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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

Date: September 29, 1970

Reply to
Attn of: ADOL, RMPS

Subject: Material for November 9 Council Meeting

To: Members of RMP National Advisory Council

Enclosed is a copy of the most recent paper prepared by the Inter-Society Commission for Heart Disease Resources entitled "The Primary Prevention of the Atherosclerotic Diseases." Your comments will be welcome.

We have asked Drs. Wright, Stamler, Lilienfeld, and Fredrickson to attend the Monday afternoon session of your Council meeting on November 9, 1970, in order to provide the members with an opportunity to question them regarding the report and to discuss its recommendations. Publication of this paper is scheduled for the December issue of Circulation.

We shall look forward to seeing you at that meeting.

Margaret H. Sloan, M.D.
Margaret H. Sloan, M.D.
Associate Director for
Organizational Liaison

Enclosure

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Page 2 - Mr. Kenneth M. Crosby

different forms of heart disease, then moving to the subject of diagnosis and treatment and finally to rehabilitation and continuing care. These papers have been distributed to the National Advisory Council for their information and comment as rapidly as they have been completed. They began appearing in Circulation in the May issue and will probably be completed next summer. They will then be updated, published in monograph form, and given wide distribution.

I am enclosing copies of the documents which have been reviewed by the Council and published, and also a copy of the most recent contribution entitled "The Primary Prevention of the Atherosclerotic Diseases," on which we would appreciate your comment.

We have asked Drs. Wright, Stamler, Lilienfeld, and Fredrickson to attend the Monday afternoon session of your Council meeting on November 9 in order to provide the members with an opportunity to question them regarding the atherosclerosis report and to discuss its recommendations. Publication of this paper is scheduled for the December issue of Circulation.

We shall look forward to seeing you at that meeting.

Sincerely,

Margaret H. Sloan, M.D.
Associate Director for
Organizational Liaison

Enclosures

Letter for new Council members

September 25, 1970

Mr. Kenneth M. Crosby
Resident Vice-President
Merrill, Lynch, Pierce
Fenner and Smith, Inc.
Washington, D.C. 20036

Dear Mr. Crosby:

The Regional Medical Programs Service has made a contract with the American Heart Association to develop guidelines for the delivery of the latest advances in diagnosis and treatment of heart disease. This is to provide a basis for the future development of criteria for the evaluation of medical facilities in accordance with Section 907 of our legislation which reads as follows:

"The Surgeon General shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, or stroke, together with such related information, including the availability of advanced specialty training in such facilities as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the Surgeon General shall from time to time consult with interested national professional organizations."

Similar contracts have been made in the field of cancer with the American College of Surgeons and in the field of stroke with the American Neurological Association. Both the American College of Surgeons and the American Neurological Association have elected to wait until the end of their activity before releasing a report. However, the Heart Disease Guidelines Group (the Inter-Society Commission on Heart Disease Resources under the chairmanship of Dr. Irving Wright) has decided to release their contributions, as completed, in a series of papers beginning with the prevention of

5- Heart Guidelines

THE ROLE OF THE REGIONAL MEDICAL PROGRAMS IN THE CARE OF CANCER PATIENTS*

By MARGARET H. SLOAN, M.D.†
BETHESDA, MARYLAND

IT IS a great honor to be requested to address the members of the American Radium Society, and I shall try my best to fulfill the responsibility such an invitation entails.

Three years ago the Department of Health, Education, and Welfare began the implementation of new legislation—PL 89-239—which former HEW Secretary John Gardner called an experiment in “creative Federalism.” This legislation was based on *some*, but by no means all, of the recommendations of the President’s Commission on Heart Disease, Cancer, and Stroke which made its report in December of 1964.

Most of you are already aware of the history of PL 89-239 and the nature of the program finally passed by the Congress and signed into law on October 6, 1965, as the Heart Disease, Cancer, and Stroke Amendments of that year. You know that, during the lengthy legislative process, the proposed bill was significantly transformed from the concept of a network of Federally supported and constructed *centers* to that of a series of Federally supported *programs* based on voluntary cooperative arrangements between the major health interests of a region. These programs were to help narrow the gap between the level of medical care we know how to deliver, based in large part on the knowledge gained through the tremendous investment in biomedical research since World War II, and the extremely variable quality of medical services actually available to patients across the country. The goal of the legislation is quite specific: “To afford to the medical profession and the medical institutions of the Nation. . . the opportunity of making available to their patients the latest advances in

the diagnosis and treatment of these diseases.”

