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WHAT SPECIFICALLY IS A REGIONAL COOPERATIVE ARRANGEMENT?

A Regional Cooperative Arrangement or regionalization is the process whereby the benefits of scientific advance can be efficiently and effectively brought to those in need by the full array of health resources. Such a process can only be successful if it is based upon the commitment of individual, professional, institutional, and governmental resources which is voluntarily given. There is no longer any question that Regional Medical Programs is a mechanism which can engender this voluntary commitment across the entire spectrum of health resources.

HOW LONG WILL IT TAKE TO MAKE THESE LATEST ADVANCES AVAILABLE TO ALL OUR PEOPLE AND WHAT WOULD THE COST BE?

The full development of Regional Medical Programs to accomplish this objective will probably take many years. The mechanism being developed will be utilized continuously to translate into improved health services the continuing advances of medical knowledge. While we can make some projections of costs for the next five years, a more accurate understanding of what proportion of our health resources should be devoted to this purpose will emerge from the initial experience now just beginning. It is the intent of the Regional Medical Programs to stimulate these improvements in health care, but the ongoing costs of the improved services will continue to be paid for out of the normal mechanisms for financing health-care costs after the improved capabilities have been integrated into the broader health-care system. It is not the purpose of Regional Medical Programs to pay for certain health-care services on a permanent basis.

HOW LONG WILL THE REGIONAL PROGRAMS CONTINUE AND WHAT IS THE PROJECTED FEDERAL ROLE?

The goal of each Regional Medical Program is to make available to everyone within the Region the best possible patient care for heart disease, cancer, stroke and related diseases. This goal can be achieved only over a process of many years, perhaps decades. It is reasonable to expect that the role the Federal Government is now playing would have to continue in order to assure the viability of Regional Medical Programs, although the specific activities which are funded under P.L. 89-239 would alter as the needs of the Regions change over time.

HOW IS LOCAL CONTROL OF A REGIONAL MEDICAL PROGRAM INSURED?

Each Regional Advisory Group provides overall advice and guidance in the planning and operation of the Program. It is actively involved in the development of regional objectives. And it by law must review and approve any operational proposal before it can be submitted to the Federal Government for possible funding.

Each Regional Advisory Group is broadly based including physicians, medical center officials, hospital administrators, medical society members, other health professionals, and voluntary health agency representatives, as well as members of the public.

(If the Committee is interested, I can provide more detailed information on the membership of the Regional Advisory Groups for the Record).

ISN'T PUBLIC LAW 89-239 PRINCIPALLY A CONTINUING EDUCATION PROGRAM?

The object of Regional Medical Programs is to influence the present arrangements for health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke and related diseases to be available to all. To reach this goal, a multifaceted program is necessary. Continuing education of the practicing physicians, members of the allied health professions and members of the public, is certainly an important facet. Other aspects of the program--health services research, demonstrations and training, and the care of patients--are other equally important facets. Since the ultimate objective of Regional Medical Programs is improved care for patients with Heart Disease, Cancer, Stroke and Related Diseases, this objective cannot be reached by any one single approach.

ISN'T THE PRINCIPAL PURPOSE OF THIS PROGRAM RESEARCH?

The principal purpose of this program is to influence health services in a manner that will permit the best in modern medical care for heart disease, cancer, stroke, and related diseases to be available to all. In order to reach this objective without undue interference in the patterns of medical practice into better means for making the advances of medical science more widely available, research becomes one effective tool for Regional Medical Programs. Other effective tools include demonstrations, programs for continuing education and training programs. Research and specifically health services research will be a powerful instrument for Regional Medical Programs but the total effect of these research activities will be increased by integrating them into the program so that research can interact with the other activities.

WOULDN'T IT BE BETTER IF THERE WERE NO LIMITATION BY DISEASE CATEGORIES IN THESE PROGRAMS?

These disease problems, which cause more than 70 percent of all deaths in the United States and afflict millions more, constitute an appropriate nucleus for the development of an effective broadly based regional cooperative arrangement among the health-care resources. Because of the tremendous scope of these disease problems, they have a major impact upon the total range of personal health services; and in order to plan effectively for these diseases, it is often necessary to consider the entire spectrum of resources available for personal health services. However, these major disease areas have served as useful action objectives for the cooperative arrangments and relationships being established in the Regional Medical Programs. As these initial actions prove the effectiveness of these regional arrangements for these disease problems, the experience can also be useful in accomplishing other health purposes. At that time it may be appropriate to consider an expansion of the scope of this legislation, but at this time the focus on these major diseases is appropriate and effective.

HOW MANY AND WHICH RELATED DISEASES ARE SUPPORTED AS A PART OF REGIONAL MEDICAL PROGRAMS?

