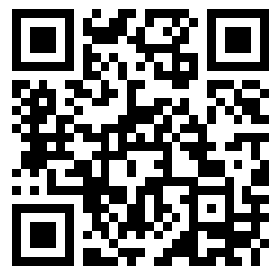

Emergency Health Services

Selected References

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Division of Emergency Health Services
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(See page 12 for free publications on the Medical Self-Help Program).

(HSM)72-2010
(formerly DEHS-15)
Revised April 1972

Emergency Health Services

** Selected References

CONTENTS

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Services and Mental Health Administration
Division of Emergency Health Services
5600 Fishers Lane, Rockville, Md. 20852

INTRODUCTION

This booklet has selected references that community groups have found useful to promote and develop various aspects of an emergency medical care system. Many titles are available FREE; others are for sale only. Title numbers 1-45 show letters of the alphabet which are identified on page 3 by name and address as the sources of these entries.

The material will be especially helpful in the development of hospital emergency departments and ambulance services and the training of emergency medical technicians. Several survey questionnaires are among publications off press in late 1971 and early 1972. Other material has been found very effective in training to date over 14 million citizens to help their families and others during medical emergencies when doctors cannot be reached.

SOURCES OF MATERIAL LISTED

A. Division of Emergency Health Services (Information Office),
Health Services and Mental Health Administration,
Public Health Service,
U.S. Department of Health, Education, and Welfare,
5600 Fishers Lane, Rockville, Maryland 20852.

B. Superintendent of Documents, U.S. Government Printing Office,
Washington, D.C. 20402.
Quantity rate: 25 percent discount given on orders of 100 or more copies of any one publication mailed to one address.

C. U.S. Department of Transportation, 400-7th Street, S.W.,
Washington, D.C. 20591.

D. National Academy of Sciences, Printing and Publishing Office,
2101 Constitution Ave., N.W., Washington, D.C. 20418.

E. American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

F. American Academy of Orthopaedic Surgeons, 430 North Michigan Avenue,
Chicago, Illinois 60611.

G. American Medical Association (Commission on Emergency Medical Services),
535 North Dearborn Street, Chicago, Illinois 60610.

H. Joint Commission on Accreditation of Hospitals, 645 North Michigan Ave.,
Chicago, Illinois 60611.

I. Local chapters of the American Cancer Society.

J. International Association of Laryngectomees, 219 East 42nd Street,
New York, New York 10017.

K. Bureau of Mines, Department of the Interior, 4015 Wilson Blvd.,
Arlington, Virginia 22203.

L. American Hospital Association, 840 North Lake Shore Drive,
Chicago, Illinois 60611.

M. American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.
Or--contact local offices of the AHA throughout the United States.

N. American National Red Cross, National Headquarters,
17th and D Streets, N.W., Washington, D.C. 20006.
(National headquarters suggests that local chapters should be contacted for copies of Red Cross publications).

1. Accidental Death and Disability: The Neglected Disease of Modern Society.

National Academy of Sciences/National Research Council. First published by the Academy in 1966. Reprinted 9/70 by the Division of Emergency Health Services as Public Health Service Publication No. 1071-A-13. U.S. Government Printing Office. 38 pp. Price 25 cents.

Coordinated systems of emergency medical services are urged for communities to help cope with the problems of sudden illness and injury.

Free single copy: see A, page 3. Sales stock: see B, page 3.

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2. Ambulance Design Criteria.

U.S. Department of Transportation/National Highway Bureau. Prepared by the Committee on Ambulance Design Criteria with assistance from National Academy of Engineering/National Research Council. U.S. Government Printing Office. 57 pp. Feb. 1970. Price 60 cents.

Gives recommendations for a vehicle suitable for present day practices, plus provision for future advances in equipment and administration of emergency health care.

Free single copy: see C, page 3. Sales stock: see B, page 3.

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3. Cardiopulmonary Resuscitation. A reprint.

National Academy of Sciences/National Research Council. JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 198, No. 4, 373-379, Oct. 24, 1966.

This is a summary of recommendations by the Ad Hoc Committee on Cardiopulmonary Resuscitation made at a conference sponsored by the NAS/NRC in May 1966. See next entry on the full proceedings of the conference.

Free single copy: see A, page 3.

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4. Cardiopulmonary Resuscitation - Conference Proceedings.

National Academy of Sciences/National Research Council. Published by NAS/NRC. 232 pp. 1967. Price $5.25. Quantity discount.

A group of experts on cardiopulmonary resuscitation discussed new medical and scientific knowledge on the subject and its application. Among other things endorsed were mouth-to-mouth and mouth-to-nose techniques of artificial respiration without adjunctive equipment for an apneic person of any age.

Sales copies only: see D, page 3. See previous entry.

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5. Cardiopulmonary Resuscitation ... a Manual for Instructors.

American Heart Association. Published by the AHA. 72 pp. 1967.

This manual is directed to physician instructors and others qualified to instruct in the techniques of cardiopulmonary resuscitation. Prompt application of these techniques can sustain life in victims of cardiac arrest.

Free single copy: see M, page 3. Bulk price: $33.50 per 100 copies.

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6. Cardiopulmonary Resuscitation ... Materials and Training Aids. Free.

American Heart Association. 2-fold leaflet. 1967.

Heart Associations throughout the U.S. organize and conduct training courses in cardiopulmonary resuscitation. This leaflet describes various instructional aids useful in training professional and lay groups.

For single free copy: see M, page 3.

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7. Community-Wide Emergency Medical Services. A reprint.

American Society of Anesthesiologists/Committee on Acute Medicine. JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 204, No. 7, pp. 595-602, May 13, 1968.

Guidelines to improve emergency medical services at the scene of the emergency, during transportation to the hospital, and in hospitals.

Free single copy: see A, page 3.

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8. Compendium of State Statutes on the Regulation of Ambulance Services, Operation of Emergency Vehicles, and Good Samaritan Laws.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. Public Health Service Publication No. 1071-A-11. 105 pp. Revised June 1969. Price $1.50.

Gives statutes current in May 1969. Intended for use by public health officials and other groups working to improve the organization and delivery of emergency medical services.

Free single copy to eligible community groups: see A, page 3. Sales stock: see B, page 3.

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9. A Curriculum for Training Emergency Medical Technicians. A Reprint.

Farrington, J.D. and Oscar P. Hampton. BULLETIN OF THE AMERICAN COLLEGE OF SURGEONS, Vol. 54, No. 5, pp. 273-276, Sept. - Oct. 1969.

A continuing course of 24 three-hour sessions (72 hours), plus four in-hospital training sessions.

Free single copy: see E, page 3.

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10. Developing Emergency Medical Services ... Guidelines for Community Councils.

American Medical Association/Commission on Emergency Medical Services. Published by the AMA. 14 pp. 1971.

The community emergency health care council will provide the spark to bridge the gap between policy and action.

Free single copy to eligible community groups: see G, page 3.

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11. Emergency Childbirth--A Manual. Sales copies only. Price $3.00.

Gregory J. White, M.D. Published by Police Training Foundation, 3410 Franklin Park, Illinois 60131.

For the lay person who must give assistance when professional aid cannot be reached and a baby is born or a woman is in labor.

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The next six titles (12-17) are related training publications.

12. Emergency Care and Transportation of the Sick and Injured.

American Academy of Orthopaedic Surgeons/Committee on Injuries. Published by the Academy. 293 pp. 1971. Price $4.95.

Official textbook for the U.S. Department of Transportation's 80-hour training program for "Emergency Medical Technician--Ambulance." Refer to the five titles that immediately follow this entry. This material is endorsed by the American College of Surgeons; American Medical Association; National Academy of Sciences/National Research Council; U.S. Army Medical Training Center; the American National Red Cross; U.S. Department of Transportation; and the Division of Emergency Health Services of the U.S. Department of Health, Education, and Welfare.

Sales copies only: see F, page 3.

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13. Basic Training Program for Emergency Medical Technician--Ambulance: Concepts and Recommendations.

U.S. Department of Transportation/National Highway Safety Bureau. U.S. Government Printing Office. 45 pp. Oct. 1969. Price 35 cents.

This and the next four publications are related. Provides guidelines on how to organize, administer, and teach a basic course for ambulance personnel. The training emphasizes medical aspects.

> Standard 11 of the new Highway Safety Program requires that all emergency ambulances be equipped with a minimum of certain life-saving equipment and manned by at least two trained technicians. The Standard clearly identifies the responsibility of ambulance services to provide more than transportation, namely ... to bring skilled emergency medical care to victims of sudden illness and injury, to stabilize their conditions as much as possible, and only then ... to take them quickly and safely to a hospital.

Free single copy: see C, page 3. Sales stock: see B, page 3.

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14. Basic Training Program for Emergency Medical Technician--Ambulance: Course Guide and Course Coordinator Program.

U.S. Department of Transportation/National Highway Safety Bureau. U.S. Government Printing Office. 40 pp. Oct. 1969. Price 30 cents.

Gives a detailed outline of the course; prerequisites for students and instructors; suggested scheduling and class size; requirements for facilities training aids and reference materials; et al.

This and the two previous publications are related to the three titles that immediately follow.

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15. Basic Training Program for Emergency Medical Technician--Ambulance: Instructor's Lesson Plans.

U.S. Department of Transportation/National Highway Safety Bureau. U.S. Government Printing Office. 257 pp. Feb. 1970. Price $2.50.

This and the three previous publications are related to the next two titles. The course accents the development of student skills to recognize symptoms of illnesses and injuries, plus proper procedures in emergency medical care. Intended to provide the know-how and skills to care for victims of sudden illness and injury, short of the care rendered by physicians.

Free single copy: see C, page 3. Sales stock: see B, page 3.

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16. Advanced Training Program for Emergency Medical Technicians--Ambulance.

National Academy of Sciences/National Research Council. Published by NAS/NRC 9 pp. September 1970.

Outlines additional training for a minimum of 480 hours for those emergency medical technicians (EMT) who have completed the basic course. The course emphasizes the anatomic and pathophysiologic changes and their correction, rather than symptom treatment. See the next title and the four titles that immediately precede this entry.

Free single copy: see A or D, page 3.