Each region would organize itself, determine its own boundaries, identify its own needs, and, with Federal support, develop a program to meet those needs. Each region would have a Regional Advisory Group composed of representatives of all the major health interests of the region, including the consumer. Each program would build on the resources of manpower, facilities, and relationships already in existence. Initiative would come from the regions and decision-making would be left at the local level to the maximum extent possible consistent with responsible administration of the taxpayers’ funds. Since no two regions in the United States are alike, each regional program was expected to be unique and responsive to the specific needs and opportunities of that region.

The kinds of activities which could be supported under regional medical programs would include: continuing medical education of physicians, nurses, allied health personnel and of the public; research, demonstration and training; and the improvement of facilities and services. They would *not* include patient care costs unless the patient was involved in research, demonstration or training for the purposes of a regional medical program (RMP). They would not interfere with the essentially voluntary system of American medicine, with physician-patient relationships nor with the methods of payment for medical services.

A Division of Regional Medical Programs was established within the National Institutes of Health in February of 1966, guidelines and regulations were published, and the first grants were awarded as of

* Presented at the Fifty-first Annual Meeting of the American Radium Society, Philadelphia, Pennsylvania, April 27-30, 1969.
† Associate Director for Organizational Liaison, Division of Regional Medical Programs.

July 1 of that year. These were planning grants awarded to give support to a regional medical program staff while it was engaged in planning an operational program. (In the HEW reorganization of last summer, the Division was relocated in the Health Services and Mental Health Administration, and the National Center for Chronic Disease Control was joined with it in what is now called the Regional Medical Programs Service.)

We now have 55 regional medical programs which cover the entire population of the United States, the Commonwealth of Puerto Rico, Guam, American Samoa, and the Trust Territories. Thirty-seven of these have been converted to operational status and 43 are expected to be operational by the end of this fiscal year. These regional medical programs vary greatly in size and population, all the way from a single metropolitan area, as in New York or Washington, D. C., to an area encompassing the four mountain states of Idaho, Nevada, Montana, and Wyoming. In population they vary from 600,000 people in Vermont to the inhabitants of the entire state of California, which are approaching 20 million.

How are they really doing—these 55 different programs? Some are going very well. Some are not yet off the ground. And in some, town and gown problems, interschool rivalries, reluctance of some medical schools to broaden their horizons from research and the teaching of medical students to include service to the community, and the preoccupation of some physicians with business-as-usual, or as they have known it for many years, have prevented the development of the cooperative arrangements on which these programs are based. Nevertheless, in each of these regions some cooperative arrangements have been developed within which doctors, nurses, hospital administrators, allied health personnel, community leaders and consumers who are interested in improving prevention, diagnosis, treatment, and rehabilitation of patients with heart disease, cancer, stroke, and related diseases can work together.

We have seen medical schools working together and medical schools working with medical societies, hospital associations and practicing physicians as they have never done before.

Each of you has the opportunity to participate in your local program, to make sure that the needs in the field of radiotherapy in your region are adequately considered. You may try to help and find the field dominated by surgeons, internists, or those preoccupied with continuing medical education, but at least we hope you will try.

I should point out that PL 89-239 is not a bricks and mortar program; that is, it has no construction funds. However, it can provide rental of space, the purchase of equipment, and up to 90 per cent of the cost of renovation. I think the prohibition of construction funds was a wise limitation, for if all the organizers of Regional Medical Programs had been turning to the Division for help in building a new addition to the hospital or a new wing for the medical school, they would never have concentrated on the development of cooperative arrangements among the health interests of the region and on identifying the needs of small hospitals and practicing physicians to deliver better care to patients.

What potential do Regional Medical Programs have to aid in achieving the goals of the American Radium Society? After all, our goals and yours are in part the same. We all want to help improve the quality of medical care actually reaching the patient. And in the field of radiotherapy, it means that every patient requiring the use of radium, radioisotopes, or radiation from whatever source for the treatment of cancer should be able to obtain it within his region, delivered by a well-trained radiotherapist. In the field of radiodiagnosis, it means that the most complicated diagnostic tests requiring x rays or radioisotopes can be performed as close to home as feasible, but certainly somewhere within his region of the country. Eventually, we would like to see that each of our 55 regions has at least one radiation center where the most complicated diagnostic and treatment