Several related diseases were specifically mentioned in the legislative history of P.L. 89-239, such as hypertension, kidney disease and diabetes. The relationship of other diseases, such as emphysema, to heart disease can be established. We have required, however, that all grant applications requesting support for activities in the area of related diseases make the case for why the proposed activities relate to heart disease, cancer, or stroke. For example, support would not be provided for kidney disease activities which sound professional judgment could not relate to problems of the cardiovascular system.

WOULDN'T IT BE BETTER IF FUNDS UNDER P.L. 89-239 WERE DISTRIBUTED ON A FORMULA GRANT BASIS?

It would not be at all feasible to administer this legislation on a formula basis. Regions and their programs are developing at different rates and in different ways. Accordingly, it would be difficult if not impossible to develop a formula which would be flexible enough to take these varying rates of progress into account on an equitable basis. This is especially important when one takes into account the fact that the boundaries of each region are not determined here in Washington, but by the regions themselves. Consequently, there is great diversity in their size, population, and complexity. Furthermore, the flexibility inherent in this process of self-determination makes it likely that regional boundaries may be modified as the program develops.

A formula distribution of funds would have the effect of stultifying Regional Medical Programs.

Why has the program developed so slowly?

The rate of increase of obligations for RMP grants has been rapid--$2.5 million in fiscal year 1966, $29 million in fiscal year 1967, and $54 million in the current fiscal year--and obligations of nearly $100 million are projected for fiscal year 1969. The delay has been in the initial awards of planning grants to the Regional Medical Programs. This delay is the result of the difficulties involved in organizing diverse interests in the health field into a workable cooperative arrangement that calls for new relationships and new perceptions among the participants. The staff of the Division and the National Advisory Council felt that it was important to avoid the pressures of a crash effort. Instead, they sought assurance that the Regional Medical Programs had worked out its initial organizational problems before a planning grant was awarded. In most instances development of the RMP has been rapid once the planning phase has been launched and effective leadership recruited.

WHY HAVE THE ADMINIST[illegible] APPROPRIATION REQUESTS BEEN SUBSTANTIALLY LESS THAN THE AUTHORIZATION LEVELS?

This program did not begin to really function until the latter part of the first year of its authorization. Therefore, it was appropriate to request only partial funding at the start of the program. Subsequent funding has been sufficient to sustain the early development of the program. Indeed the actual rate of increase in the obligation of funds and the projected increase in the President's Budget for fiscal year 1969 represents a sizable and consistent growth in program activities. Much of the initial time was spent within the regions in establishing the organizational and planning base for the programs. Now that this time-consuming process has been accomplished in most areas, the programs are moving forward more rapidly.

WHAT IS THE STATUS OF THE FUNDS WHICH WERE EARMARKED BY THE CONGRESS LAST YEAR?

In the last session of Congress, the Appropriations Committee directed Regional Medical Programs to support programs in coronary care, community hypertension programs, community detection and treatment programs in stroke, chronic pediatric pulmonary disease centers and chronic pulmonary disease programs for adults (emphysema) to the extent possible. The appropriation included one million dollars for each, except chronic pulmonary disease centers, $750,000, and emphysema programs, two million dollars.

The regions were advised of Congress' intent in a special communication forwarded to each region in December. The Regional Advisory Council made special plans so that programs submitted for these earmarked funds could receive prompt and critical reviews.

Although significant interest was generated in many regions, each expressed concern to insure the mechanism for local initiative and local review. As a result the Division has considered only programs which have had the endorsement of the Regional Advisory Groups.

The congressional intent was largely anticipated in most regions. Therefore, regions were able to respond promptly because of planning which by and large had predated the earmarked funding. In fact the program had previously funded activities in coronary care units in small hospitals and coronary care unit manager training programs, but had not funded activities in the areas of mobile units or pre-coronary care. Three regions had undertaken planning in the area of mobile units and were able to develop proposals. No regions, however, had significant planning in the area of pre-coronary care and we have thus far been unable to support activities

in this area. We anticipate, however, that in the very near future we will be in receipt of proposals in this important area. Similar experience has occurred in the area of stroke detection and treatment programs and community hypertension treatment programs. Planning in each case was catalyzed by the region's awareness of congressional interests in these specific areas.

The National Advisory Council for Regional Medical Programs has met once since the receipt of the earmarked funds. In that meeting, programs in stroke and coronary care obligations totaling $2.8 million were made. The Council has scheduled a second and final meeting for April 8, when commitments in all areas will be made. On the basis of proposals now available the program anticipates expenditure of funds for Regional Medical Programs in the area of earmarks in excess of the amounts designated by Congress.

How many lives have been saved by Regional Medical Programs?

