingly with a good relationship between the two.

15           One of the items -- perhaps Doctor Vaun mentioned  
16 this -- but we again run into the situation where the funds  
17 for the continuation of the projects already proposed or  
18 already on the boards is \$1,200,000 and their proposals --  
19 the funds for their new proposals are \$1,155,000, which  
20 means that requests for new funds are just about as great for  
21 -- as for the continuation enterprises.

22           In brief, I think that this was an extremely well-  
23 done proposal; it indicated a considerably higher degree of  
24 strength than several of those that I have reviewed earlier,  
25 and I ended up with an evaluation of this project as being in

1 a good to excellent stage.

2 DOCTOR WHITE: Mrs. Wyckoff has been doing a techni-

3 cal review here and has a question to ask.

4 MRS. WYCKOFF: What is "Pierre the Pelican"?

5 MR. CHAMBLISS: That was a policy question we raised

6 too; we wanted to know.

7 DOCTOR VAUN: I thought I went through that very

8 carefully, and I don't remember any pelican.

9 MRS. WYCKOFF: Pierre the Pelican is No. C-179.

10 There is also 137, "Solid Waste," and "Solid Waste

11 Management Training."

12 MR. VAN WINKLE: It is education of illiterate

13 mothers. It is a pamphlet that goes out; it is quite well

14 done.

15 MR. CHAMBLISS: Would the reviewers have any recom-

16 mendations here?

17 DOCTOR VAUN: Our independently arrived-at judgments

18 are reasonably close it would appear, so I would make a recom-

19 mendation that the Mississippi RMP be funded for \$2,200,000.

20 MR. CHAMBLISS: Is that a motion?

21 DOCTOR VAUN: I so move.

22 MR. CHAMBLISS: Second?

23 DOCTOR WHITE: Seconded.

24 MR. CHAMBLISS: It is moved and seconded that

25 Mississippi be funded at a level of \$2,200,000.



WHD-125

1 Are there questions or discussion?

2 DOCTOR MILLER: Yes, I would like to ask the  
3 reviewers: did you look at the magnitude of the collective  
4 -- of the renal programs?

5 I see two programs which total \$230,000; are they  
6 running a statewide renal program, and is that contrary to  
7 RMP principles?

8 MR. CHAMBLISS: No, it is not contrary.

9 DOCTOR VAUN: But that, plus a few others, when I  
10 said I arrived at my personal evaluation --

11 MR. VAN WINKLE: I raised the question because of  
12 the substantial increase in the costs.

13 They are opening up a new unit and I think we will  
14 have to flag this for Doctor Goodman, in kidney, because it  
15 is an expansion for dialysis facilities. We want to be very  
16 sure whether they have proper clearances on this sort of  
17 thing.

18 DOCTOR MILLER: How about EMS here? It goes from  
19 17 to 92; that is only four and a half times, it isn't 20  
20 times.

21 MR. CHAMBLISS: We don't see the magnitude there  
22 that you referred to earlier on, Doctor Miller.

23 DOCTOR MILLER: No, not quite.

24 MR. THOMPSON: What happened to the turf problems  
25 they were having with Memphis for a while?

1 MR. CHAMBLISS: There has been an agreement between  
2 the two Regions on the overlap areas in Northern Mississippi,  
3 I believe, has there not?

4 MR. VAN WINKLE: Yes, including the CHP A agencies.

5 As a matter of fact there is combined funding.

6 MRS. WYCKOFF: There is a beautiful interface and  
7 it is working very well; very nice interface -- joint funding,  
8 joint meetings, both RMP and CHP.

9 There is one CHP in Northern Mississippi and both  
10 Mississippi RMP and Memphis RMP have funded it and started  
11 it --

12 MR. VAN WINKLE: And are evaluating it.

13 MISS MURPHY: Right, and it is a very nice inter-  
14 face.

15 MR. CHAMBLISS: Shall I call the question then?  
16 All those in favor of the motion?

17 (Chorus of "Aye")

18 Those opposed?

19 (No response)

20 The motion is carried and the level is set at  
21 \$2,200,000 for Mississippi.

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## REGIONAL MEDICAL PROGRAM REVIEW

## ILLINOIS REGION

MR. CHAMBLISS: Shall we now turn our attention to a review of the Illinois Regional Medical Program?

Doctor Slater is here, Doctor Scherlis is not here, and --

We have Staff support for you, Doctor Slater, in the person of Mrs. Kyttle, who is very knowledgeable about that region.

DOCTOR SLATER: I was just going to say, Mrs. Kyttle and I have power of veto over this group, because we both agree that Illinois is first-class, recommend it have full funding; I have nothing adverse to say and I am handing in my recommendation as good-excellent, with a final superior at the end.

Do you want to hear about this program? I would like to tell you, because I think it is really good.

You may take my light-hearted vein as a little bit of hypoglycemia.

All right. I think the main reason to proceed with this is really to bring into focus the orientation that this particular program has, which I find exciting after having listened to points of view expressed from the various regions today.

The staff role -- the program leadership, as I can

1 make it out, has been very strong. Doctor Creditor has been  
2 able to carry a very strong program forward while phasing  
3 down. He went from a professional staff level of four --  
4 this has now been built up to approximately 12, and he counts  
5 on a few more people but he does not plan on grossly expanding  
6 the central staff, despite a considerable -- a 100 percent  
7 expansion of funding requests.

8 During the course of the phasing down they felt that  
9 there was a great deal to be learned out of the experience  
10 they had been through, and joining forces with the CHP, they  
11 actually sat down and looked at the planning techniques and  
12 the outcomes and developed a planning model which was built  
13 on the comprehensive social approach to health care planning.  
14 It was for this reason that they really wanted to spend a  
15 couple of million.