procedures can be performed. I am delighted that Dr. del Regato described so graphically this morning the potential role of a community hospital in the treatment of cancer because this is the level at which Regional Medical Programs seem likely to have their greatest impact. Eventually, we would hope to see trained manpower and sophisticated equipment located also in the smaller community hospitals and larger clinics, as close to the patient's family as possible, but the great shortage of radiotherapists in the United States will make it extremely difficult to achieve this in the foreseeable future. And in this day of sharp competing demands for every dollar, it is extremely difficult to justify the location of radiotherapy equipment on any basis other than patient load. Finally, it is recognized that a radiotherapist, like a cardiac surgeon, requires a certain volume of work to keep his talents sharp and to support a program of clinical and basic research and training. For these reasons, then, the Committee on Radiation Therapy Studies of the National Cancer Institute has proposed, and the American College of Radiology and the Committee on Guidelines for Cancer Care Facilities supported by the Division of Regional Medical Programs have agreed, that no hospital should consider establishing a supervoltage radiotherapy facility unless it will receive at least 300 new cancer patients requiring radiotherapy each year.

It is doubtful that the number of trained radiotherapists in the country today will permit the establishment of as many radiotherapy facilities as the country really needs, if every patient who ought to have such therapy should receive it. On the other hand, there are supervoltage units available in the country today which are not fully used or are not staffed by well-trained radiotherapists. A goal of Regional Medical Programs, therefore, is to aid in the development of radiotherapy departments on a regional basis in relation to patient need and the availability of trained radiotherapists.

The supply of qualified radiotherapists is being increased slowly through the radio-

therapy training programs largely supported by the National Cancer Institute, but Dr. Juan del Regato has suggested that additional members might be added to their ranks if some radiologists could be persuaded to take additional training in radiotherapy and the care of patients undergoing this form of treatment. Perhaps the Regional Medical Programs will soon be able to support such specialized training.

Similar problems exist in the field of Nuclear Medicine. Capability in this field also should be available on a regional basis and eventually in all major hospitals.

Now what have the Regions actually supported to date in the field of cancer and of radiation therapy in particular? As of mid-April, 1969, 52 cancer projects have been funded in 37 operational regions, representing a level of \$3.2 M per year. This constitutes about 7 per cent of the total project budget for these regions. In contrast to this figure, 8 per cent has been devoted to the field of stroke and 28 per cent to heart disease.

Of the 52 funded cancer projects, 12 are concerned with radiotherapy, including activities directed toward continuing education of physicians as to the potential benefits of radiotherapy for certain types of cancer and the indications for referral, consultation on treatment planning, dosimetry, and the management of irradiated patients; instruction for physicians in radiophysics and in nuclear medicine; and the training of radiologic technicians. In three cases we have provided partial funding for a cobalt 60 unit when all other funding sources had been exhausted.

Applications now approved but unfunded include 4 additional projects: 2 radioisotope training programs for physicians and/or technicians; a mammography training program; and the augmentation of radiation therapy departments to serve regional needs. Radiotherapists appear to be increasing their participation in Regional Medical Programs, for of the 15 cancer projects in the present review cycle, no less than 11 are in the field of radiotherapy and nuclear medicine.

You might be interested to know more about one of the three regions in which we aided in the purchase of supervoltage x-ray equipment in order to assure the availability of optimum therapy within a reasonable geographic distance. Please don't ask me to define what a "reasonable distance" would be, but I think you will agree that if you lived in Alaska and a member of your family—let us say, your son—developed Hodgkin's disease, or some other form of cancer for which radiotherapy was indicated, it would be unreasonable to have to send him 2,000 miles to Seattle for a long series of treatments. Early in the development of the Washington-Alaska Regional Medical Program, a supervoltage radiotherapy facility was identified as one of the highest priority needs in the Alaska half of the two-state region. Application for assistance was made to the Washington-Alaska RMP, approved at the local level, and forwarded to Washington for review, which also resulted in approval. The community responded in an amazingly cooperative way. A fund-raising drive was initiated among the citizens of Alaska, and funds were obtained to build the building for the therapy department. Then the construction trade unions of Anchorage held a meeting and voted to contribute their labor free of charge to the cause, and the RMP came along with the cobalt 60 unit. The whole facility was officially opened for business in a great celebration about a month ago.