This question clearly focuses on the purpose of the program--to improve the care of patients with heart disease, cancer, stroke and related diseases. The ultimate measure of the success of the program will be reflected in one measure by increased longevity. Longevity will, however, not be the only measure. Before the impact of the program can be tested, many other factors will have to be taken into account. Has care been made more available, has care been made more accessible, has care become comprehensive and continuous? In short, are those living longer doing so in comfort? Are those living longer enjoying meaningful lives? Longevity that is an extension of misery has little to recommend it.

Eight programs are operative. On the average these have functioned for less than 8 months. The effect of Regional Medical Programs on mortality and morbidity statistics cannot be measured in this brief period. Time will be required to answer the question. Our expectation is that the answer will justify the support that the program has received. Further, our expectation is that longevity will be achieved and the increment to life will be meaningful.

WHY ARE THE REGIONS SO DIFFERENT IN SIZE AND POPULATION?

The character, magnitude, and complexity associated with heart disease, cancer, and stroke vary across the country. Similarly, the availability of resources which can deal with these problems also is not uniformly distributed. Additionally, there was no rigid plan which would have artificially determined what area each Regional Program must service. Consequently, each Region has had to fashion an area in its own way, basing its decisions on the problems it faces and the resources it can bring to bear in making progress against them. Some were concerned that this process might result in areas of the country not being included in any Region. This has not occurred. In fact some Regions overlap at their respective peripheries, and we think that is fine.

HOW MANY PERSONS ARE EMPLOYED IN THE AVERAGE REGIONAL MEDICAL PROGRAM?

Based upon experience to date, it is estimated that the average size of the staffs of the 54 Regional Medical Programs is 33. This figure is arrived at through the following data:

		Average Size	Nos. of Regions
I.	Planning		
	1. Regions in 02 planning year	26	33
	2. Regions in 01 planning year	11	15
II.	Operational	92	8

Total Staff

Planning	1023
Operational	736
	1768

WHAT HAS BEEN THE INVOLVEMENT OF THE GENERAL PRACTITIONER IN REGIONAL MEDICAL PROGRAMS?

General practitioners, like practicing physicians in other specialties, have been involved in all levels of Regional Medical Programs. Since the beginning of the program, there has been a representative of the AAGP on the National Review Committee. At the regional organizational level general practitioners are among the 1253 physicians on Regional Advisory Groups and subcommittees; at least three program coordinators are general practitioners. Many of the operational programs have been designed specifically for those physicians practicing in areas remote from the medical centers.

WHAT VOICE DOES THE CONSUMER HAVE IN THE DEVELOPMENT OF A REGIONAL MEDICAL PROGRAM?

All regional advisory groups have representation of "members of the public familiar with the need for services to be provided under the program" as required by the law. Often these members represent specific consumer groups, such as labor unions. The Regional Medical Program Guidelines specify that the program shall be developed to serve the needs of the people of the region for improved medical care for these diseases rather than to serve the interests of the medical institutions and personnel involved in the program. A breakdown of the types of representation present on the regional advisory groups can be supplied for the record.

HOW DOES THIS PROGRAM AFFECT THE INCREASING COST OF MEDICAL CARE?

The regional scope of these programs and the involvement of the broad spectrum of health resources within the region provides a means for taking specific action to share limited health manpower and facilities in maximizing the quality and quantity of care and service available to the regions population. The stimulation of this process of regionalization of complex health services serves the need for more efficient and economical functioning of our health-care system. The training and continuing education activities of the Regional Medical Programs also contribute to this goal by improving the effectiveness of the current activities of scarce health manpower. Regional Medical Programs are also exploring the utilization of computer technology and automated procedures for making available improved services while at the same time moderating the increase of costs of those services. Some regions are also utilizing systems analysis and operations research techniques in developing regional activities with specific attention to the efficient and effective utilization of resources (specific examples can be provided for the record).

HOW MUCH WILL REGIONAL MEDICAL PROGRAMS COST DURING THE OPERATIONAL STAGE?

Given the great diversity in the needs, population to be served, and resources available in each of the 54 regions, it is very difficult to answer this question in terms of an "average" region. On the other hand, based on the operational awards which have already been made, regional estimates of program growth; and our estimates of the funds which will be needed, it is probable that by Fiscal Year 1973 each Regional Program would require approximately ten million dollars if Regional Medical Programs are to be able to achieve the goals which are stated in the legislation. This level of program operation is consistent with the _Surgeon General's Report to the President and the Congress_.

WHAT IS THE RELATIONSHIP OF OTHER PRIVATE AND PUBLIC FUNDING TO FUNDS AVAILABLE UNDER P.L. 89-239?