16 They finally published a book which has just come  
17 out, on health care development which I think is worthwhile  
18 spending a moment on, but as back-up on this I can say that  
19 the RAG had been intimately involved in this along with CHP,  
20 and in general, the program, against this kind of backing,  
21 has been organized into two types of approach.

22 A health process approach, if you like, which is  
23 looking at problem-oriented medical records, patient educa-  
24 tion techniques, on the one hand, and disease-oriented pro-  
25 grams, improvement and specific care, models such as kidney,

HD-129

1 cancer and hypertension, on the other.

2 They have elected, within that framework, to put  
3 a great deal of emphasis on a few specific types of prominent  
4 concerns. Problem-oriented records, for one, and problems  
5 of hypertension for another, and thus have in-depth experience  
6 with a high investment history in those two areas, and at the  
7 same time they have had very good out-reach to the disadvan-  
8 taged urban areas as well as the areas in the Region of  
9 Chicago, in terms of the types of RMP support for primary care  
10 and the like, which I will mention briefly.

11 Let me just give you an inkling in their approach  
12 to planning. They decided that rather than take the rather  
13 global, generally-stated type of expression of goodwill that  
14 has been really traditional to RMP's, they would take an  
15 objective approach to planning, so they sat down with the CHP  
16 group and the RMP group and said:

17 "Well, what are the human goals? What are we  
18 attempting to achieve here? And within that framework,  
19 what are our objectives?"

20 Objectives being slightly more sharply defined, and then, out  
21 of this one comes health-care goals -- more specifically,  
22 health-care objectives, and then down -- finally down to  
23 programmatic goals.

24 So that, one: when this was developed with the  
25 people they had available, they were listening to consumers

130 1 as representatives of CHP, and finally coming out with RMP  
2 professional providers providing an answer to the expressed  
3 desires of the people in that Region.

4 A couple of examples. At the Human Goals approach,  
5 the most broadly oriented description, the people wanted  
6 optimum functioning of the health system, optimum longevity  
7 of life, optimal tranquility.

8 Well, this is pretty general when you start moving  
9 along to the kinds of interpretations of objectives. The  
10 lay people said they really wanted to be able to prevent dis-  
11 ease, they wanted to be able to cure curable conditions and  
12 treat treatable conditions.

13 It is interesting that Creditor goes on and says:

14 "The interpretation of those sets of objectives  
15 by any group in an area really is dependent upon the make-  
16 up of the group, and depending on the environmental-  
17 educational-health orientation, socio-economic relation-  
18 ships, you may come out with a variety of different  
19 projects which lead to these ultimate goals."

20 So that on the basis of that CHP type of activity,  
21 the provider looks at this, then comes down to the presentation  
22 of health-care goals, which is emphasis on accessibility,  
23 quality of care, effective management, optimum cost relation-  
24 ships, and so on.

25 Moving to another stage down the line, they take a

HD131

1 more sharply defined look at objectives, such as improving  
2 the understanding of health care; specifically, availability  
3 of the entry points of the system, optimal relationships of  
4 the system.

5 I won't go on, except to say that when they get to  
6 programmatic levels, they have specific series of approaches  
7 that can be taken within these health care objectives, and  
8 then they have taken a variety of programs or projects which  
9 have been fed into them from the Illinois area, and categorize  
10 them specifically as meeting these objectives within the frame-  
11 work as a whole.

12 Now, that to my mind, is a pretty neat way of putting  
13 in specific terms of reference some workable pattern, instead  
14 of five lines of such general statements that one wonders  
15 what -- whether or not the thinker is very clear when he is  
16 attempting to do it.

17 It does provide a procedure to examine what projects  
18 one is covering now, where there are gaps in the system, and  
19 it really puts into a highly analytical form some of the more  
20 philosophical objectives that we are groping to satisfy all  
21 the time.

22 So I was impressed with that, and that is the project  
23 of the phasing back. They have taken time to analyze where  
24 they have been and where they are going.

25 So now, everything that is presented in the present

WHD132

1 proposal is cast within those general frameworks, and all  
2 batted out by the RAG and Comprehensive Health Planning.

3 Well, I guess, against that background, then, how  
4 have they performed?

5 They have had a series of projects, I think, that  
6 there are about ten here, which have been started up over the  
7 past few years and in one way or another have been spun off  
8 and picked up fully operational by other groups.

9 Health care at home has been picked up as a free-  
10 standing enterprise by a group in the area.

11 Health information and referral is terminating  
12 because they had inflated ideas about what they could perform  
13 and they just decided to phase it out.

14 Multiphasic screening in industry has been picked  
15 up by the Heart Association and shared with a variety of  
16 industrial managements.

17 I won't go into all of them, except to say that  
18 they have had a series of specific projects started, proven  
19 and moved on out while they used their funds catalytically  
20 to start something else.

21 I was interested then in a series of proposals  
22 that they put forward. I have not mentioned that part of  
23 the specific activity -- well, which I just mentioned in  
24 passing -- part of the specific activity is to go into depth  
25 on how the problem-oriented medical record might be more



WHD133

1 effectively utilized, and then put a great deal of funding  
2 into that in the past, a great deal having been spent in  
3 teaching other groups and institutions how best to use the  
4 problem-oriented record, and they have about four pages of  
5 institutions and groups, that they have set up training and  
6 demonstration programs for, and they plan to continue that  
7 in this next year.

8         The other major venture, of course, has been in  
9 hypertension, and they have been attempting to develop a  
10 computer technique which will provide a simplified diagnostic  
11 and therapeutic protocol for that. In fact, relatively simple  
12 screening and input of information can provide back a protocol  
13 which is applicable to large numbers of people in the disad-  
14 vantaged areas.

15         I am fascinated by the fact that they figure they  
16 can have that computer program so that it is about ten cents  
17 per computer run after you go through the matter of data  
18 collection, and input.