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17. Refresher Training Program for Emergency Medical Technician--Ambulance: Course Guide.

U.S. Department of Transportation/National Highway Safety Bureau. U.S. Government Printing Office. 26 pp. March 1971. Price 35 cents.

This refresher course provides for a periodic review and updating of the skills and knowledge of emergency medical technicians (EMT).

This publication is related to the five titles immediately preceding.

Free single copy: see C, page 3. Sales stock: see B, page 3.

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18. Emergency Services in the Hospital.

American Hospital Association (AHA). Published by the AHA. 72 pp. 1966. Price $2.00.

Gives general principles for appraising and planning emergency medical care facilities.

For sales copies: see L, page 3.

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19. Essential Equipment for Ambulances. A reprint.

American College of Surgeons. BULLETIN, AMERICAN COLLEGE OF SURGEONS, May 1970. 13 pp.

The Committee on Trauma lists minimum equipment needed by the emergency medical technician to provide adequate medical care for the critically ill and injured at the emergency scene and during transport to a medical facility.

Free single copy: see A and E, page 3.

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20. Field Staff Directory: Division of Emergency Health Services (DEHS).

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. 4 pp. Revised Oct. 1971.

A list of the names and addresses of (1) the DEHS regional program directors; and (2) the DEHS program representatives for the States and Territories.

Free copies: see A, page 3.

o o o o o

21. First Aid for Laryngectomees (Neck Breathers). Single copy free.

International Association of Laryngectomees. Published by the American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017. 10 pp. 1965.

A laryngectomee is a person who has had the larynx (voice box) removed, either totally or partially. This booklet makes known to first aid

personnel the information needed to identify laryngectomees and the special first aid measures or procedures that should be carried out.

Single copy free from local offices of the American Cancer Society.

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22. First Aid for the Mineral and Allied Industries ... A Bureau of Mines Instruction Manual.

U.S. Department of the Interior/Bureau of Mines. U.S. Government Printing Office. 191 pp. 1971. Price $1.25.

A revised and retitled edition of an earlier booklet entitled, "First Aid, A Bureau of Mines Instruction Manual."

Free single copy: see K, page 3. Sales stock: see B, page 3.

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23. First Aid Manual

American Medical Association. Published by the AMA. 47 pp. Revised 1967. Price 15 cents; $12 per 100; $80 per 1,000.

Presents general recommendations of the AMA for first aid. The pocket-size booklet does not replace instruction in first aid techniques. Useful to the general public rather than the emergency medical technician.

Free single copy or sales copies: see G, page 3.

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24. First Aid Textbook. Fourth edition. Sales copies only.

The American National Red Cross. Publisher: Doubleday & Co., Garden City, N.Y. 249 pp. Illustrated. Revised 1957.

Sales copies: Local chapters of the American Red Cross. Price 75 cents, paper binding; and $1.00, cloth binding.

o o o o o

First Aid Textbook for Juniors. Second edition. Sales copies only.

The American National Red Cross. Publisher: Doubleday & Co., Garden City, N.Y. 145 pp. 1953. Cloth binding. Price $1.00

For sales copies: see N, page 3.

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Title numbers 25-27 are related publications.

25. Hospital Disaster Plan...External Plan-Internal Plan. DEHS-7. A reprint.

Joint Commission on Accreditation of Hospitals. From Accreditation Manual for Hospitals, pp. 87-90. Reprinted 4/71 by the Division of Emergency Health Services, U.S. Department of Health, Education, and Welfare. 4 pp.

Hospitals are expected to have written plans to take care of disasters within communities. This plan should be rehearsed at least twice annually, preferably in coordination with other participating community agencies.

Free single copy: see A, page 3. See next two titles.

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26. Hospital Emergency Services. DEHS-8. A reprint.

Joint Commission on Accreditation of Hospitals. From Accreditation Manual for Hospitals, pp. 69-76. Reprinted 4/71 by the Division of Emergency Health Services, U.S. Department of Health, Education, and Welfare. 7 pp.

Standards interpreted on scope of emergency services; organization and staffing; facilities and supplies; policies and procedures; and patient medical records. The material highlights the principle that adequate appraisal, and advice or initial treatment, shall be rendered to any ill or injured person who presents himself at the hospital.

Free single copy: see A, page 3. See the preceding title and the one following.

o o o o o

27. Accreditation Manual for Hospitals. Sales copies only.

Joint Commission on Accreditation of Hospitals. Published by JCAP. 160 pp. 1971. Loose-leaf binder edition that includes updating service through 12/72 is $8.00; or a soft-cover edition, $2.25. See two previous titles.

These standards became effective July 1, 1971.

Sales stock only: see H, page 3.

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28. Immediate Care of the Sick and Injured.

Edited by Arnold M. Lewis, Jr. Published by the Kansas Medical Society and Medical Society of Sedgwick County, 1102 South Hillside, Wichita, Kansas 67211. 122 pp. Revised 1969. Price $1.25.

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464-766 O - 72 - 2

29. Medical Requirements for Ambulance Design and Equipment.

National Academy of Sciences/National Research Council. Published in 1968 by NAS/NRC. Reprinted April 1970 as Public Health Service Publication No. 1071-C-3. U.S. Government Printing Office. 24 pp. Price 25 cents.

Gives recommendations for general vehicular design, security of patient, rescue equipment, and equipment and supplies for emergency care.

Free single copy: see A or D, page 3. Sales stock: see B, page 3.

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MEDICAL SELF-HELP

30. Medical Self-Help Training for You and Your Community. PHS Publication No. 1042.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services and the U.S. Department of Defense /Office of Civil Defense. U.S. Government Printing Office. 32 pp. Revised 1970.

See the description for the next entry.

Free single copy: see A, page 3. Sales stock: see B, page 3.

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31. If Disaster Strikes and There Is No Doctor. Unnumbered PHS Publication.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services and the U.S. Department of Defense/Office of Civil Defense. U.S. Government Printing Office. 2-fold leaflet. 1964.

Sudden illness or injury often strikes people when a doctor cannot be reached quickly. At least one member in every family should be trained in medical self-help. This or the previous publication explain the MEDICAL SELF-HELP TRAINING COURSE that schools and other local groups may get through State health departments and State civil defense offices. The project is endorsed by the American Medical Association and other national organizations. Over 14,000,000 graduates have been trained to date.

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32. The Medical Self-Help Shoulder Patch. Unnumbered DEHS publication.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. 1 page. 1971.

This publication tells community groups how to get the SHOULDER PATCH that may now be worn by graduates of the Medical Self-Help Training Course.

See two previous listings. The flyer gives a price list for the PATCH and the address of the company from which it may be obtained.

Free single copy of the leaflet (not the shoulder patch): see A, page 3.
See inside front cover for illustration of the PATCH.

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33. A Model Ordinance Regulating Ambulance Service.

American College of Surgeons, American Association for the Surgery of Trauma, and the National Safety Council. 19 pp. 1965. Reprinted by Division of Emergency Health Services, U.S. Department of Health, Education, and Welfare.

A joint recommendation by the three organizations that is intended to lead toward uniformity of ambulance regulations in the United States. The material with appropriate changes might be used as a model to develop a State statute.

Free single copy: see A, page 3. No sales copies.

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34. Proceedings ... New Jersey Training Program for Physicians in Hospital Emergency Departments. DEHS-9.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 86 pp. May 1971.

Nine clinical papers presented at seminars conducted by the Committee on Emergency Medical Care of the Medical Society of New Jersey in cooperation with the New Jersey Department of Health and the U.S. Public Health Service.

Free single copy: see A, page 3.

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35. Public Health and Medical Aspects of Chemical and Biological Defense. DEHS-6.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 6 pp. March 1971.

An announcement and application form to request attendance at two upcoming classes to be held Jan. 31-Feb. 4 and May 22-26, 1972. The course is offered by the Public Health Service with cooperation in instruction from the U.S. Army Chemical Center and School, at Fort McClellan, Alabama.

Free copies: see A, page 3.

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36. Recommended Standards for Development of Emergency Medical Services Systems. DEHS-4.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 4 pp. July 1971.

Includes a list of basic references for community groups that are planning action to improve ambulance services, hospital emergency departments, and other elements of an emergency health care system.

Free single copy: see A, page 3.

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37. Training of Ambulance Personnel and Others Responsible for Emergency Care of the Sick and Injured at the Scene and During Transport.

National Academy of Sciences/National Research Council. Published by NAS/NRC. 1968. Reprinted 4/70 as Public Health Service Publication No. 1071-C-4. U.S. Government Printing Office. 23 pp. Price 25 cents.

One of three related projects intended to develop nationally acceptable standards for ambulance design and for the equipment that will be used by ambulance personnel. It prescribes the special training necessary to administer optimal emergency medical care at the scene of sudden illness or injury and during the transport of the patient to the hospital. This is for policy makers such as hospital administrators and community emergency health care councils rather than the individual emergency medical technicians.

Free single copy: see A, page 3. Sales stock: see B, page 3.

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Some Recent Publications

Late 1971 and Early 1972

See Next Three Pages

38. Emergency Department Policy and Procedures Guidelines. DEHS-12.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 15 pp. Revised 1972.

This checklist will help hospital administrators and their staffs to develop, evaluate, and update policies and procedures applicable to their emergency departments.

Free single copy: see A, page 3. No sales copies.

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39. Guide for Conducting State and Community Surveys of Ambulance Services and Hospital Emergency Departments. DEHS-14.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 33 pp. 1972.

The material will help communities to obtain basic material that will show the status of ambulance services and hospital emergency departments. The survey questionnaires will identify current activities in need of change; point to gaps that require new services; and assist in establishing priorities.

Free single copy: see A, page 3. No sales copies are available.

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40. Proceedings--Second National Conference on Emergency Health Services, December 2-4, 1971, Bethesda, Maryland. DEHS-16.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 108 pp. 1972.

The conference was sponsored jointly by DHEW and the Committee on Trauma of the American College of Surgeons. Today's inadequate emergency medical care accounts for a minimum 60,000 premature deaths annually, plus untold disability. Both families at home and medical-paramedical people must be made to realize that the medical care provided during the first hour after onset of sudden illness or injury may be more important than the entire subsequent episode. All concerned can be much more efficient with their application of present knowledge.