The aim of RMP is to help make the best care for heart disease, cancer, stroke, and related diseases available to all; but it is obviously not the intent to finance all of the costs of that care. Progress reported to date from the Regional Medical Programs around the country indicates that the cooperative arrangements already being developed provide a framework and a favorable climate for creating new relationships among existing and emerging health programs in sources of financing within the Regions. For example, the Regional Medical Programs themselves cannot directly pay for the cost of medical care except as they are incident to research, training and demonstration of patient care. However, the programs being developed are intended to influence patient care activities which are funded under other sources, such as Medicare, Medicaid, and similar health and welfare direct assistance programs.

The following are some specific examples of contributions from other sources of funds to activities initiated by the Regional Medical Programs.

- In the Albany Region, the RMP will furnish equipment for "learning centers" in community hospitals. The first eight hospitals to participate are providing the space, lighting, heating, and personnel supervision. In addition, their commitment includes a contribution of a minimum of $800 annually to share in the cost for production of educational audiovisual instruction materials.

- The Oklahoma Regional Medical Program, concerned with the shortage of skilled manpower in the State, is providing the impetus for the development of a regional health career recruitment program. Fifteen cooperating private and public agencies in the State have pledged yearly contributions, totaling $28,000 to support this program.

- In the Albany Region, some thirty community hospitals are contributing one-half of the programming costs to permit their medical and nursing staff to participate in post-graduate education conferences via a two-way radio network, originating from the Medical Center.

- In the State of Alaska, there has been no existing medical library adequate to the needs of the physicians and other health team professionals. To establish a library to meet this critical need, the Anchorage Medical Association membership agreed to assess themselves to provide the basic financing, the Alaska Native Medical Center provided the space and the services of a full-time librarian. With this local commitment, an application was made to the Regional Medical Program to provide the additional support that would add new text books, journals and a copying service, never before immediately available to the practicing physician in Alaska.

HOW HAVE YOU KEPT FROM INTERFERING WITH THE PRACTICE OF MEDICINE?

These programs are concerned with stimulating desirable changes and improvements in the medical services in these disease fields and in promoting the wider availability of improved services. These constructive changes are not interfering with the practice of medicine but are supporting and catalyzing existing forces and trends which were already underway and being increasingly recognized by the health professions. This positive and constructive approach in stimulating improvements without undue interference is supported by the wide participation of practicing physicians in the development of the Regional Medical Programs, including the active involvement of medical societies at the state and local level.

WHAT ACTION HAS BEEN TAKEN TO IMPLEMENT SECTION 907 OF P.L. 89-239?

In carrying out Section 907, the Division of Regional Medical Programs has sought the advice of its National Advisory Council, experts in the subject diseases, as well as national professional organizations.

The American College of Surgeons several years ago established a Cancer Commission to supervise the evaluation of hospitals in the field of cancer, the purpose of which was to improve the diagnosis and treatment of cancer throughout the country. This Commission includes in its membership representatives of the principal surgical specialties and other professional organizations particular interested in the field of cancer, and also the National Cancer Institute, the Cancer Control Program of the National Center for Chronic Disease Control and the Veterans Administration.

Accordingly, the Division of Regional Medical Programs has entered into a contract with the American College of Surgeons, to develop "Guidelines for Cancer Care" which would define those characteristics of staffing, equipment and organization which should be present in an institution capable of providing the highest quality of care in the field of cancer. The American College of Surgeons established a committee of experts chosen from the membership of the constituent organizations under the chairmanship of Dr. Warren Cole, has developed draft guidelines and is now testing their practicality.

These guidelines will eventually be made available to each Regional Medical Program to assist in the evaluation of medical facilities in that region and identify those needs which might be met on a regional basis

through RMP activities. The guidelines will also be made available to the hospitals of the United States as a basis for their self-evaluation and guidance in future development.

Discussions are now in progress with all professional and voluntary organizations and agencies of the Federal Government which have reason to be interested in developing similar guidelines in the field of heart disease. All those contacted have expressed enthusiasm in participating in this effort. The leaders of the American Heart Association and the American College of Cardiology reached agreement in San Francisco on March 1st regarding their relative roles in such an undertaking. It is hoped that a contract can be let for this purpose by the end of April. A similar contract will then be negotiated in the field of stroke.

HOW HAVE YOU IMPROVED THE HEALTH FACILITIES OF THE NATION?

Regional Medical Programs are contributing to the improvement of the Nation's health facilities by enabling health facilities to be utilized both more effectively and efficiently.