19         So the proposals then boil down into two parts:  
20 those that are going to be continued, and those that are  
21 going to be new.

22         Problem-oriented record -- they want to proceed  
23 with implementation, as they have already been doing, for  
24 \$105,000. They sent in an evaluation report, and the evalua-  
25 tion indicated that this was a very influential program up to

WHD134

1 now.

2 The computerized hypertension treatment, they  
3 needed to continue to work on that, and that is \$205,000.  
4 A group of physicians in residence out of Champagne County  
5 are looking to problem-oriented record systems integrated  
6 into what is called the "Plato 4 Dance Computer," about which  
7 I know nothing. Apparently it has been funded before and  
8 they want to continue that into the future.

9 They have had a Chicago alliance for VD awareness  
10 under way, and that is to be continued.

11 Peoria frozen blood program, which is simply a  
12 matter of providing frozen blood for people in need, undergo-  
13 ing kidney dialysis and other types of extreme problems.

14 Now, the new programs have moved beyond the existing  
15 problem-oriented record to take this out into ambulatory  
16 care programs that they have in the out-patient program depart-  
17 ment and elsewhere, for the next year, and they provided  
18 evaluation as well as to the effectiveness applied to ambula-  
19 tory care. \$128,000.

20 And then a nice little touch here. The Christian  
21 Action Ministry are concerned about access to care services  
22 of a broad type; inner-city health and social needs. This is  
23 such matters as day-care centers that have a health component,  
24 and they all interact. Not much -- \$44,000, but well-spent  
25 money, in that type of thing.

WHD135

1           They want to hold a series of dialysis consumer  
2 workshops for \$30,000. Again, I think a valuable type of  
3 patient education.

4           And Access Chicago, a rehabilitation institute  
5 program, to take a look across the city and find out how  
6 barriers to handicapped people can be decreased and develop  
7 this as a public monitoring system; just \$12,000.

8           And then, finally, this is interesting because I  
9 would like to know about this project; an institutional cardiac-  
10 vascular center. They are asking for \$100,000 to help organ-  
11 ize this. This is against a background grant of \$38 million  
12 to pull together eleven institutions to develop a multi --  
13 or at least a consortium of activity in cardiovascular dis-  
14 ease.

15           I think that is real original planning. Who has  
16 that proposal? Does anybody have that?

17           MRS. KYTTLE: National Heart and Lung.

18           DOCTOR SLATER: I would like to look at it sometime;  
19 I think this is what cities need to do more of.

20           Finally, they are asking for \$643,000 for statewide  
21 hypertension control program. That is going to be built on  
22 their model, which is going ahead from the present funding  
23 because of the action -- the present action that they are  
24 also funding for -- 350,000 inner-city people who are going  
25

HD-136

1 to be programmed into that computer and hopefully monitored.

2 They have developed a very fine record of starting  
3 little projects and seeing that they work, either spinning  
4 them off or expanding them up to a broader application at  
5 the state level, and clearly they are moving in the direction  
6 of hypertension.

7 Now, looking at all of this in terms of the feasi-  
8 bility, I would say that the feasibility of what they are  
9 asking for this year in new projects have a good chance of  
10 flying, and if they run out of funds by the end of the year  
11 they will spin these off or re-fund them or find ways to  
12 carry them out. That has been their record and it has been  
13 very successful.

14 No question about their relationship with CHP , and  
15 overall, I give this a rating of superior, and I feel that I  
16 would recommend that they have all of the funds they are  
17 asking for, which is only 78 percent of the funding that is  
18 allocable to them, and if there have to be any cuts at all  
19 made, we provide them the chance to cut back where they deem  
20 fit.

21 I doubt if that is going to be necessary.

22 MR. THOMPSON: I guess I have one problem. I wish  
23 somebody would do what the RMP did in the early days when  
24 finally we got sick and tired of giving money to computers  
25 and money to this and that, and finally somebody came in with

1 a big print-out out of a computer, and told us all the money  
2 was being put into computers.

3 And I want to know how much money is being put into  
4 the problem-oriented record. Not only here, which is a  
5 \$3 million grant going up there out of Research and Development,  
6 out of Gerry Rosenthal's shop. I mean, boy! I don't know  
7 where all that money is going.

8 I am not against the problem-oriented record; don't  
9 get me wrong. This is kind of getting over-killed with money.

10 DOCTOR SLATER: Do you think it would be worth-  
11 while for RMP as one of its final acts to lay on a sophistica-  
12 ted -- a professional visit, not just to this program, but  
13 to take a look at the financing of problem-oriented records  
14 or computer-type programs just so as we go out of business  
15 here and face probably a lot more money available through  
16 other agencies in the field, where we are at with this?

17 MR. THOMPSON: Now we are talking about something  
18 else. What does it -- what is the take out of all the RMP  
19 activities?

20 DOCTOR SLATER: Well, you would like to get a  
21 national fix on this; it would be interesting to have a play-  
22 back from the other Regions.

23 MR. THOMPSON: Computerizing the problem-oriented  
24 record? That is a new catchword, along with " quality assur-  
25 ance."

VHD-138

1 MR. CHAMBLISS: I do think that is a rather sub-  
2 stantive question you raised.

3 The Council did look at multiphasic screening in  
4 the same way that you are looking at the computerization of  
5 records. I don't know how we can go about getting a fix on  
6 that; we will raise your concerns, though, and appreciate  
7 your observations here.

8 MR. THOMPSON: Well, you know, we went through  
9 that cervical screening mess for a while. You know, that  
10 was all there, and if you read --

11 DOCTOR SLATER: That's a horse of a different  
12 color. I think that here you are really providing a real  
13 aid to differential diagnosis and the position tracking of  
14 the patient; the cervical diagnosis was prefaced on incorrect  
15 information.