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41. Emergency Medical Services Councils--Report of Activities. DEHS-13.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 15 pp. December 1971.

Shows a wide variety of activities in which emergency medical services councils engaged in a single calendar year. The material is intended to suggest to councils old and new additional activities that might be included in their planning for ensuing years.

Free single copy: see A, page 3. No sales copies.

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42. Categorization of Hospital Emergency Capabilities, Recommendations of the Conference on the Guidelines for the ...

American Medical Association/Commission on Emergency Medical Services. Published by the AMA, 535 North Dearborn Street, Chicago, Illinois 60610. 37 pp. 1971.

Four gradations or categories of hospital emergency services are presented for consideration by community planning groups. The basic purpose of categorization is to identify the readiness of the hospital and its staff to receive and treat correctly and expeditiously emergency patients.

Free single copy from the American Medical Association.

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43. Digest of Surveys Conducted 1965 to 1971 ... Ambulance Services and Hospital Emergency Departments. DEHS-11.

U.S. Department of Health, Education, and Welfare/Division of Emergency Health Services. U.S. Government Printing Office. 128 pp. May 1971.

37 Statewide surveys of community ambulance services were reviewed; also, 21 Statewide surveys of hospital emergency departments. The publication summarizes each of the State surveys, plus four selected area surveys--Baltimore (Md.), Chicago (Ill.), Detroit (Mich.), and Maricopa/Gila counties (Ariz.). The material will help community planning and training organizations to: (1) note trends in elements of emergency medical care systems; (2) compare their operation with Statewide operations; and (3) establish a baseline for planning improvements.

Free single copy: see A, page 3.

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Emergency Medical Identification Symbol

Stop! Look before you treat. This is the message of the Emergency Medical Identification symbol that is worn or carried by many people. The American Medical Association designed this symbol to identify people who have medical problems that might be neglected in an emergency or aggravated by usual emergency treatment.

For information about the symbol and its uses, contact the American Medical Association, 535 North Dearborn St., Chicago, Illinois 60610.

46. Emergency Medical Identification Symbol.

American Medical Association. Published by AMA. A 2-fold leaflet. 1964. Reprinted May 1971 by the Division of Emergency Health Services, U.S. Department of Health, Education, and Welfare.

Explains the meaning of the universal emergency identification symbol developed by the AMA to draw attention to a patient's special medical problems. Refer to next entry.

Free single copy: see A or G, page 3.

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47. Emergency Medical Identification Card.

American Medical Association. Published by the AMA. 1965.

A card to carry in pocket, wallet, or purse. Gives a person's special medical problems that should be known to physicians, first aiders, and others when sudden illness or injury strikes. Lists medicines taken regularly, allergies, immunizations, names of physicians, and other pertinent information. Refer to previous entry.

Free single copy: see A or G, page 3. Sales stock: write G for bulk prices.

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U.S. DEPARTMENT OF
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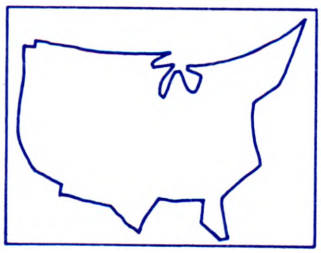
(formerly DEHS-15)

Revised April 1972

ADDENDUM

GUIDELINES



REGIONAL MEDICAL PROGRAMS

FEBRUARY 1970

Health Services and Mental Health Administration

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PREFACE

This Addendum to the Guidelines - Regional Medical Programs contains all additions, changes, supplements and policy statements which have been issued since that publication was revised in May 1968. These are now in effect either as part of the official Guidelines, or related to them.

Until the next full revision of Guidelines, this interim publication consolidates all additional materials which have been printed and distributed to this time, and eliminates all temporary issuances which have been superseded.

Rockville, Maryland
February 1, 1970.

CONTENTS

THE FOLLOWING REPLACES:

- Chapter III, Section VI, page 12, Change in Approved Program
- Chapter III, Section VII, page 17, Rebudgeting of Funds
- Chapter IV, Section III G, page 21, Application for Revision
- Special Issue - News, Information and Data February 11, 1969, "Option to Reallocate Operational Funds"

APPLICATION FOR PROGRAM REVISION (REBUDGETING OF FUNDS)

Under the authority of the Regional Medical Programs legislation, a single grant, based officially upon a single budget, is made to each Regional Medical Program. Although this transaction is based upon the financial requirements of a great many program components, each justified and approved separately, its purpose is the support of a total Regional effort. In attaining operational status each Region accepts the obligation to evaluate the progress of each of the components and assess the total program they comprise. It also has the option of periodically reassigning its available resources in accordance with emerging plans and priorities. At this crucial time when the amounts of new funding are uncertain and at least temporarily limited, it is important for the Program to understand fully the process of rebudgeting--both the opportunities it provides and its limitations.

Based upon its own assessment a Regional Medical Program may propose reallocation of its grant resources among (1) the direction, planning, and professional service activities of its central staff; (2) funded operational projects; and (3) projects or staff activities which have been approved by the National Advisory Council. Such reallocation requires prior approval of the Division of Regional Medical Programs and is usually applied for as part of the Type V (non-competing continuation) application. Transfer of funds between budget categories within component budgets may continue to be made without prior approval but only to the extent that it makes no substantial change in the approved activity.

A Region may propose rebudgeting of funds committed for the continuation year and carryover of funds unexpended in the year ending. In applying for program revision a Region must fully understand the provisions under which approval of its plans may be granted.

> The program components involved in the reallocation--those from which, as well as those into which, the funds are to be transferred--may not be substantially altered in their purposes, goals, or methodologies. A decision to discontinue a project, short of the time for which it was initially approved and for which funds were committed, must be explained.
>
> Rebudgeting of funds among projects may not serve to increase the general level of funding of the entire program in the

current or future years (e.g., the size of a project staff may not be increased so that the annualized payroll is in excess of the approved budget).

Funds carried forward from a previous budget period may be used for initiation or expansion of projects or staff activities which can be completed within one year. The temporary increase in the level of funding created by the approval of carryover funds does not constitute a commitment to increase the level of funds for subsequent years. NOTE: Funds remaining unexpended at the end of a period of committed support (i.e., the one, two, or three year program period) generally cannot be carried forward. Due to the complexities of individual situations, however, Regions planning to request carryover as part of Type II - competing renewal applications are advised to contact the Grants Management Branch.

APPLICATION

Application for program revision should, as often as possible, be made as part of the regular Type V (non-competing continuation) application, whether the proposed revision is to be accomplished by rebudgeting or by use of carryover funds. Application for revision submitted at any other time will be considered under special circumstances and after direct discussion with the Division staff. Each such application must be made utilizing the regular face page and budget pages (NIH-925-1 Rev. 5/66); with a budget for each of the projects affected by the revision and a consolidated budget for the entire program.

Under no circumstances will such requests be considered following the effective date of the final Report of Expenditures (NIH-925-3) which is due 120 days after the end of each budget period.

If a project selected for initiation with rebudgeted funds was originally applied for and approved for more than one year, the application must include not only a budget for that project but a statement explaining how it has been revised to be accomplished within that budget and within the one year for which the request can be considered. Such applications should include a statement concerning proposed sources of support for proposed continuation of the activities.

REVIEW

When adequately presented as part of a Type V application, the Division staff can review and act on such requests for revision in the usual time required for the Type V alone. However, if the staff concludes that the proposed reallocation will result in alterations either in individual grant components or in the nature of the applicant's total program, staff may defer action on the revision request and submit it to the National Advisory Council at its next regular meeting. This can be done without delaying processing of the other elements of the Type V application.

REPLACE Chapter III, Section VII. Financial Management, Allowable Direct Costs, B. Consultant Services (page 14) with:

B. Consultant Services - Regional Medical Program grant funds may be used to pay consultant fees and supporting costs such as travel and per diem in payment for services related to any program element of a Regional Medical Program. Consultants may be selected from both within and outside the grantee or affiliated organization, providing that these services are the most effective means of accomplishing a particular purpose.

It is expected that grantee organizations will normally have their own policies with respect to use of consultant services, that those policies will apply equally to the use of consultants paid for by grant funds and that they will include, as a minimum, the standards for documentation described below. However, in the absence of such policies, the following documentation in support of the use of consultants must be provided:

- A statement of the services to be performed and evidence that they cannot be provided by payment of direct salaries to staff members of the grantee or an affiliated institution;

- A brief description of the process of selection of the individuals most qualified to provide the required services;

- Evidence that the fee is appropriate considering the qualifications of the individuals, the nature of the services performed, and the amount normally paid for such services from sources other than Regional Medical Programs.

As a general rule, when services of a salaried staff member of the grantee or an affiliated institution are to be provided fulltime for periods of two weeks or more, or on a regularly occurring basis throughout the year, the individual should be compensated on a part-time salary basis rather than as consultation.

Grant funds may not be used to pay fees and supporting costs to U.S. Government employees regardless of their employment or pay status.

REPLACE Chapter II, Section IV, parts F, G, and H (pages 5 and 6) with:

EXPANDED STATEMENT OF EDUCATION AND TRAINING

GUIDELINES FOR REGIONAL MEDICAL PROGRAMS*

(SUPPLEMENT 1)

*Issued August 1968.

I. Introduction

General grant policies for Continuing Education and Training activities are given in Chapter III, Section V, of the revised Guidelines - Regional Medical Programs. Allowable direct costs are discussed in Section VII-C of the same chapter, wherein is stated: "Detailed information and policies concerning all eligible training activities will be supplied upon request by the Division of Regional Medical Programs." The following statements supplement the more general policies given in the revised Guidelines.

Education and Training activities of Regional Medical Programs are to meet the carefully defined and documented needs of each individual Region. It may therefore logically be assumed that these activities may vary widely in character. The following statements are intended as guides. If questions pertaining to any particular activity arise which cannot be answered by reference to the revised Guidelines or this document, they should be directed to the Division of Regional Medical Programs.