- By providing physical linkages in the form of computer and electronic networks between medical centers of excellence and community hospitals and practicing physicians, particularly those in rural areas or otherwise "isolated" circumstances, it is making available and expanding scarce and sophisticated facilities, skills, and techniques for diagnosis and treatment.
- By provision of new and often expensive equipment and renovation and remodeling of the space required to house such, it is upgrading the diagnosis and treatment capability of many community hospitals and thereby more efficiently utilizing scare facilities
- For example, in Missouri three small rural hospitals have been hooked into the University of Missouri computer center to improve radiological diagnosis and to examine the possibility of ultra sound in diagnosis and therapy. In addition, data phones with facilities for transmitting electrocardiograms to the Medical Center are being installed in physicians offices and clinics in rural areas to provide instantaneous analysis for areas where competent ECG readings were unavailable heretofor.

There are numerous demonstrations of new models in the techniques of patient care including radiological diagnostic and coronary care units. Regional Medical Programs has provided funds for the establishment or enlargement of almost twenty such units of both kinds, thus making available to patients the best possible care as well as providing facilities for training medical and paramedical personnel.

HOW HAS THE HEALTH MANPOWER OF THE NATION BEEN IMPROVED?

Given the shortages of health manpower, Regional Medical Programs have placed high priority on training activities during their initial stages of development. The Regional Medical Program mechanism offers a unique opportunity for more efficient manpower utilization. For example: (1) the development of new techniques for diagnosis and treatment that increases the productivity of existing manpower; (2) the development of new types of manpower; and (3) the more efficient division of labor among different levels of manpower and among the several parts of the regional framework. Additionally, the use of operations research and systems analysis in the development of Regional Medical Programs may contribute to development of new ways to use health manpower. Applications of these analytical and management tools are already under development in a number of regions.

HOW DO YOU INSURE THAT FUNDS AWARDED UNDER P.L. 89-239 DO NOT SUPPLANT OTHER AVAILABLE SOURCES OF FUNDS?

Each operational activity is subjected during the review process by the Review Committee, the National Advisory Council on Regional Medical Programs, and by the staff of the Division of Regional Medical Programs to analysis and evaluation. Part of this analysis involves a determination of the possible availability of other Federal or non-Federal funding which might be more appropriate for the activity than P.L. 89-239 funds. There have been several activities which have <u>not</u> been funded as a result of the availability of other funding mechanisms.

UNDER WHAT CIRCUMSTANCES ARE PATIENT CARE COSTS PAID UNDER P.L. 89-239?

Patient care costs under Regional Medical Programs are paid only if the care is incident to (that is, bears a direct relationship to) the principal activities of the Regional Program. Furthermore, no patient care costs may be paid unless the patient is referred by a practicing physician.

To what extent have the medical schools dominated the Regional Medical Programs?

This program is intended to assist in bridging the gap between advance of medical science and its application to the benefit of people. Since the medical schools are the primary institution concerned with the development and transmission of new knowledge in medicine, it is logical and essential that they be thoroughly involved in the Regional Medical Programs. The establishment of an improved relationship between the capabilities of the medical schools and the health care needs of their regions is one of the objectives of the Regional Medical Programs. Neither the purposes of the Regional Medical Programs nor the interests of the medical schools would be served if the medical schools dominated the Regional Medical Programs to the exclusion of other health interests. In reviewing applications the National Advisory Council has looked for the possibility of dominance by one institution or one type of institution, and applications which seem to indicate this type of domination have not been found acceptable. Regional Medical Programs calls for the development of a new type of relationship between the medical schools and the other health resources of the region that utilizes the unique capabilities of the medical schools and at the same time preserves their ability to perform their primary functions of teaching and research.

HOW MUCH MONEY HAVE YOU GIVEN TO MEDICAL SCHOOLS?

Public Law 89-239 authorizes the Surgeon General upon recommendation of the National Advisory Council to make grants for the planning or establishment of Regional Medical Programs. In order to insure regional cooperation there can be only one grantee per region. Medical schools are only one of a number of agencies, institutions, and non-profit corporations which have either singly or in combination become a Regional Medical Program grantee. It is also important to remember that in a high proportion of instances the grantee, while accepting the fiscal and program responsibility for the funds which are awarded, does not itself spend these monies. Rather, the numerous agencies which actively cooperate in the Regional Program are the recipients of these funds.

(If the Committee would be interested, I can supply for the Record an analysis of the types of agencies which cooperate in Regional Medical Programs as well as which have become Regional Medical Program grantees).

WON'T THE LIMITATIONS OF PROFESSIONAL AND TECHNICAL MANPOWER PREVENT THE PROGRAM FROM DEVELOPING AS RAPIDLY AS YOU HAVE PROJECTED?

Manpower shortages face the health service industry and will remain a reality for the forseeable future. The need to conserve and use wisely these scarce resources are if anything a spur to the development of Regional Medical Programs. To the extent, however, that competent people are needed to administer the program in the region shortages may retard development. On balance, however, the need for more rational systems of health services to conserve manpower compels the more rapid development of Regional Medical Programs.