What else could Regional Medical Programs do which would be of special interest to this audience? Another area certainly could be the training of radiation technologists to become radiotherapy technicians, for that seems to be a shortage category in the United States today. The entire area of radiotechnician training, presently supported by the Cancer Control Program, is in serious jeopardy, as you are well aware, and, with present budgetary restrictions, it is doubtful that any relief will be forthcoming in fiscal year 1970. It would be perfectly feasible for all grantees with training programs for radiotherapy technicians to

apply for continued support through their local Regional Medical Programs, and we have already funded a few which were considered of high quality and essential for continuation. Unfortunately, Regional Medical Programs Service is also participating in the current budgetary restriction, and we cannot be very encouraging at this time, but as soon as some easing of the budgetary crunch will be possible, such training programs would be appropriate for RMP support.

One other area has been brought to our attention recently by Dr. Robert Loevenger of the National Bureau of Standards. I know that this audience is well aware of the difficulties encountered in the calibration of radiation equipment and the checking of the calibration equipment itself. A proposal has been made to the Division to develop a network of calibration services in the United States based on geographically distributed radiology centers, where calibration instruments which have been checked against the standards at the National Bureau of Standards would be located. Anyone wishing to check his own calibration equipment against one of these secondary standards would then not have to travel very far to do so, and the chances of error would be decreased. Radiophysicists could be based at such centers and render calibration and dosimetry services to the radiologists in that region, as is being done now in the Washington-Alaska Regional Medical Program and in Texas through the M. D. Anderson Hospital and Tumor Institute.

Perhaps the activity of greatest interest to you would be the Division's response to Section 907 of our legislation. This reads as follows:

"The Surgeon General shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced methods and techniques in the diagnosis and treatment of heart disease, cancer, or stroke, together with such related information, including the availability of advanced specialty training in

such facilities, as he deems useful. . . . To the end of making such list or lists and other information most useful, the Surgeon General shall from time to time consult with interested national professional organizations."

The Surgeon General and the Division were quick to turn to the appropriate national professional organizations for help in carrying out this requirement of the legislation. Although many people feared that a Surgeon General's list would mean the imposition of Federal "standards" on hospitals throughout the country, our Advisory Council considered that our response to Section 907 would be satisfactory if we developed Guidelines for Medical Facilities capable of providing the latest advances in the diagnosis and therapy of Heart Disease, Cancer, and Stroke. These guidelines would be prepared by the most outstanding leaders in the treatment of these diseases we could find. The guidelines, when completed, would be used just as the word implies, to serve as guides to the further development of medical facilities so that physicians would be aided in delivering the highest quality of medical care we know how to provide.

The Division has therefore entered into three contracts with appropriate national professional organizations which could coordinate the participation of all other interested professional organizations in these three fields. In the area of cancer, we have contracted with the American College of Surgeons, which, through its Cancer Commission, already had a nucleus of the major national professional and voluntary health organizations, specialty groups, and Government agencies deeply concerned over the need to improve the care of cancer patients. An expert committee was organized under the Chairmanship of Dr. Warren H. Cole, and I am sure many of you have heard something about the "Cole Committee" on Guidelines for Cancer Care Facilities. Dr. Justin Stein, Dr. Milford Schulz, and Dr. Antolin Raventos have participated in drafting for that Committee a statement on radiotherapy requirements

which should be available in any major medical center. When completed, these guidelines will be distributed to all hospitals, interested professional organizations, and physicians. There will be nothing compulsory about these guidelines, and yet we believe their very existence will serve as an important stimulus toward improvement in quality of services delivered. It is possible that accreditation utilizing these guidelines may be carried out eventually on a voluntary basis by the American College of Surgeons or the Joint Commission on Accreditation of Hospitals.

SUMMARY

Regional Medical Programs represent a new channel for the improvement of medical care in the United States. Their emphasis is on cooperative arrangements which will provide for:

1. The optimal utilization of existing resources of manpower and facilities;
2. the identification of gaps in information, manpower, or facilities, which need to be filled;
3. the initiation of research, demonstration, and training activities with a major emphasis on continuing education of physicians, nurses, allied health personnel, and the public; and
4. the development of facilities and services on a regional basis.

In all of these efforts, we seek for new and innovative approaches, local initiative, the greatest possible support from the health interests of a region, and cooperative arrangements leading to regionalization. If any of you have ideas which you believe would contribute to these goals, please contact your own Regional Medical Program or the Division in Bethesda. We welcome your suggestions and advice. After all, *these are your programs.*

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