II. Continuing Education and Training - Definitions

Section 900a of P.L. 89-239 authorizes Regional Medical Programs to use, as means of accomplishing its purposes, research and training (including continuing education) and related demonstrations of patient care. While the wording of the law is quite general, it is clear from the legislative history and other sources that the primary educational interest of Regional Medical Programs is in continuing education and training activities. As an operational definition of continuing education, the following has been accepted: "Those educational endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in the health related fields." Generally, activities should not be designed principally to qualify one for a degree, diploma, or board certification. In general, standard internship and residency programs would not qualify as "continuing education." Continuing education and training activities should lead to the assumption of new responsibilities in the already chosen career field, update knowledge and skill in the chosen career field, or add knowledge and skill in a different but basically related health field.

III. Criteria for Funding

We have further specified conditions which should be met by the continuing education or training activity submitted for funding:

(1) The activity must be shown to meet documented Regional needs.
(2) Evidence should be presented to show that such activities do not already exist or do not exist in sufficient number.

(3) An operational activity must have been approved by the regional advisory group.
(4) In accordance with the provisions of Section 904(b)(1)(B) of P.L. 89-239, the availability of other sources of funding must have been fully explored.
(5) The goal of the activity should be to maintain or improve the quality of practice of health professionals. In general, activities will fall into one of three categories:

(a) Maintaining the level of practice of the health professional (e.g., refresher courses, seminars, conferences, etc.).
(b) Improving the level of practice of the health professional (e.g., special training courses in coronary care, cancer therapy, etc.).
(c) Developing new areas of interest for the health professional (e.g., training leading to the assumption of new responsibilities in a chosen career field, obtaining knowledge and skills in a different but basically related health field, the development of new types of health professionals, including, for example, the medical planner and administrator.

It is recognized, as stated in the revised Guidelines that "grant funds may be used for innovative training approaches and the development of new types of health personnel...." Such activities and others may require investment in basic training or education. Such activities will be judged on their merit and on the documentation by the Region of the need for such an activity.

Exclusions:

It should be emphasized that Regional Medical Program funds are not to be used to "supplant funds that are otherwise available for establishment or operation...." (Sec. 904(b) 1, P.L. 89-239). Therefore, generally excluded from funding is training designed specifically to prepare one for a research career in the biomedical sciences.

We urge Regional Medical Programs to become familiar with all available sources of support for education and training, including private as well as other Federal sources, e.g., the National Institutes of Health, the National Science Foundation, and the Department of Defense. It is to be expected that Regional Medical Programs will seek support or help cooperating agencies or institutions seek support for a wide variety of training and education activities, basic and continuing, from several different sources. In many instances, shared funding by a number of cooperating agencies will be appropriate. The Division of Regional Medical Programs may be of help in such cases.

IV. Allowable Direct Costs for Education and Training Activities

The following statements amplify those made in Chapter III, Section VII-C of the revised Guidelines:

A. Categories of Training:

(1) Training Conferences and Seminars: Presentations which are planned for full-time participation for periods from one full day to five consecutive days, or intermittently on a regular basis.
(2) Short-Term Training: Activities which are planned for full-time participation for more than five consecutive days, but not more than a single academic session (quarter or semester).
(3) Long-Term Training: Activities requiring full-time participation for more than a single academic session (quarter or semester).

B. Levels of Training:

Determination of the level of stipend is to be based upon the general level of training to be presented. In the case of training designed specifically for teams of physicians and ancillary personnel, an appropriate stipend level for each general level of participant may be selected, based on educational level attained, experience and current salary level.

(1) Post-High School/Nonacademic: Training which requires completion of a secondary education or having an appropriate equivalent background and experience.
(2) Baccalaureate: Training requiring at least some relevant collegiate preparation, but not more than the baccalaureate degree.
(3) Graduate: Training which requires at least some relevant post-baccalaureate academic preparation but not more than a doctoral degree. Training creditable toward the degrees of M.D., D.D.S., D.O., D.V.M., or similar medical degrees is excluded from support.
(4) Postdoctoral: Training programs designed for holders of a doctoral degree, or who have had equivalent training.

C. Stipends:

Stipends are not authorized for training conferences and seminars, but stipends may be paid for short-term and long-term training programs in accordance with the following general policies:

If the trainee is employed by an affiliated institution, a stipend may be paid directly. A maintenance of income principle can be used to determine the amount of stipend. If desired, the trainee's employer can be reimbursed for the amount of the trainee's salary, including the personnel share of benefits paid by the employer at the time the trainee enrolls in the training being conducted.

Payments of stipends (followships, scholarships, etc.) should not exceed the amounts presented in the appended schedule. In no case should such payments exceed the amount set by the policy of the training institution for similar training or training requiring similar pre-requisite education.

Stipends for short-term training are based on a daily rate and are to be paid only for actual training days (weekends, holiday, etc., excluded)

Stipends for long-term training which is less than a full twelve months are to be calculated on a pro-rata basis, and leave and holiday policies of the training institution are to be followed.

Stipend rates for full-time, long-term postdoctoral training are to be paid according to the current policy of the training institution. The Division of Regional Medical Programs will not undertake reimbursement at private practice levels.

D. Dependency Allowances:

Dependency allowances for those long-term trainees at the Baccalaureate level and higher, who are in training for a full academic year, may be awarded in the amount of $500 (per year) for a dependent spouse, each dependent child, and each dependent relative, provided that during the trainee appointment the dependent receives more than one-half of total support from the trainee. A dependency allowance may not be claimed for any person who during the trainee's appointment period will be receiving a fellowship or traineeship stipend under Federal educational assistance program (other than loans), or for whom an allowance will be made as a dependent of any other person during that period.

The Division of Regional Medical Programs has adopted the following dependency schedule and a dependent may now be defined as any of the following individuals over half of whose support, during the period of appointment, is received from the trainee or student:

(1) A spouse,
(2) A son or daughter of the student, or a descendant of either,
(3) A stepson or stepdaughter of the student,
(4) A brother, sister, a stepbrother, or stepsister of the student,
(5) The father or mother of the student, or an ancestor of either,
(6) A stepfather or stepmother of the student,
(7) A son or daughter of a brother or sister of the student,
(8) A brother or sister of the father or mother of the student,
(9) A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law of the student,
(10) An individual who, for the school year has as his principal place of abode the home of the student and is a member of the student's household, or

(11) An individual who -
   (a) is a descendant of a brother or sister of the father or mother of the student,
   (b) for the school year of the student receives institutional care required by reason of a physical or mental disability, and
   (c) before receiving such institutional care, was a member of the same household as the student.

E. Travel Allowance:

The cost of the trainee's travel to the training institution may be allowed only for the purpose of, and at the time of, entering and leaving the training program. The allowance is payable only once to any one trainee from any one training project. If private transportation is used, a travel allowance of 8 cents per mile, as computed by standard mileage charts, may be paid from grant funds for travel to the training institution from the trainee's last place of residence and return. Payment of travel allowance is limited to participants who must travel more than 50 miles round trip between their residence and the training site. In general, travel policies of the training institution will apply, or in the event no such policies exist, Government Travel Regulations will apply. No allowance can be made for transportation of dependents, or for shipment of household goods or personal effects.

F. Per Diem Allowance:

An allowance of $16 per day may be paid to participants in training conferences and seminars, and in short-term training programs (see schedule) who must travel more than 50 miles round trip between their place of residence and the training site.

G. Supplementation:

As used in all Public Health Service policy statements and procedural guides dealing with training stipends, the term "supplementation" means the provision of funds by a grantee to a trainee in addition to his grant-supported stipend, in a combination which then exceeds established Public Health Service stipend ceilings. Trainees in full-time, long-and short-term programs funded by the Division of Regional Medical Programs are required to devote their entire professional effort in the pursuit of the training objectives.

The source of funds for supplementation must be non-Federal.

H. Schedule of Stipends:

Grant funds used for the payment of stipends and related benefits to eligible persons undertaking an education or training activity approved as part of a Regional Medical Program grant may not exceed the following schedule:

	Stipend		Dependency Allowance	Per Diem	Travel
	Per Year	Per Day			
I. Training Conferences & Seminars	None	None	None	Yes	Yes
II. Short-term Training					
1. Post high school	-	$10	None	Yes	Yes
2. Baccalaureate	-	$20	None	Yes	Yes
3. Graduate	-	$30	None	Yes	Yes
4. Post doctoral	-	$50	None	Yes[1]	Yes
III. Long-term Training[2]					
1. Post high school	$1500	-	Yes	No	Yes
2. Baccalaureate	$2400	-	Yes	No	Yes
3. Graduate					
a. (first post-baccalaureate year)	$2400	-	Yes	No	Yes
b. (years between first and terminal year)	$2600	-	Yes	No	Yes
c. (terminal year)	$2800	-	Yes	No	Yes
4. Post doctoral					
a. Board creditable	[3]	-	Yes	No	Yes
b. Special	[3]	-	Yes	No	Yes

[1] Per Diem can be paid in lieu of (not in addition to) a stipend.

[2] The following DHEW stipend policy is applicable.: "The purpose of the the student support is to provide for a level sufficient to enable the student to continue his studies without delaying the attainment of the degree or causing him to seek outside sources of financial aid."

[3] Stipend may be negotiated on the basis of trainee's education, experience, and current salary level, and then must be approved by the Division of Regional Medical Programs.

I. Tuition and Fees:

Tuition and fees for training activities may be paid from grant funds providing no other charges for the cost of that training are made against the grant. When allowable, only the same resident or non-resident tuition and fees charged to regularly enrolled non-Federally supported students may be charged for trainees. Tuition and fees for courses which satisfy requirements related exclusively to the M.D., D.D.S., D.O., D.V.M., or similar degrees may not be charged to a grant. When the courses are creditable to satisfying Ph.D. requirements in combination with any of the aforementioned degree requirements, however, tuition and fees may be charged for those courses within the combined degree program that are required specifically for the attainment of the Ph.D. degree. The training must be relevant to the purposes of the grant.

V. Other Training Provisions

A. Citizenship:

The Division of Regional Medical Programs adheres to the policy which provides that only United States citizens and those foreign nationals having in their possession a visa permitting permanent residence in the United States may be appointed as trainees on training grants.