THE SURGEON GENERAL'S REPORT ON REGIONAL MEDICAL PROGRAMS CALLS FOR CONSTRUCTION AUTHORITY TO MEET SPECIALIZED REGIONAL NEEDS. WHY IS NO SUCH AUTHORITY REQUESTED IN THIS BILL?

The Report documents certain, limited construction needs which are essential to the full development of Regional Medical Programs, for example, space for continuing education programs or additional space for new or expanded diagnostic laboratory services. These kinds of construction needs by definition go beyond the individual needs of single institutions to the needs of the entire region. Accordingly, it is not reasonable to expect that any single institution should bear a disproportionate amount of these costs of construction.

No authority for construction is requested in the bill before you, given the fact that the President's Advisory Commission on Health Facilities is now in the process of analyzing and evaluating the Nation's need for health facilities. We will want to have the benefit of their recommendations prior to specifically proposing legislation.

TO WHAT EXTENT HAS RMPs PAID DISPROPORTIONATELY HIGH SALARIES?

Salaries which are charged to a grant under P.L. 89-239 must be in accordance with applicable institutional policies and adequate time and effort records must be maintained in order to substantiate these costs. The salaries of personnel whose full-time is charged to the RMP grant should not exceed the salaries of full-time administrative personnel in position of comparable responsibility in major medical institutions in the Region. If a corporation is established for the purpose of becoming the RMP grantee, it must establish salary policies which will have the same effect as the policy stated above.

TO WHAT EXTENT HAVE HOSPITALS BEEN INVOLVED IN REGIONAL MEDICAL PROGRAMS?

The involvement of hospitals in Regional Medical Programs has been considerable and is increasing. Shortly after the establishment of the Division of Regional Medical Programs, discussions were begun with representatives of the Nation's hospitals. These discussions are continuing.

More importantly, most state hospital associations (40) are now participating in Regional Medical Programs, and more than 800 hospitals are directly involved in the planning and operation of these programs.

Last November the Board of Trustees and the General Council of the American Hospital Association "voted its full support of the Regional Medical Programs." In addition, Dr. Edwin Crosby, the Director of the American Hospital Association, and Dr. James T. Howell, Executive Director of the Henry Ford Hospital, of Detroit, a member of the Association's Board of Trustees, are members of the National Advisory Council on Regional Medical Programs.

The American Hospital Association has recently decided to convene an invitational conference on the role of hospitals in Regional Medical Programs. This meeting, to be held this June, will offer another excellent opportunity to further involve hospital associations and individual hospitals in Regional Medical Programs.

Furthermore, the widespread involvement of physicians who constitute the medical staff of hospitals in Regional Medical Programs results in increased hospital participation in these programs.

Will this amendment for multi-regional services result in some sort of a national network?

This amendment is intended to serve the needs of Regional Medical Programs. No grant under this authority would be awarded until it had been established that a need for the multi-regional service was expressed by two or more Regional Medical Programs. The resulting services, therefore, will be defined in terms of regional needs not in terms of centrally determined national purposes.

HOW HAS THE DEVELOPMENT OF REGIONAL MEDICAL PROGRAMS AFFECTED THE AVAILABILITY OF PHYSICIANS IN THE RURAL AREAS OF THE UNITED STATES?

Involvement of physicians in rural areas in the planning for the implementation of the Regional Medical Programs has been a key step in many areas. Physicians in the rural areas are serving on Regional Advisory Groups, task forces and subcommittees, and community-based local action groups. Working in concert with medical schools, hospitals, voluntary health agencies, state health departments and other medical and health organizations, they are attempting to plan programs to meet local needs. For example;

- Community-based planning committees provide an excellent example of planning by rural community leaders for their own community. In Georgia, for example, over 120 such groups, based around local hospitals are serving as the mechanism for rural physicians to help develop programs for their areas.
- Many planning studies are now being carried out which are investigating the needs and problems of rural physicians and their constituent communities. In the Northlands Region, for example, studies which relate to rural physicians include: (1) study of rural health care patterns and (2) survey of continuing education needs and resources for physicians.
- Increased capability of rural hospitals-coronary care units-- Rural physicians in the Tennessee Mid-South region will have available to them in their local hospital a small coronary care unit linked by computer to the medical center in Nashville.

WHY HAVEN'T REGIONAL PROGRAMS DESIGNED TO SERVE THE MAJOR URBAN AREAS DEVELOPED MORE RAPIDLY?