16 MR. THOMPSON: I am not arguing about the validity  
17 of it; I just wonder how much bucks?

18 DOCTOR SLATER: I would like to pick up Mr.  
19 Thompson's concern and say that I feel this program is work-  
20 ing, is producing so well that we should not hold back on the  
21 funding for this, but that the larger concern that is raised  
22 by this type of activity probably will be the basis for a  
23 recommendation for a task review of not what just RMP has  
24 been doing, but an overall picture of the Federal Government  
25 in supporting this type of activity, and what is its meaning,

WHD-139

11 what is the situation today?

2 MR. CHAMBLISS: Doctor Carpenter?

3 DOCTOR CARPENTER: I have some questions about the  
4 problem-oriented record, too. You need a piece of paper at  
5 a staff meeting and you have to have something on the paper  
6 in order to make it go, and I don't understand what the money  
7 is for.

8 MR. THOMPSON: They are all computerized.

9 DOCTOR CARPENTER: What I actually want to raise  
10 is the issue of \$643,000 for screening program for hyperten-  
11 sion.

12 MRS. WYCKOFF: It's a million if you count the  
13 other two projects with it.

14 DOCTOR CARPENTER: Okay, a million. Thank you.  
15 How many previously unrecognized hypertensives will be brought  
16 to treatment as a result of this program, and who will do the  
17 treating?

18 DOCTOR SLATER: Now you are getting into project  
19 detail for which there is not information here.

20 DOCTOR CARPENTER: I am raising a management ques-  
21 tion; I think if those questions have not been dealt with in  
22 the application, there is something wrong with the Region's  
23 management.

24 DOCTOR SLATER: I am assuming that the quality of  
25 the review process, if it is affected by the quality of the

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1 way this is written, can answer that question. I can't  
2 answer it.

3 MR. CHAMBLISS: Do you have comments, Mrs. Kyttle?

4 MRS. KYTTLE: I don't know the preciseness of the  
5 treatment, but I know the protocol and the thrust of the  
6 proposal, and it is an empirical thing.

7 It mobilizes the state into local organizations  
8 that will specifically survey for hypertensives, assure that  
9 they are recognized, identify, treat it in a fashion so that  
10 the rest of the state can get the information, so that the  
11 basic data shows in Illinois that hypertension is epidemic.

12 But no one is organized to attack the problem, and  
13 this is not so much a treatment of the specific patient as  
14 it is organizing the system of care that treats the patient.

15 DOCTOR CARPENTER: What part of that budget is  
16 invested in personnel?

17 MRS. KYTTLE: I can tell you that in just a minute.  
18 \$48,800 -- no, no; wait a minute. I have the wrong one.

19 \$291,000.

20 MR. THOMPSON: How much?

21 MRS. KYTTLE: Out of \$743,000 -- no; excuse me.

22 \$100,000 of it is coming from other sources, and  
23 the \$743,000 is the total cost, but RMP is being asked for  
24 \$634,000. \$291,000 is a line item for salaries and wages;  
25 \$170,000 for equipment, \$28,000 for supplies, \$15,000 for



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1 travel, \$23,000 for rent.

2 It creates local consortia of some type, and  
3 there are charges listed here, and \$25,000 in the other  
4 categories.

5 MRS. WYCKOFF: How is it related to Project 18  
6 and 32?

7 MRS. KYTTLE: This is statewide; 18 is Mid-State  
8 and Southside. Southside is a cooperative B that Illinois  
9 has used as a springboard for a lot of its activity that it  
10 tries out in Mid and Southside, and then comes off a later  
11 timeframe as a national --

12 DOCTOR SLATER: This is not a final program, but  
13 they are estimating a million hypertensives out there; 360  
14 in this experimental program.

15 MR. THOMPSON: My concern now -- well, two questions.  
16 One is that you said the control program is based  
17 on a computer print-out, computer diagnosis.

18 MRS. KYTTLE: That is in a controlled population.

19 MR. THOMPSON: Yes, I understand that, but somebody  
20 said that they were fooling around with some kind of a computer  
21 program in hypertension, and would apply this computer pro-  
22 gram -- which again, unless I misunderstood you, is not com-  
23 pleted yet -- to a statewide control program.

24 DOCTOR SLATER: I think I left that impression.

25 MRS. KYTTLE: The precepts of that program will be

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1 fed to the local boards that will be established, but to  
2 speak to the whole future of the thing, three things have  
3 happened in Illinois all at once, that the Illinois Regional  
4 Medical Program has been waiting for for a long time.

5 They got a new A man; they could not move statewide  
6 well with their former CHP A man, who was replaced by a  
7 former Board member of the Illinois Regional Medical Program  
8 Board of Trustees.

9 The concept of the key factor analysis for planning  
10 has been a philosophy of the program before phase-out but  
11 could not be moved statewide because it met A opposition.

12 It no longer meets A opposition, and they are now  
13 able to move it.

14 They have a new State Health Officer who is a former  
15 RAG member, and she is now working with the program in state-  
16 wide areas that they have not had an opportunity to work well  
17 in before, and most importantly of all for this project, we  
18 are thinking about now the statewide hypertension, and we  
19 have a new Governor that stood off from that -- from matters  
20 medical.

21 No one, not the A man, not the new Public Health  
22 Director, and not the existing RMP could open his door,  
23 because he had other assessments to make. He only now has  
24 established someone in his office to work with the Illinois  
25 Regional Medical Program to develop a regional legislative

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1 package.

2 They got to him with the epidemic hypertension  
3 figures, and he is working with them for a legislative pack-  
4 age that they hope will continue much of this.