B. Long-Term Training Appointments:

A "Statement of Appointment of Trainee" (Form PHS 2271, PHS-3190-5, or PHS-4885-2 as appropriate) will continue to be required for each appointment or reappointment of a trainee receiving stipend, dependency allowance, tuition costs, or travel from a program supported by the Division of Regional Medical Programs' funds. For each appointment, or reappointment, the statement must be submitted at the time the training period of the individual begins. No obligation for trainee support may be made against grant funds until this statement is submitted.

If there are changes in the terms of the appointment (e.g., support period, stipend, supplementation, dependency allowance, tuition) an amended Statement of Appointment is required.

C. Reporting of Short-Term Training Programs:

Short-term training supported by the Division of Regional Medical Programs' funds will be reported in the aggregate on a regional basis. To be included in such a report are the number of trainees who participated, occupational categories represented, and the grouping of levels of academic preparation of the trainees.

August 1968

THE FOLLOWING PAPER contains statements concerning continuing education and training issued by the National Advisory Council during 1969, particularly as they relate to allied health personnel:

BACKGROUND INFORMATION AND AMENDED STATEMENTS

CONCERNING CONTINUING EDUCATION AND TRAINING

INTRODUCTION

The Expanded Statement of Education and Training Guidelines for Regional Medical Programs, Supplement 1 to Guidelines, August 1968, provides guides to Regional Medical Programs regarding activities in continuing education and training. The National Advisory Council meeting in February, May and August, 1969, expanded on the statements in the Guidelines and made several recommendations concerning Regional Medical Programs support for health careers recruitment; for basic training of established allied health professions and for basic training in newly developing allied health professions.

This summary combines the statements made by Council and provides some background information to explain their recommendations.

CONTINUING EDUCATION AND TRAINING - DEFINITIONS

The primary educational intent of Regional Medical Programs is in continuing education and training. As an operational definition of continuing education, the following has been accepted: "Those educational endeavors which are above and beyond those normally considered appropriate for qualification or entrance into a health profession or an occupation in a health related field." Continuing education activities must not be designed principally to qualify one for a degree, diploma or certification; therefore, internship and residency programs have been excluded from primary consideration. Training designed principally to prepare one for a research career in the biomedical sciences has also been excluded.

Continuing education and training activities should lead to the assumption of new responsibility in the already chosen career field, update knowledge and skills in the chosen career or add knowledge and skill in a different but basically related health field but not provide for career change. In general, therefore, interest is in task-oriented training.

CRITERIA FOR FUNDING

The following criteria have been adopted for determining those continuing education activities most suitable for funding:

- The activity must be shown to meet documented Regional needs.
- Evidence should be presented to show that such activities do not already exist or do not exist in sufficient numbers.

- The goal of the continuing education activity must be to maintain or update knowledge and skill in order to improve the level of practice of the already qualified health professional.

- The activity must relate to the categorical nature of the program and be part of a comprehensive plan to enhance regional capability in the care of patients with heart disease, cancer, stroke and related diseases.

- RMP funding is not to be used to replace existing sources of support for educational activities.

REASONS FOR SEPARATION OF BASIC AND CONTINUING EDUCATION WITHIN REGIONAL MEDICAL PROGRAMS AND EMPHASIS ON CONTINUING EDUCATION

Regional Medical Programs has emphasized in the past and continues to emphasize continuing education and training rather than basic education as a means of providing the opportunity "of making available to their patients the latest advances in the diagnosis and treatment of these diseases" for the following reasons:

- There still exists a lack of emphasis on continuing education as an important facet in the total educational development of health personnel.

- RMP provides a meaningful regional framework of cooperative activity into which continuing education programs can be incorporated. Continuing education can play a role in developing cooperative arrangements and, conversely, regional cooperative arrangements are essential to the development of continuing education programs.

- RMP, because of its focus on the practitioner and his effect on patient care as well as through its mechanism of "demonstrations of patient care," provides the ideal setting for the connection between acquisition and utilization of knowledge that is the key to the learning process in continuing education. It is the health care needs of his patients that dictate the continuing education needs of the health practitioner and it is his utilization of this continuing education that sets the quality level of his practice. RMP, therefore, has the opportunity to make continuing education relevant to its real purpose--that of improving the health care of people with heart disease, cancer, stroke and related diseases.

- As a result of specialization, sub specialization and the development of new technologies, the health establishment has proliferated so that there are now many different kinds of health professionals. A variety of medical care teams has resulted but continuing education remains largely unidisciplinary. The

cooperative arrangements of regional medical programs can provide an excellent base for multidisciplinary inter-professional continuing education with its primary focus--the care of the patient with heart disease, cancer, stroke and related diseases.

- Generally speaking, other agencies exist whose primary efforts are aimed at supporting supply and training of health manpower at the basic and postgraduate level.

BASIC TRAINING

As has been stated previously, support of basic education and training programs in the medical, allied and associated professions is not the primary "target" of RMP and is not, therefore, normally anticipated. The supply and basic training of manpower is more logically the "target" of other Federal agencies such as the Bureau of Health Professions Education and Manpower Training, Office of Education, and Department of Labor. However, because of the number of applications received by DRMP requesting basic training support in the allied health professions, Division staff divided these proposals into three categories, - health careers recruitment, basic training in "established" allied health professions and basic training for the development of new types of health personnel. The February, May and August Councils have taken these under consideration and made the following recommendations:

HEALTH CAREERS RECRUITMENT

The Council recognized the need for additional health manpower but because of the time span between recruitment and improved patient care, it recommended that further support of health careers recruitment projects with Regional Medical Program funds be granted only when a project is related to a clearly focused (specialized) short-range approach to the critical needs of a region, and

- Has the documented committed support not only of the sponsoring agencies, but of the Region's hospitals, schools, and colleges whose cooperation is essential for the success of the immediate project and its continuation after Regional Medical Programs support can no longer be made available;

- Includes a plan for evaluation of the impact of the program on the rate of production of trained health manpower;

- Is directed at special population groups, especially those who do not usually seek, or have available, opportunities for training or education beyond secondary school;

- Other sources of funding have been explored.

BASIC TRAINING OF ESTABLISHED ALLIED HEALTH PROFESSIONS

Definition

A health profession will be considered established if a Board of Schools AMA Council in Medical Education, or some similarly recognized mechanism, has been set up to approve schools, outline standards for admission, curriculum requirements and certification procedures and/or if definitive formal educational programs in the particular health occupation have already been instituted in the educational and training systems of hospitals, technical schools, junior and senior colleges.

Council recommends that no RMP grant funds be used for the cost of providing basic education and training in established allied health professions as defined above.

Regions are encouraged, however, to use professional staff assistance as well as direct support of special planning studies to encourage educational institutions in conjunction with clinical resources to provide new educational and training opportunities in established allied health disciplines and to add new disciplines.

NEW TYPES OF HEALTH PERSONNEL

Both the original and revised Guidelines state that "Grant funds may be used for innovative training approaches and the development of new types of health personnel or new arrangements of health personnel to meet the Region's goal of improved patient care for those suffering from heart disease, cancer, stroke or related diseases." Some of these activities may fall into the category of basic education.

Definition

The definition accepted by Council for the training of new types of health personnel is that training which relates to newly developing technologies or new modalities of diagnosis and treatment for which no standard curriculum is yet recognized and no minimum national standards for certification or licensure are yet established and which is not generally part of the regular offerings of the health-related educational and training system of hospitals and/or technical schools, junior and senior colleges.

Criteria for Funding

The training activity must satisfy a documented need of a Regional Medical Program, and must be shown to have a relatively high priority for funding.

- The Region must show evidence that other avenues of funding have been explored and are inadequate.

- The Region itself must also explore the possibility of phasing out the Regional Medical Program funding as money becomes available from other sources.

- The Region must have explored the possibility of joint funding with other interested agencies.

- The training activity must relate to the categorical and public health relevance of Regional Medical Programs and must be part of a comprehensive plan to enhance regional capability in the prevention, diagnosis and treatment of patients with heart disease, cancer, stroke and related diseases.

- Training programs should include cooperative arrangements and documented commitment of educational institutions, clinical resources, health practitioners and accreditation groups all of whose cooperation is essential to insure the success of the program.

- If the education and training activity has been shown to be necessary to achieving the purposes of a Regional Medical Program, and the above criteria have been met, then the proposed project may be approved for funding.

It is further recommended that every effort be made to use a systematic approach to identify new health professions, e.g., task analysis of present health occupations, followed by curriculum development and testing of pilot training programs. If an ad hoc approach is taken to the development of new types of health personnel, we might end up with a vast array of highly specialized persons ministering to the patient which may not have the desired result of either improving patient care and/or of reducing costs.

Use of RMP funds will be limited to actual cost of provision of training and for payment of student support and assistance.

GENERAL BACKGROUND INFORMATION REGARDING OTHER FEDERAL SUPPORT

The Nurse Training Act provides Construction grants, Basic formula grants to Schools of Nursing, Special project grants to establish new programs or improve existing ones and advanced traineeships to RNs for teaching, supervision and professional nurse specialties.

- The Allied Health Professions Personnel Training Act provides Basic Improvement (formula) Grants for only those professions specifically listed in the legislation. Those which are not listed could qualify under the Act's Developmental Grants but funds are severely limited. Advanced traineeships are provided to individuals through institutions eligible as training centers for allied health personnel.

- In general, State Department of Education funds are awarded only to educational institutions. Vocational education funds, therefore, go to vocational-technical area schools, junior and community colleges, technical institutes and four-year colleges and universities under an approved State plan. The 1968 Amendments to the Vocational Education Act of 1963 expands the activities and increases the authorization for State grant programs. States are now required to spend at least 15% of their basic allotment for the disadvantaged. The amendments also stress that no less than 15% of funds available for State vocational educational programs shall be used for post secondary vocational education.

  The House of Representatives, U.S. Congress has recently voted to increase Federal appropriations to the States to look at their educational needs and to supply the training to meet those needs. Further increases in the number of allied health training programs should, logically, follow if local areas make their needs known to the State Departments of Education.

- The Occupational Training Programs, Manpower Development and Training Act is co-administered by the Department of Labor and HEW and emphasizes training programs for the unemployed and underemployed. State plans should provide for 2/3 of MDTA basic program enrollees to be disadvantaged individuals.