Paradoxically, it has been particularly difficult to develop effective Regional Medical Programs where the greatest concentration of medical talents and facilities is to be found--the heart of our urban areas. On the other hand, the complexities of the problems requiring solution in these areas go far beyond those of most other areas. The crises in our urban areas present both a danger and an opportunity. The danger is that a "crash" effort will distort or destroy the potential inherent in Regional Medical Programs. More important though is the opportunity to use the Regional Medical Program as a mechanism to begin to deal with these problems effectively. For example, the Watts Section of Los Angeles with a population density of 10,000 per square mile, is cut off from the mainstream of modern medicine in an affluent society. The backwardness of its existing delivery of medical care can be overcome only by bold imagination, ingenuity and effort. A Regional Medical Program Advisory Committee, divided into Task Forces, aided by a staff of personnel with high academic excellence and deep community motivation, could bring some order into the health service chaos now existing there. The medical schools of USC and UCLA and the Charles R. Drew Medical Association are commited to this approach.

WHAT IS THE RELATIONSHIP BETWEEN REGIONAL MEDICAL PROGRAMS AND NEIGHBORHOOD HEALTH CENTERS UNDER THE OFFICE OF ECONOMIC OPPORTUNITY?

In carrying out its essential function of promoting the availability of high quality care for heart disease, cancer, stroke, and related diseases, Regional Medical Programs must interrelate with a whole spectrum of other programs having similar objectives. While the Neighborhood Health Centers are focused on out-patient services to the under-priviledged, they nonetheless constitute an important instrument for the delivery of care for heart disease, cancer, stroke, and related diseases to a segment of the population having a high degree of need. Consequently, a mutually fruitful relationship between these two programs has developed, both in Washington where the working staffs of both programs are in continuing contact, as well as out in the field where the program action is developing. Examples of related activities between Regional Medical Programs and neighborhood health centers include:

- The California Regional Medical Program has submitted a proposal to develop a subregion in the Watts-Willowbrook area of Los Angeles for the development of projects specifically related to the area and in cooperation with the Watts Neighborhood Health Center.
- The Tennessee Mid-South Regional Medical Program has in its most recent application a number of projects which affect the health care of the poor. Included are proposals to: develop continuing education programs for Negro physicians; establish a super-voltage radiation therapy program aimed at specifically improving cancer therapy for a large indigent population and for the improvement of graduate and undergraduate radiology training at Meharry Medical College and test the effectiveness of multiphasic screening examinations in the early diagnosis of heart

disease, cancer, and stroke. In this latter example, a screening center would operate in support of a comprehensive neighborhood health center funded by the Office of Economic Opportunity, which will serve a population of 18,000 persons.

DO YOU PLAN TO TREAT CIVILIANS IN VETERANS ADMINISTRATION HOSPITALS IF THIS AMENDMENT IS MADE PART OF THE ACT?

This amendment would make possible the full participation of Veterans Administration hospitals and other Federal hospitals in the Regional Medical Programs. The specific activities in the Federal hospitals supported by Regional Medical Program funds would have to be justified on the basis of the contribution of those activities to the region's health needs in these disease fields. However, the activities of the Federal hospitals would also have to be consistent with their statutory authorities related to particular beneficiary groups. If civilians were treated in Veterans Administration hospitals with regard to some activity of the Regional Medical Program, such care would have to be consistent with the current Veterans Administration authority which authorizes the sharing of VA facilities with the broader community. Many activities which might be supported by the RMP in a Federal hospital would not have to involve the treatment of civilians. For example, a VA facility might be utilized for training purposes to meet training objectives of the Regional Medical Program. The training objective could be accomplished utilizing the existing patient population of the Veterans Administration hospital.

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20420

YOUR FILE REFERENCE:

IN REPLY REFER TO: 15

CHIEF MEDICAL DIRECTOR'S LETTER NO.

TO: Directors of Hospitals, Domiciliary, and VA Outpatient Clinics, and Managers of Regional Offices with Outpatient Clinics

SUBJ: To clarify relationships between the Veterans Administration and the Regional Medical Programs of the Public Health Service, and to provide guidelines for implementation of VA participation in those Programs

1. The General Counsel's Office of the Department of Health, Education and Welfare has recently offered an opinion regarding the degree of participation of Federal facilities in Regional Medical Programs which now allows clarification of potential VA involvement in those programs. Title IX of the Public Health Service Act, "Education, Research, Training and Demonstrations in the fields of Heart Disease, Cancer, Stroke, and Related Diseases," (PL 89-239), is the basis for the establishment of the Regional Medical Programs (RMP). The purposes of the RMP will be effected via the grant mechanism. RMP grants are to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, hospitals, and other medical institutions and agencies -- to make available the latest advances in the diagnosis and treatment of these diseases. Grant funds will support, through these cooperative arrangements, research, training (including continuing medical education) and related demonstrations of the highest standards of patient care. Through these means the Programs are intended to improve generally the health manpower and facilities of the Nation.*

2. The Regional Medical Programs have an important role in effecting cooperation among essential elements of health resources in a region to overcome fragmentation and insularity and thereby obtain the best use of complex, specialized, expensive and rare resources required for patient

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* See Guidelines, Regional Medical Programs, DHEW, PHS, NIH, June 1967.