5 DOCTOR SLATER: Let me give you the wording on this,  
6 John. I think we may have it here:

7 "The immediate objective is to develop a  
8 state network of hypertension registries which is to  
9 evaluate quantity and quality. CHP B agencies would be  
10 asked to assist in components of the program, which in  
11 turn will mobilize regional resources to determine  
12 registry input, reporting of requirements and action to  
13 be taken in terms of screening, referral, management,  
14 and consumer and professional education.

15 Discussion has begun with state officials,  
16 and heart association legislation."

17 MR. THOMPSON: Is it against the law for CHP B  
18 agencies to run programs? They are not the implementers, if  
19 that is the question that I hear you stating.

20 DOCTOR SLATER: CHP B agencies will be asked to  
21 assist in regional components of the program, which in turn  
22 will mobilize resources and essentially determine registry  
23 input, and so forth.

24 MR. CHAMBLISS: There is a substantive issue here,  
25 I think, and that is one of balance on the part of the RMP,

1 and is there -- and we would like your judgment here -- is  
2 there an over-emphasis in the area of hypertension, especially  
3 since there are 350,000 people to be screened on the computer  
4 set up?

5 I simply throw that out for your assessment. Of  
6 course we would like to have your views here on feasibility.

7 DOCTOR SLATER: My impression of this as I read  
8 it through, and I would like to hear what Mrs. Kyttle's under-  
9 standing is, having visited there, is that they made a speci-  
10 fic decision programatically, sometime ago to go to two  
11 routes.

12 One is to satisfy some of the start-up needs of  
13 what you might call community-action programs, health care  
14 access and the like, which have been reflected in these pro-  
15 grams that have been passed on, and are not free-standing.

16 And the second decision, some of these mass-popula-  
17 tion approaches which are clearly associated with the mechan-  
18 ical improvement of screening and information gathering, so  
19 they can be applied to masses of individuals who are disad-  
20 vantaged, and in order to get to that level of technology,  
21 they need a reasonable level of hardware, as John was putting  
22 forth.

23 Now, I think the question is whether or not this  
24 is incorrect, that at the national level we have decided like-  
25 wise to go this route of kind of the task approach to cancer --

1 originally it was heart disease, cancer, stroke, and now even  
2 more so we have oriented our efforts on a programmatic basis  
3 to such things as cancer.

4 So I have trouble making a decision at this level  
5 based on the -- that they have done the wrong thing. I think  
6 they have taken an experimental approach as part of the  
7 pluralistic way of going about it, and they are not doing it  
8 to the exclusion of all other activities.

9 They could have a lot more Christian Action Ministry,  
10 and I think they might -- I think that would be very effect-  
11 ive and I am sympathetic to that, but I say there, they decid-  
12 ed to put a lot of money into this one orientation.

13 DOCTOR VAUN: I move that Illinois get their full  
14 request.

15 MR. CHAMBLISS: All right. There is a motion on  
16 the floor, and will you cite the dollar level that you are  
17 referring to, please?

18 DOCTOR SLATER: I suggested that they get what  
19 they requested -- 78 percent of what you indicated.

20 MR. VAN WINKLE: \$2,816,935.

21 DOCTOR WHITE: I'll second.

22 MR. CHAMBLISS: It has been moved and seconded  
23 that Illinois be recommended for the level they have requested,  
24 \$2,816,935. Is there further discussion here?

25 DOCTOR MC PHEDRAN: I guess I'll go along with that,

1 but I think we ought to mention we think it is going to be  
2 difficult for them to spend that amount of money on hyper-  
3 tension, on the hypertension identification in that length  
4 of time. I really think it is going to be hard.

5 There are places where similar efforts have been  
6 tried in the past. Doctor Joe Wilburfore, in Atlanta, and  
7 there are a lot of problems with it, and the implications  
8 that Doctor Carpenter makes are a very important one.

9 That is, in places where there are a large number  
10 of hypertensives, particularly in deprived people, it is  
11 extremely difficult to get them into effective treatment  
12 programs, and it always seems a pity to identify a lot of them  
13 and not be able to follow up at all, and I think it takes  
14 away from the luster of the Regional Medical Program that is  
15 engaged in an activity like that that is effectively followed  
16 up.

17 So I think -- I guess that maybe is one of the  
18 things that Doctor Carpenter is concerned about.

19 DOCTOR SLATER: We are more concerned about the  
20 fact that they are attempting to do too much in too short a  
21 period of time rather than that.

22 MR. THOMPSON: Plus the fact we have gone through  
23 cancer detection, we have gone through multiphasic screening,  
24 we have gone through all these kinds of things where everybody  
25 runs around, finds a lot of pathology that nobody sees until

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1 the damned stuff is treated, because it is outside the system.

2 MRS. KYTTLE: Mr. Thompson, not in Illinois. When  
3 I followed up there, Illinois had an interesting spin-off  
4 from the follow-up.

5 It was referring all of these people with identified  
6 hypertension to doctors, and the doctors all said:

7 "You know, I've got sicker people in my office."

8 And so the RAG in Illinois decided that one of the spin-offs  
9 from their next controlled hypertension would be to educate  
10 physicians to treat mild hypertensives. They were willing  
11 to take on the referred critical hypertensives, but they  
12 couldn't get the mild, even though they followed them up,  
13 they hauled them right into the doctor's office and that is  
14 where it fell down.

15 MRS. KYTTLE: But you know, some screening dropped  
16 the man and didn't follow up, but they did not. They followed  
17 up; they re-screened.

18 DOCTOR SLATER: It is very important; even if it  
19 is negative, it is certainly something that helps the system.

20 DOCTOR MILLER: Mister Chairman, could I ask a  
21 question?

22 I have known a good deal about the Illinois program,  
23 and to a great extent the strength of the Illinois program is  
24 directly related to Doctor and Mrs. Creditor.