  During fiscal year 1970, the Manpower Administration will encourage programs that include training for new occupations to relieve more highly skilled personnel of routine duties, e.g., training of assistants to health professionals, upgrading existing personnel such as nurses aides to LPNs, training in connection with development of career ladders and training which may assist in reducing turnover. The new Comprehensive Manpower Training Act proposed by President Nixon advocates that all Department of Labor manpower development programs be consolidated under the Manpower Administration and that flexible funding be provided for manpower training so that they can be sensitive to and focused on local needs.

- Comprehensive Health Planning, under 314(e) grant funds, will fund that training that relates to Health Services Development Projects, that meets needs of limited geographic scope, is of specialized regional or national significance or supports for an initial period a new program of health services.

- National Center for Health Services Research can support research, experiments and demonstrations relating to the development and assessment of new ways of utilization of health manpower, e.g., new staffing patterns and new types of supporting health personnel.

- Rehabilitation Services Administration provides long-term and short-term training grants to educational institutions and allied health personnel in the field of rehabilitation.

- There now exists throughout the country Cooperative Area Manpower Planning Systems Committees. CAMPS is an interagency effort with representatives from the Departments of Labor, Health, Education, and Welfare, Office of Economic Opportunity, Agriculture, Commerce, Housing and Urban Development, Interior and Civil Service Commission to identify manpower problems in an area, delineate resources and develop linkages between programs.

  Division staff recommends that regions be given information concerning CAMPS so that manpower programs can be coordinated with them. Upon request, the Department of Labor has compiled a list of the Chairmen of all of the CAMPS Committees throughout the country which has just been made available to the Division.

For further information see pamphlet, Federal and non-Federal Programs Relating to Allied Health, as published in Regional Medical Programs News, Information and Data, April 1, 1969.

THE FOLLOWING RECOMMENDATION was made by the National Advisory Council, Regional Medical Programs Service, at its May 26-27, 1969 meeting. It supplements the preceding paper on Background Information and Amended Statements Concerning Continuing Education and Training:

Training of Cytotechnologists

"Upon recommendation of the Council, the Division has identified Cytotechnology as an established allied health discipline. Its training programs are approved by the American Medical Association Council on Education when properly recommended by the profession, and graduates are certified for practice by a nationally recognized examination administered by the profession. The techniques of exfoliative cytology are now of universally recognized value in screening and diagnosis of pathologic states.

Therefore, in line with general policy relative to support of established programs and in keeping with above policy guidelines on training, the Council recommends that Regional Medical Programs grant funds not be used for the costs of providing the basic education and training of cytotechnologists, either as a grant for an independent project or as part of a project demonstrating the application of exfoliative cytologic techniques to patient care."

THE FOLLOWING POLICY GUIDELINE was restated by the National Advisory Council, Regional Medical Programs Service, at the December 16-17, 1969 meeting. It had been adopted at the August 1969 meeting in regard to a group of pending projects:

Cardiopulmonary Resuscitation Training

"Regional Medical Program grant funding for projects in cardiovascular resuscitation training must be limited to activities which are directed principally to medical and allied health personnel. Such personnel must be employed in hospitals and other inpatient facilities, or in outpatient or emergency facilities operated by or directly related to institutions which can provide immediate followup care."

Minutes of Meeting of National Advisory Council, Regional Medical Programs Service, December 16-17, 1969

SUPPLEMENT Chapter III, Section VII. Indirect Costs (page 16) with:

I. Negotiation of Indirect Cost Rates for Grantee Institutions

A. The Division of Grants Administration Policy (DGAP) - Department of Health, Education, and Welfare will establish rates for each grantee institution which requests indirect cost.

B. These rates will be based on proposals submitted by the grantee institution as follows:

1. If the grantee is the recipient of awards under other DHEW programs which reimburse indirect cost, it will submit a single annual submission to DGAP proposing rates for all DHEW programs. A RMP rate will be established at the time the rate(s) for the other programs are negotiated. In most instances the RMP rate will be identical to the rate used for research and development awards.

2. If the grantee is not the recipient of awards under other DHEW programs, it must submit a rate proposal for the RMP award together with supporting financial statements. This proposal will be requested by and submitted to the Grants Management Branch - Division of Regional Medical Programs which will review it for completeness and, if adequate, forward it to DGAP for processing.

C. When a rate has been established by DGAP, it will be incorporated in a rate agreement and identified as being applicable to the RMP grants.

D. The DRMP had established a number of rates for provisional use before the rate setting function was assumed by the DGAP. These rates will continue to be utilized until revised by DGAP in the normal course of business.

E. The DRMP will advise the DGAP immediately of any grantee institution under category I.A. for which rates are required but not now available.

The DRMP will immediately procure proposals from those institutions under category I.B. for which rates are required but not now available.

F. If DRMP makes an award to a new grantee which has an established research rate with DGAP, it may, with the concurrence of the grantee institution, utilize the research rate as a provisional rate in the initial award in order to fund the grant.

II. Negotiation of Indirect Costs for Affiliate Institutions

A. It will be the responsibility of the grantee institution to establish indirect cost rates with its affiliated institutions. Affiliated institutions generally will not communicate directly with the Division of Grants Administration Policy-DHEW regarding the establishment of indirect cost rates for Regional Medical Program grants. The Division of Grants Administration Policy will provide technical advice to the grantee institution upon request.

B. Some grantee institutions do not now possess the resources to establish indirect cost rates with their affiliates. Such grantee institutions are expected to develop the necessary resources. We appreciate that these resources cannot be developed immediately and are amenable to an interim, short term arrangement whereby DGAP will, upon request, and the condition that all parties are agreeable, establish rates with the affiliate(s) on behalf of the grantee. DRMP will advise DGAP of such instances and the grantee will instruct the affiliate institution to forward its proposal and supporting financial statements to the Grants Management Branch - Division of Regional Medical Programs. DRMP will review the proposal for completeness and, if adequate, forward it to DGAP. DGAP will conduct its negotiation directly with the affiliate(s).

C. Some institutions participating in the Regional Medical Program as affiliates are the direct recipients of grants or contracts under other DHEW programs. In such situations DGAP will establish rates for the RMP grant when it establishes rates for the other program awards. It is understood that this is an arrangement of administrativ convenience for all parties involved. If the grantee institution desires to conduct direct negotiations with its affiliate, it may do s DGAP will be advised, however, of the grantee's option, in order that the RMP award may be considered in DGAP's negotiation for the other programs performed by the grantee institution.

The Division of Grants Administration Policy-DHEW has developed cost principles applicable to educational institutions, hospitals, state and local government agencies and other non-profit institutions. The following brochures are enclosed to assist you in developing the required indirect cost rate proposals:

OASC - 1 A Guide for Educational Institutions
OASC - 3 A Guide for Hospitals
OASC - 4 A Guide for State and Local Government Agencies
OASC - 5 A Guide for Non-profit Institutions

SUPPLEMENT Chapter IV, Section IV. Application Procedure (page 21) with:

"As non-competing continuation applications (previously recommended support-type V) become more complex, an increasing amount of time is required for the staff of the Division of Regional Medical Programs to adequately review them. This fact, coupled with the need that Award Statements for such continuing support arrive prior to the scheduled starting date of the new grant period, now makes the following policy necessary and effective immediately:

> Programs scheduled to start their next budget period on August 1, 1969 or thereafter, must submit their continuation applications to the Division at least 45 days in advance of that new starting date, rather than the 30 days presently required.

Similarly, the Division will advance its schedule for contacting Regions regarding the submission of their Type V applications."

ADD TO Chapter III, Section II. Types of Grants (page 8):

Project Grants for Multiprogram Services

Section 910 of the Act authorizes that funds appropriated under this title shall also be available for grants to any public or nonprofit agency or institution for services needed by, or which will be of substantial use to, any two or more Regional Medical Programs. Grant applications submitted under this section may be received from any Regional Medical Program or eligible institution or agency. If the application is for activities to be carried out in specific Regions, the approval of Regional Advisory Groups of all Regions covered by the proposed activity is required by the Division.

If the application is from an institution or agency seeking to provide services which may be utilized by two or more Regional Medical Programs, without a specific regional focus, Regional Advisory Group approval is not necessary. The application must include evidence documenting the need for the activity by two or more Regions, or show how the proposed service may be of use to two or more Programs. If a Regional Medical Program proposes to carry out such activity, the application must be approved by its Regional Advisory Group.

REPLACE Chapter III, Section IV. Assurances - General Responsibilities (page 9) with:

General Responsibilities--The grantee institution is responsible for administering the grant in accordance with regulations (Appendix 2) and policies of the Division of Regional Medical Programs. This responsibility applies both to itself and to each affiliated institution. When an affiliating institution does not have an officially stated or an applicable policy, then the grantee institution policy prevails.

For example, if an affiliating community hospital does not have salaried physicians who serve on a fulltime basis and thus has no applicable salary policy, then compliance with Division of Regional Medical Programs guidelines on salaries, as found in Chapter III, Section VII, page 14 (Allowable Direct Costs - A. Personnel Costs), would require use of the salary policies of the grantee institution.

Similarly, if an affiliating institution does not have an established travel policy, then the travel policies of the grantee prevail and, in any case, the general restrictions on travel policy apply, in accordance with Chapter III, Section VII, page 16 (Allowable Direct Costs - L. Travel).

THE FOLLOWING RECOMMENDATIONS were made by the National Advisory Council, Regional Medical Programs Service, at its February 20-21, 1969 and May 26-27, 1969 meetings. They are policies with regard to various types of Regional Medical Programs projects:

Chronic Renal Disease

"Recognizing the complexity of treating chronic renal disease and the enormous cost of mounting a service program even in a restricted locale, the Council recommends that Regional Medical Programs grant funds awarded to projects in chronic renal disease be limited to support of those projects which provide for:

> Training of physicians and other allied health professionals for management of chronic renal disease patients, and
>
> Regional planning for a coordinated Regional approach to prevention, diagnosis, and clinical management of renal disease."