Include Zip Code in your return address and give veteran's social security number.

care, education and training. PL 89-785, section 203 authorizes the Administrator of Veterans Affairs and the Secretary of Health, Education and Welfare to coordinate to the maximum extent practicable programs carried out under the Heart Disease, Cancer and Stroke Amendments of 1965 (Title IX of the Public Health Service Act). Involvement of VA hospitals in the Regional Medical Programs can contribute to the missions of both. The described goals of the Regional Medical Programs can be considered as an expanded version of similar goals toward which the VA hospital system has moved during the last 20 years. Via affiliation with medical and dental schools the VA has sought to extend the highest quality of the interrelated research, education and patient care activities of academic centers into its hospitals. The recent extension of the VA mission via the exchange of medical information section of PL 89-785, emphasizes the need to extend these medical center qualities into the remote unaffiliated VA hospitals as well. The many common goals of the VA and the RMP warrant closely related programs.

3. Discussions with the Division of Regional Medical Programs have clarified the potential of relationships with the VA, and have allowed development of the following guidelines:

a. An eligible grantee (the grant recipient at a non-VA institution) under an approved Title IX operational grant, may include in his proposal (and budget) activities in which local VA hospitals might be utilized and receive appropriate reimbursement for those activities. Utilization of such funds must be for cooperative activities for whose performance the VA has authority.

b. The authority for the VA to enter into cooperative sharing and exchange of use agreements has been clearly delineated (see Circulars 10-67-86; 10-67-145; and Chief Medical Director's Letter No. 67-61). Because appropriate use of such agreements to reach full utilization of VA specialized medical resources will result in significant improvements in the DM&S patient-care mission, VA Central Office policy has been to encourage their implementation (CMD's Letter No. 68- . Exchange of use agreements allow both the VA hospital and the non-VA institution to provide better care for their respective patients. Such agreements also provide the VA and other institutions with means deliberately to plan location of various specialized medical resources within the institutions so as best to meet the needs of all.

c. It must be recognized that the contribution of RMP funds to VA installations must be demonstrated to result in benefits to the Regional Medical Programs separate from and/or in addition to those to VA missions.

At the local planning and operational levels, the provision of RMP funds for VA equipment, supplies, minor improvements, personnel, etc., must be accompanied by a clear flow into components of the RMP of an additional output which otherwise would not have occurred, i.e., the use of specialized VA facilities by the RMP for patient care demonstrations, for research, or training of individuals at levels beyond those which would have resulted from VA funding alone. Demonstrations of patient care using non-veteran patients could be provided in VA facilities via agreements for sharing of incompletely used VA resources (Circular 10-67-86), agreements for exchange of use of specialized medical resources (Circular 10-67-145), or by contract with the RMP grantee. Via these mechanisms, RMP funds may be provided to VA institutions (in accordance with existing VA regulations) for investigators' or trainees' salaries, equipment, supplies, minor alterations and renovations, and indirect costs pursuant to the general rules and regulations of the PHS.

d. For specific participation of a VA hospital in a Regional Medical Program, application for funds would be made to the grantee institution. The professional, administrative, and fiscal responsibilities for RMP funds used in VA facilities will lie with the RMP grantee institution, in the same fashion as for other components of a Regional Medical Program. The administrative details for the reimbursement to the VA of such funds is the subject of a forthcoming budget letter. The individual Regional Medical Program with the VA Hospital Director and Deans Committee must negotiate potential agreements which provide mutually acceptable benefits to their respective programs. Details of planned VA participation in a Regional Medical Program will be submitted by the Hospital Director to the Chief Medical Director for approval.

H. M. ENGLE, M.D.
Chief Medical Director

WHAT IS THE RELATIONSHIP BETWEEN PUBLIC LAW 89-239 AND PUBLIC LAW 90-174?

The Comprehensive Health Planning Program and the Regional Medical Programs can serve complementary purposes. The Regional Medical Programs provide an action focus for evolving improved systems on a regional basis for translating the advances of medical science into improved health care and in making that improved capability widely available. The Comprehensive Health Planning activities can provide information and analyses to the Regional Medical Programs which can contribute to the development of their plans for action. Comprehensive Health Planning can also serve as a mechanism for stimulating effective relationships between the activities of the Regional Medical Programs and other health activities at the state and local level. Thus, each program can contribute to the more effective accomplishment of the objectives of the other.