25 Doctor and Mrs. Creditor are both moving to Urbana,

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1 and though he is going to spend 25 percent of his time on  
2 continuing this program, the magnitude of the effort has got  
3 to be led by somebody better than just a Creditor on 25 per-  
4 cent of his time from Urbana.

5 What assurance do we have that a similar competent  
6 person is going to take over or that he will be able to help  
7 recruit, or maybe can we help them recruit one?

8 DOCTOR SLATER: I apologize for forgetting to men-  
9 tion that.

10 MR. CHAMBLISS: That is very critical, yes.

11 DOCTOR MILLER: The two of them ran that program.

12 MR. CHAMBLISS: Would Staff have any comments on  
13 the efforts in recruitment there?

14 MRS. KYTTLE: What I mean -- well, as I mentioned  
15 in my staff paper, the Board talked with Dean Bloomfield, and  
16 I have talked with Dean Bloomfield.

17 The Board has decided that 25 percent of Doctor  
18 Creditor, which they think will also bring them 25 percent  
19 of Mrs. Creditor for free, is good enough, and they would  
20 rather go with that than to recruit hastily. They are recruit-  
21 ing; they have a Search Committee.

22 Bloomfield is a member of the RAG; he is deeply  
23 involved in the problem-oriented record. That is how a lot  
24 of it got going down in Smithfield or Champagne and Urbana  
25 in the first place. Dean Bloomfield assures the Board, and me,



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1 that that is not going to be a skimpy 25 percent, and that  
2 it would be his assessment that it would be the better of  
3 the two arrangements, at least through December, and recruit-  
4 ment efforts are going on.

5 They have found no one; the Board wants an M.D.  
6 and they are simply not coming up with a successor to Doctor  
7 Creditor, and there is no assurance.

8 MR. CHAMBLISS: I would simply ask the Committee,  
9 is there a judgment that it wishes to express on the issue  
10 of recruitment?

11 DOCTOR WHITE: I would like to agree that the Board  
12 is using some sense, because I can't imagine, knowing what is  
13 going to happen in July of 1975, that they could get anybody  
14 who is really effective as a replacement.

15 DOCTOR CARPENTER: There can't be anyone who could  
16 solve the problem of bringing 66 percent of the hypertensives  
17 in a population to effective treatment that wouldn't make a  
18 national contribution that would be enormous. That will take  
19 someone five years of his life to prove that he's a relative  
20 failure in this area, as a lot of people have done that in  
21 other screening areas.

22 Is there a Project Director here that we have not  
23 heard about who is committed in the long run to the control of  
24 hypertension in a population?

25 DOCTOR SLATER: Doctor Kyttle -- Doctor Koe. Can

1 you talk to that?

2 MRS. KYTTLE: Well, they thought Fred Coe might  
3 have met this, but he can't at this time. Can not be dis-  
4 tracted from what he is doing.

5 Doctor Creditor is temporarily listed as the Project  
6 Director in hypertension. That is temporary, and it is almost  
7 a cloak; because this project creates a State Board, they  
8 have proposed a candidate, and I do not know who it is, that  
9 the Public Health people, the CHP people, the Medical  
10 Committee and the IRMP would proposed to the Governor's  
11 office, and now that the Governor's office has gotten  
12 involved, and this they look at as the possibility of the pro-  
13 ject for the hypertension effort being the continuing  
14 Regional Medical Program Director.

15 So they are approaching it cautiously, because the  
16 man has to be ratified by so many different interests.

17 MR. CHAMBLISS: We have a call for the question?

18 The motion has been to recommend a level of funding  
19 for Illihois at \$2,816,935.

20 All those in favor?

21 (Chorus of "Aye")

22 Those opposed?

23 (No response)

24 One in opposition, and the "Aye's" have it.

25 I would say that with regard to Illinois, the

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discussion will be noted and taken into account, as presented here by the members of the Committee.

I would call your attention to one thing, that our workload for today is still one short, in terms of the number of Regions to be reviewed.

The last Region for today is Louisiana; I would have a hope that we might finish by ten after 6:00. Is it your pleasure to continue? Let's go.

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## REGIONAL MEDICAL PROGRAM REVIEW

## LOUISIANA REGION

MR. CHAMBLISS: All right, the reviewers for Louisiana are Doctor White, who will be supported by Mr. Zivlavski.

Doctor White, will you proceed, please?

DOCTOR WHITE: I am sorry that this comes at the end of the day, because I have yet to make up my mind what should be done about Louisiana; as I was saying earlier to Doctor Vaun, I had a feeling I was in an intensive care unit, and I really had a patient who had died but was on a respirator and I didn't quite know how to pull the plug.

Yet, on second thought, perhaps there is a feeble beat going on there that I didn't detect at first glance, and maybe something can be salvaged.

Well, with that as a preamble, you can see my confusion.

Louisiana has had a checkered career in the past. It had a Regional Medical Program, but it has never been awarded a triennial status.

It was a difficult chore to even get the concept accepted in the state of Louisiana for many years. Doctor Zabatlyea took on the job, I forgot when -- sometime ago; he had been President of the State Medical Society, he was an acceptable individual, and on the basis that they knew him and

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1 on the basis t hat the thrust would be on planning initially,  
2 it got off the ground, and in reality the Regional Medical  
3 Program has functioned there for a number of years much like  
4 the CHP agencies were supposed to function.

5 And on a site visit a year or two ago, this was  
6 noted, and I was asked then that a Regional Advisory Group  
7 begin to become more action-oriented. At the same time we  
8 became aware that Doctor Zabatlyea was really running this  
9 thing; the Regional Advisory Group was sort of there in name  
10 only.

11 Mr. Smith then took over as Regional Advisory  
12 Group Chairman and turned things around, but only at the time  
13 Washington was turning around, and this disillusioned them  
14 totally. Doctor Zabatlyea resigned from his position, and I  
15 guess is now donating some amount of time, and a doctor whose  
16 name I don't recall -- a dentist -- is filling in for him.