-- May 26-27, 1969 Council Meeting

Dial Access Audiotape

"The technique of direct telephone access to pre-recorded tapes on selected topics of interest to physicians and allied health personnel is becoming increasingly popular in Regional Medical Programs. The Council recommends that proposals for projects of this kind meet the following criteria before being referred for review as part of a Regional Medical Programs application:

> The application should contain an explanation of the way in which the project fits into the total regional education effort for physicians and other health professionals.
>
> Proposed evaluation of the service must involve its receptivity and value to the professionals in their practice. The mere measurement of numbers of the incoming calls is insufficient.
>
> When the request includes the establishment of an independent network (in contrast to sharing an already established facility), the statement of justification for the hardware investment should include the rationale for a new network as well as a plan for long-term use of the network.
>
> There must be a plan (both long and short range) for the development of the tape library, justifying any decision to make rather than share or purchase tapes; for the selection of subject matter; and for the identification of target groups (i.e., physicians, nurses, etc.)."

-- May 26-27, 1969 Council Meeting

Disease Categorical Versus Comprehensive

"The Council reaffirms its endorsement of the policies in this regard as set forth in the Regional Medical Programs Guidelines Chapter III, Section V. However, in so doing, it emphasizes that full consideration will be given to applications for activities which pertain to problems in heart disease, cancer, stroke, and related diseases but which also have an impact on the diagnosis and treatment of other diseases, and/or fulfill a specified objective of the Region."

-- February 20-21, 1969 Council Meeting

Major Investments in Medical Equipment

"The Council agreed that, in order to be considered for final recommendation by it, all applications which include requests for purchase of major items of fixed and moveable therapeutic and diagnostic equipment must include....

- A statement of the rationale for charging any or all of purchase price of the equipment to the grant, and of the justification for the proportioning of the shared costs among those involved in the purchase;
- A proposed plan for accounting and fiscal control of the revenues accruing to the project (see HEW Grants Administration Manual Issuance, Disposition of Grant-Related Income);
- Adequate evidence that the project plan, including the acquiring of the equipment, has been reviewed, and if necessary, approved by the appropriate local planning agencies."

-- February 20-21, 1969 Council Meeting

Radiation and Dosimetry Services

" In accordance with the recommendation of the Council in its February meeting, an Ad Hoc Committee on Radiotherapy Dosimetry Services was convened on April 8 to discuss the general subject of radiotherapy consultation and dosimetry services in Regional Medical Programs and to provide guidance to the Council for the review of proposals in this area. The following are the Committee's recommendations, which were approved by the Council, of what should be included in proposals asking support of radiotherapy consultation and dosimetry services:

Indication of the applicant's intention to participate with representatives of other specialties involved, in a multi-disciplinary approach to the treatment of cancer patients.

- Assurance that the radiologists who are to receive the dosimetry service are adequately trained in radiotherapy or are willing to accept clinical consultation and assistance from the Radiotherapy Department providing the dosimetry service.

- Indication of measures to be taken to assure accurate record keeping, careful followup of each patient, continuity of care, and feedback of information on length and quality of survival.

- Assurance that there will be regular monitoring of all radiotherapy equipment, including calibration of the calibration instruments themselves.

- Indication of plans to make the dosimetry and calibration services self-supporting within a relatively short period of time."

-- May 26-27, 1969 Council Meeting

Targeted for Specific Population Groups

"The Council, recognizing the diverse problems of medically disadvantaged consumer groups, both urban and rural, urges that specific planning to meet the health needs of such groups be a function of Regional Medical Programs.

"NOTE: In discussing this matter, the Council expressed its interest in further discussion of the special problems and appropriate role of Regional Medical Programs in metropolitan communities, especially in high density population areas served by many centers of medical excellence. Such an item will be placed on the agenda for the next meeting."

-- February 20-21, 1969 Council Meeting

Television Production and Network Facilities

" Council recommends that all new operational projects requesting major investments or funds for equipment and activities in television be thoroughly studied by Division staff and expert consultants for consideration for funding under the new authority for Multi-program Services provided under Section 910. It further recommends that applications for continuation and renewal of previously funded major television activities be reviewed by the same group of expert consultants on the basis of the progress being made in the applicant Region toward its television objectives, and how those activities might be related or expanded to a Multi-program Service."

-- February 20-21, 1969 Council Meeting

ADD. See Chapter III, Section VII. Financial Management, Part F (page 15):

REGIONAL MEDICAL PROGRAMS

ALTERATION AND RENOVATION GUIDE*

(SUPPLEMENT 2)

PART ONE: APPLICANT'S GUIDE

I. Introduction

The objective of the Division of Regional Medical Programs Alteration and Renovation program is to support fully documented program needs of individual regional medical programs. Included in this category are alteration, major repair, remodeling and renovation of existing buildings (including initial built-in equipment) and replacement of obsolete built-in equipment within existing buildings.[1] It is intended that Regional Medical Programs provide funding for such activities only when other sources of funds, Federal or non-Federal, are not reasonably available to implement DRMP approved projects. Up to 90 per cent of the cost may come from Regional Medical Programs operational grant funds.

II. Definitions

For the purposes of the Regional Medical Programs Alteration and Renovation program, the following definitions shall apply:

A. Built-in Equipment

Built-in equipment is that affixed to the facility and customarily included in building construction contracts (e.g. - fixed equipment as autoclaves, x-ray equipment, building elevators, air conditioning, pumps and compressors).

B. Alteration, Remodeling, and Renovation

Work designed to modify existing space and to supply the required utilities and services.

C. Major Repair

The restoration of an existing building to a state of soundness.

D. Site

Site is the tract or plot of land on which the facility is located. It is limited by the minimal requirements for construction and operation of the building.

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[1]Construction of facilities, per se, is not permitted under the enabling legislation. An existing building, to be eligible for construction funds, must be in reasonably good condition with a life expectancy of ten years or more.

E. Project Site

Project site refers to the operational area within the interior finish line of the requested RMP construction project.

III. Allowable Alteration and Renovation Funding

A. General

Allowable alterations and renovations, as noted above, exclude the construction of a new building or the expansion of an existing building.

A completed structure (building or part of a building) must include finished floors, ceilings, walls and essential structural attachments, (e.g. - wiring, electrical fixtures, plumbing, heating and air conditioning, if air conditioning is a part of the original building plan) to make it structurally complete and functionally prepared to accommodate the occupants or the activity for which it was planned and built.

A building would not be considered complete and ready for occupancy if the interior walls, ceilings and floors were unfinished, or if any of the utilities (e.g. - heat, light) were not installed and ready for use. Thus, in a two-story building, if only the first floor possessed all the structural attachments, the second floor would be structurally incomplete. Consequently, it would not be eligible for alterations and renovations with DRMP funds since this would constitute original completion of part of the structure (see, however, Section B, below). However, modification of space and utilities on the first floor which is structurally complete and ready for use, would be a proper charge to a DRMP grant.

B. Utilization of Shell Space

It is not mandatory that shell space be completely finished prior to the award of a construction contract. However, the cost of utilizing shell space shall not exceed the cost of renovating comparable space in another part of the building.

C. A & R Construction Allowances for Special Equipment

The cost of any work related to the installation of special equipment inside the interior finish line of the space in which the equipment is to be used is an allowable alteration and renovation cost. This includes structural changes in or extensions to the utility systems and refurbishing or refinishing of the building surfaces.

D. Demolition

The cost of removal of existing materials and equipment on the project site of the approved RMP project is an allowable direct cost. If these have a salvage value, an allowance should be reflected in the bid of the contractor.

E. Architect's Fee

The cost of architectural and engineering services as well as other consultant services in connection with the Alteration and Renovation project as approved is an allowable direct cost.

IV. Alteration and Renovation Costs Which Cannot Be Charged to RMP Grants

Any new construction
Administrative Costs of an indirect nature
Moving costs (except that new equipment may be F.O.B. site)
Landscaping
Decorative architecture or furnishings
Libraries, except for small reference rooms within or adjacent to RMP space
Dining facilities
Student and faculty lounges
Cafeterias
Lecture rooms (conference rooms may be included if need can be documented)
Site or building acquisition costs
Donated material or services
Legal fees, court costs, or costs for related services
Fund-raising costs
Interest on bonds or any other form of indebtedness
The cost of supplies or movable equipment
Fees for professional services of designs which were abandoned
Any costs of a damage judgment
Any charge in excess of the net cost for materials, equipment or services when a grantee receives, or is entitled to a refund
The amount of any sales tax or excise tax when the institution is normally exempt from such taxes
Any cost of ceremonies
Any portion of those institutional costs which are normally considered to be indirect costs. However, when architectural and engineering professional design services are performed by the full time staff of the applicant, they may constitute an allowable cost. In such instances, the institution must keep records to support these charges.

V. Preparation of the Alteration and Renovation Application

A. General[1]

The description of the architectural engineering documents required is based on the assumption that all of the proposed projects will include only remodeling or equipping with no new construction. Inasmuch as the projects will involve the plans of existing buildings, the application should identify the existing space and relate the program needs to the alterations and renovations required. Early consultation with DRMP staff is suggested in projects involving proration and in projects which include remodeling as part of a project concomitantly involving new construction.

The amount of construction costs requested as part of a DRMP grant is the determining factor of the type of documents needed. Two copies of the following documents are to be submitted with the project application:

1. Requests under $25,000

    a. Narrative Summary
    b. Cost Estimate
    c. A sketch of the project area

2. Requests over $25,000 (Refer to Part II)

    a. Program of Requirements
    b. Final preliminary drawing

B. Narrative Summary

The narrative summary is a statement of the proposed functional utilization of the space and equipment requirements which is developed and written by the persons who will use and be responsible for the working space. It is the foundation upon which the architect and engineer base their final drawings and specifications and is best prepared by a team representing the program, management and architectural-engineer advisors.

The summary should describe in reasonable detail the need, character, and extent of the planned functions of the RMP project to be housed in the altered or renovated space. However, since no single format best serves the wide variety of potential applications, each applicant is encouraged to prepare the narrative in a manner which best describes his program.

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[1]Part II of these Guidelines is intended to provide specific information of a technical nature for use of the applicant's architectural and engineering staff.

C. Cost Estimates

The following is a sample of the type of cost estimate to be submitted with each A & R request:

Qualifying Costs (estimated costs in which the RMP Program is requested to participate).