17 The other problem in Louisiana is -that there are  
18 two systems of medical care, and the two seem not to be meet-  
19 ing. Although, as I have down here, there had been some  
20 change under way when the axe fell.

21 So the leadership is in question at the present  
22 time. This report that we have before us was prepared by a  
23 task force, signed by Doctor Zabatlyea but obviously not the  
24 product of his thinking. It is rather disorganized, it does  
25 not follow any sequence that permits you to see the program as

1 a whole..

2 The staff has been reduced considerably; there are  
3 four and a half professional people listed with presumably,  
4 as I mentioned -- the Regional Advisory Group began the turn-  
5 around, but I have the feeling that now they really developed  
6 phase-out plans and when this new concept came along they  
7 kind of even delegated this development they had not expected  
8 to others.

9 I am not sure from the narrative how often the  
10 Regional Advisory Group has met, and as I said, I do feel  
11 that probably their work has been delegated to staff in some  
12 existing communities.

13 The past performance of this has not been good;  
14 they have begun some outreach programs in some of the rural  
15 areas, they have begun some patient care program activities;  
16 they are proposing others, and -- in this present package.

17 They have participated in the established Emergency  
18 Medical Service programs in the state, the two direct efforts  
19 toward hypertension, quality assurance and outreach counsel-  
20 ing.

21 They do recognize, and I guess they have been  
22 attuned to this for some time, that they may not get money  
23 for more than a year at a time, as they have in the past, so  
24 I guess it is nothing new to them.

25 Their efforts are reasonably feasible on a year's

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1 budget period.

2 One plus is that the state itself has finally  
3 reorganized its health-care delivery systems, evaluation  
4 systems, and has a centralized state agency which will take  
5 on and direct, presumably, many of the things that are going  
6 on in the Comprehensive Health Planning agencies, many of the  
7 things that have been going on in the Regional Medical  
8 Programs.

9 This was accomplished in 1972 when this consolida-  
10 tion was under way, and it seems to be accepted; funded by  
11 the state, at least partially, and for that reason, if nothing  
12 else, I would suggest that this request by Louisiana, even  
13 though we know the leadership is not good, at the present time,  
14 and that past performance has not been good, that there is  
15 some merit now that the state has begun to move in the focused  
16 direction, in not cutting the rug out from under them, with  
17 the hope that at least some amount of money will continue the  
18 emphasis toward this simple direction of the health services.

19 That is the only justification I can find at all  
20 for recommending any sum of money for Louisiana whatsoever.  
21 Some of their projects are adequate; a couple of them are  
22 rather biased, I think because the Director at the moment is  
23 a dentist. They have a couple of fairly sizable dental pro-  
24 grams, including a mobile bus that is going to go out and fix  
25 teeth, I guess.

1 We have another strange one, or at least it seems  
2 funny to me; they are going to establish a Midway assessment  
3 Region at the Charity Hospital, and as I read some of the  
4 comments, this is to move the patients out of the wards into  
5 another place, because these are patients they can't get rid  
6 of -- families don't want them back, they don't have any  
7 money to pay nursing care, and that is one way out. And  
8 the Midway Assessment Region is for patients flowing the other  
9 way, that come in through the Emergency Room and can't be  
10 evaluated adequately, and they have to be placed in this area  
11 and then moved into the hospital or someplace eventually.

12 But anyway -- they are at least making some efforts  
13 at bringing some services to people who are denied services  
14 at the present time.

15 Another one at the Earl K. Long Hospital -- they  
16 indicate that there is a 60-day waiting period for patients  
17 to be seen in the clinic, and they are asking a modest sum  
18 of money to open up night-time clinics and weekend clinics  
19 so that this waiting period might be shortened, and I guess  
20 that is reasonable.

21 DOCTOR SLATER: Well, that is straight operational  
22 patient-care delivery.

23 DOCTOR WHITE: Well, it is going to support some  
24 staff work to help administer that.

25 MR. THOMPSON: You can't do that with a modest sum



1 of money.

2 DOCTOR WHITE: Well, I get through saying these  
3 things; it's a bad bag all around, and yet I don't feel that  
4 it should be denied survival for as long as the rest of them  
5 are going to survive, in the hope that one more year might  
6 see something turn around even more.

7 They have asked for \$985,000, which is only 77  
8 percent of the targeted funds, which would go to them on a  
9 formula basis.

10 Mr. Zivlavski, maybe you have some comments before  
11 I come up with recommendations?

12 MR. ZIVLAVSKI: There are several negative comments  
13 which you made, and I hope I can cover these comments.

14 The phase-out of the Louisiana Regional Medical  
15 Program was taken very seriously by their Board of Directors;  
16 as of July 1st of '73, Doctor Zabatlyea was only part-time,  
17 and a -- business management was basically left to the Board  
18 staff.

19 This was a non-profit corporation, by Louisiana  
20 law; they have to notify the state 60 -- six months in advance  
21 before terminating the corporation.

22 At that time Doctor Zabatlyea did reduce his staff;  
23 he was on approximately 20-25 percent. He remained as a part-  
24 time coordinator.

25 In late June things did change. In September, things

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1 looked a little bit better when \$17.1 million was released  
2 from the Division of Regional Medical Programs. The Board  
3 of Directors, instead of submitting official notice to the  
4 state that they were going to terminate, kind of put the cor-  
5 poration in neutral gear and decided to wait.

6 It sounds like some story, but I am trying to get  
7 it in the right sequence so that you will understand.

8 As more money was released from DRMP, Doctor  
9 Zabatlyea had hired several people to the program staff; when  
10 it became clear that the lawsuit was won by the Regional  
11 Association, the Board of Trustees again, for the corporation,  
12 gave Doctor Zabatlyea another nod to go ahead and hire addi-  
13 tional staff members.

14 During this time we made a site visit; Mr. Posta  
15 and I, in November 1973. The National Council was concerned  
16 about that; we made a site visit, we discussed this with  
17 Doctor Zabatlyea in February of this year. He indicated that  
18 he was going to resign from the corporation; two months ago  
19 he handed in his resignation and the grantee would not accept  
20 it.

21 He has increased his time back to 50 percent; he has  
22 rehired several of his staff. Several of the staff have been  
23 Project Directors with the Louisiana RMP when they worked  
24 for the CHP agency and have joined the staff, and what you  
25 see here basically are eight or nine -- maybe ten people; I

1 think it is 8.6 full-time equivalents, that they have now  
2 and they are asking for \$1.25 million.

3 Doctor Cook, the Deputy Director, is 100 percent;  
4 he did come back to fill in the gaps when Doctor Zabatlyea  
5 was not there.

6 So it has been slow; the staff has been slow in  
7 building up. The present situation now is -that he is going  
8 to remain 50 percent. For how long I am not sure.

9 I would rather not comment on anything else.

10 MR. CHAMBLISS: I would if I may just make this  
11 observation to the Committee.

12 You should know that the staff has been very much  
13 concerned about this Region for some time, and that there is  
14 a concern beyond the staff as it relates to the CHP-RMP  
15 issues in Louisiana.

16 This has been one of the Regions that both Doctor  
17 Paul and Mr. Rubel have been concerned about the CHP-RMP  
18 relationships in, and I say that only to give, perhaps,  
19 Staff an opportunity to comment on those relationships between  
20 RMP and CHP and this Region.

21 DOCTOR WHITE: I should have mentioned that, too.  
22 That is apparent in the application, at least the communica-  
23 tions from some of the CHP agencies, that people there are  
24 trying to stake out territories. They want to be the surviv-  
25 ors and not RMP. They impose conditions on RMP, or try to,

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1 which I thought were totally unrealistic, in demanding that  
2 they come and present their proposals for review, and they  
3 were going to go after technical merit of the whole thing,  
4 as we were trying to avoid.

5 All that sort of thing instead of trying to determine  
6 -- yes, this is consonant with what we should be doing.

7 So I guess I also got up on my hind legs on that  
8 thinking, that I have invested time and effort in RMP and I  
9 would rather see them survive than CHP, and I shouldn't say  
10 that.

11 MR. ZIVLAVSKI: I would like to add some comments  
12 on the CHP comments. On the yellow sheets we have two para-  
13 graphs; one speaks to the New Orleans Health Planning Council,  
14 and the other speaks to the Northwest Louisiana area Health  
15 Planning Council.

16 The concern that Doctor White discussed concerning  
17 the New Orleans area; they notified the Project Directors  
18 the Friday evening before the CHP Monday morning meeting --  
19 this one, their meeting on May 28th. Doctor Cook, the Deputy  
20 Director is meeting with the CHP agency, trying to resolve  
21 this.

22 The second concern is the Northwest area, which is  
23 made up of eight parishes in the Northwest part of the state.  
24 There is a three-page summary from this agency; basically it  
25 is probably the most negative letter in the whole application,

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1 but when you read the whole letter you realize the territory  
2 that the Northwest area takes into account.

3 They have listed 12 projects here which they received,  
4 and they are all negative comments for these projects. None  
5 of these 12 projects fall into the area which their CHP  
6 agency has.

7 It is a mess, in that they received a bunch of  
8 project grant activities, which they really should not have  
9 received.

10 This will help you alleviate some of the concerns  
11 about the Northwest area. In addition, the Deputy Coordinator,  
12 Doctor Cook, is also meeting with this group on May 27th, I  
13 believe, to get this area straightened out.

14 They were favorable in three of the arthritis  
15 proposals, which this group is not reviewing, and they were  
16 favorable in another project, which again was not in their  
17 area anyway.

18 The two projects which head into the Shreveport  
19 area were continuation projects, and these were projects  
20 Number 42 and Project Number 44. These were continuation  
21 projects in this grant request in the Shreveport CHPH agency  
22 voted for approval for these two projects previously, and  
23 this is in the \$71.1 million that was awarded for October  
24 to December, so I hope we can take care of Mr. Rubel's  
25 concerns in addressing the RAG and the CHP areas.

1 I think we have taken care of these major concerns.

2 MR. CHABMLISS: Thank you.

3 We would now entertain a recommendation, Doctor  
4 White.

5 DOCTOR WHITE: Well, unless you would prefer further  
6 discussion of the CHP issue, though I don't know that there  
7 is anything further to discuss. There is an obvious influence  
8 of some kind there that has to be resolved. I don't think  
9 this Committee can resolve it. We have already identified it  
10 anyway.

11 I think that RMP has done some good work down there;  
12 Doctor Zabatlyea was a dedicated fellow, and I think he has  
13 done a lot of work the CHP should have been doing, and there  
14 are some things to be completed, and I think it would be a  
15 shame to terminate it at this time, and therefore I would move  
16 that this be approved at the requested level, at \$985,212.

17 DOCTOR MILLER: Second.

18 MR. CHAMBLISS: It has been moved and seconded that  
19 the level to be recommended for Louisiana be at \$985,212.

20 Is there discussion?

21 I hear a call for the question. All those in favor?

22 (Chorus of "Aye")

23 Opposed?

24 (No response)

25 The "Aye's" have it; the motion is carried. This

1 panel has completed one-half of its work. I wish to commend  
2 it for its patience, its stamina and its participation, and  
3 I would also like to say to the Staff and to our Recorder  
4 that we appreciate your patience and stamina also.

5 (Whereupon, at 6:10 P.M. the Committee recessed  
6 to 8:30 A.M. May 23, 1974)

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