		Total Cost	RMP Participation
A. Construction			
1. General Construction			
Carpentry			
Masonry			
Painting			
2. Mechanical			
Heating, Ventilating, Air Conditioning			
Plumbing			
Sheetmetal			
3. Electrical			
B. Exterior Elements			
1. Mechanical (Outside Project site)			
2. Electrical (Outside Project site)			
3. Architectural (Outside Project site)			
C. Architect's Fee			
D. Engineer's Fee			
E. Built-in Equipment			
F. Demolition			
G. Total eligible costs of alterations and renovations			
H. Total eligible net square foot of floor area in RMP project			
I. Estimated cost per net square feet			

D. Sketch of the Project

As built drawing or single line drawing showing the existing space and the remodeling to be accomplished by the proposed construction.

VI. Accounting for Alteration and Renovation Costs

Accounting for alterations and renovations shall be in accordance with the accounting policy of the grantee and/or affiliated institution, consistently applied to all sponsors, regardless of the source of funds. The grantee must maintain accounting records to reflect that at least 10% of the A & R cost have been paid from institutional or other non-Federal funds. The cost of the facility, including construction project costs, must be kept in a prime account so that the grantee can furnish the following upon request:

a. Total receipts
b. Total disbursements
c. Balance in the account

Cost Evidence

The grantee or affiliated institution is to have on file documentary evidence such as contracts, invoices, cost estimates, and payrolls supporting each item of cost, for five years following the completion of construction, or until the PHS gives notification of satisfactory audit.

Custody of Disbursements

Accounting alterations and renovations records should be set up to provide the information needed to identify receipt and expenditure of all A & R funds separately for each A & R project. In addition, the institution must abide by all State and local laws, regulations, and procedures governing the custody and disbursement of funds.

Rebudgeting of Funds

The grantee or cooperating institution may not make any increases in the approved alterations and renovations budget which will increase RMP participation unless written approval has been obtained from the Division of Regional Medical Programs.

VII. Related Requirements

A. Bidding Alternates

Alternate Bids are proposals required of a bidder reflecting amounts to be subtracted from or added to basic proposals in the event specific changes in the work are ordered. It is not the policy of the DRMP to encourage alternate bids. If alternates are used, the grantee must determine which costs are necessary before the bids are advertised. In these instances, DRMP participation will be limited to the necessary costs.

B. Change Orders

DRMP participation in change orders is limited to 2% of the total eligible cost of the alterations and renovations.

C. Force Account

"Force account" is used to describe the situation when the grantee's own construction and maintenance staff is utilized in the alteration or renovation project. Force accounts are not recommended for RMP projects. However, projects of up to $25,000 may present unusual problems, making them acceptable for "force account" management if justified to and approved by DRMP.

D. Davis-Bacon Requirements

Construction contracts in excess of $2,000 must comply with the requirements of the Davis-Bacon Act.

E. Equal Employment Opportunity Statement

If grant funds are requested for all or part of the cost of any construction contract in excess of $10,000 the applicant or grantee must agree to the condition in the Equal Employment Opportunity Statement required by Executive Order 11114.

PART TWO: ARCHITECTURAL AND ENGINEERING GUIDE SUPPLEMENT

I. Preparation of Architectural and Engineering Documents (for projects in excess of $25,000)

The requirement for a description of the architectural and engineering elements of the project assumes that proposals will include only remodeling or equipping, with no new construction. Hence, they will involve plans of an existing building and will show what is now existing as well as revision proposed in the existing structure. When a proposal includes remodeling as part of a project for new construction, early consultation with the DRMP is suggested to enable proper cost allocation.

II. Submission of Architectural and Engineering Documents (for projects in excess of $25,000)

A. The initial architectural and engineering documents required to be submitted with the remodeling project application include two copies of the program of requirements and one copy of the final preliminary drawings.

1. Program of Requirements

The program of requirements states the function,[1] space and total cost of the proposed remodeled space. It is the applicant's functional planning guide for his architect and should be prepared with consultation from representatives of the various participating programs in the project, the administration and management of the facility in which the space is located, and architectural-engineering advisors. The Program of Requirements should be written with the following specific, topical headings to facilitate administrative, architectural and engineering review:

1. General Information
2. Description of the RMP Functions to Occupy the Space
3. A Space Schedule
4. List of Equipment Proposed for the Facility
5. A Cost Estimate
6. Appendix (if applicable)
   a. Special design problems
   b. Description of the structural, and utility systems existing and proposed for the remodeled facility.
   c. Supplements
      1) Access for physically handicapped
      2) Provision for requirements of the National Public Safety Code

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[1]Function should be explicit, detailed beyond titling of proposed use, and descriptive of purpose toward attainment of program objectives.

3) Historical site clearance[1]
4) Model city program review

2. Final Preliminary Drawings

The final preliminary drawings should be color-coded or cross-hatched to indicate the space assigned to the RMP operation. They should also conform to the conventions described in the American Institute of Architect's Handbook on Professional Practice. See "Measurement and Identification of Building Areas" in the Handbook for a delineation of specific directions as how to code the plans for identification of RMP areas.

B. Final Submission of Architectural and Engineering Documents (After Approval of Grant)

The final submissions will include one copy of each of the following documents:

1. The final cost estimate.

2. Coded architectural floor plans showing the final arrangement of space committed to RMP.

3. The bidding documents, including final working drawings and specifications.

4. The design analysis report, describing the structural, heating, ventilation, and air conditioning systems, plumbing system, electrical power system and provisions to meet the various mandatory Federal requirements for access for physically handicapped, provisions for Public Safety Code and special clearances.

A general approach to the completion of the above would include:

FINAL COST ESTIMATE

Using the cost estimate outline as a guide, revise the cost estimate to agree with the final working drawings. The Division of Regional Medical Programs should be advised if the cost estimate has changed since the first submission.

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[1]P.L. 89-665, Section relating to the preservation of historic properties.

FINAL ARCHITECTURAL FLOOR PLANS SHOWING PROGRAM SPACE

Prepare one final set of floor plans in accordance with the guidlines on identification and tabulation of research space. All net areas under Federal support must be indicated by color coding or cross hatching. (Use different color or cross hatching codes for each agency.)

BIDDING DOCUMENTS

Specifications:

Unless adequately indicated on the drawings, the specifications should describe in full the workmanship, size, capacity, manufacture, finish, and other pertinent characteristics of all materials, products, articles, and devices.

They should include a cover sheet and/or title sheet; an index; the invitation to bid; bid proposal form; contract form; general[1] and special[2] conditions; bid bond; performance bond; labor and material bond; insurance; completion time; warranty; mandatory labor standards (including verbatim wording, wage rates and equal employment opportunity); technical sections describing material, and workmanship in detail for each class of work.

FINAL WORKING DRAWINGS

These should be on a sheet not to exceed 48 inches in length and drawn to a scale suitable to explain the project. They should include:

1. Architectural

   Cover sheet; index; legend; plot plan; floor plans; roof plans; exterior elevations; longitudinal and transverse cross sections; wall sections; interior details; material; finish, door and window schedules.

2. Structural

   Foundation or footing plan, floor framing plans for each floor, roof framing plan, structural details, column, beam, joist, and lintel schedules.

3. Heating, Air Conditioning, Ventilation

   Plans for each floor, specific details schedules, design notes.

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[1]The general conditions recommended by American Institute of Architects acceptable.

[2]Special conditions generally include Federal legislative requirements.

4. Plumbing

   Plans for each floor, specific details, schedules, design notes.

5. Electrical

   Plans for each floor, specific details, schedules, design notes.

DESIGN ANALYSIS REPORT

The design analysis report is a brief engineering report which technically describes or explains provisions for the following topics:

1. Condition and structural strength of the existing building and the proposed remodeled space (provide floor loading capability).
2. Heating, ventilation, and air conditioning.
3. Plumbing
4. Electrical power system.
5. Certification of compliance with the National Public Safety Code.
6. Access to the remodeled space by the physically handicapped.
7. Air pollution problems, if any are to be encountered or created by the completed remodeling.
8. Noise abatement control.
9. Historical site clearance.

III. ITEMS TO BE EMPHASIZED IN THE BIDDING DOCUMENTS

1. Correlation of Bids with Cost Allocation to Grants

   It is important that the bid proposal be designed to obtain bids that correlate directly with the arrangement for cost allocation to the participating grants.

2. Adequate Provisions for Maximum Competition

   The construction contractor must make adequate provision for maximum competition among manufacturers, vendors, or suppliers of materials, supplies, equipment, fixtures, processes and/or other items to be supplied under the contract. Restrictive specifications which are designed to limit bidding to one of several known sources of supply are not acceptable.

3. Time of Completion

The time allowed for completing the construction contracts must be stated in the specifications or other bidding material in the instructions to bidders.

4. Maintenance and Repair Service

Where maintenance and repair services are to be available from the lowest acceptable bidder for special items, such as elevators, the specifications or bidding material shall clearly indicate to bidders that in awarding the contract, consideration will be given to the proximity and extent of the maintenance and repair service offered by each bidder.

5. Performance Tests

The various trade sections of the specifications should clearly describe the performance tests of the particular mechanical and electrical equipment systems. The clause should be required that such field tests be witnessed by representatives of the owner (or authorities having jurisdiction) and should be performed prior to acceptance and final payment.

6. Specification Addenda

Addenda to specifications must reach bidders prior to the submission of bids. All addenda must be approved by the Division of Regional Medical Programs prior to awarding of the contracts.

7. Mandatory Labor Standards

All construction contracts financed with Federal grant-in-aid funds under Title VII, Public Health Service Act, as amended, must conform with the Copeland Act (Anti-Kickback), the Equal Employment Opportunity Executive Orders, the Davis-Bacon Act, the Contract Work Hours Standards Act, and the Civil Rights Act of 1964. Grantee institutions are responsible for insuring that grant-supported construction contracts are carried out in conformance with these Acts and Orders, and for insuring that monthly or final payrolls covering the period in question have been received.

8. Bidding Alternates

The use of bidding alternates is not recommended for RMP remodeling. If alternates are used, their order of selection must be indicated in the bidding documents and adhered to in the selection of the low bidder

The original cost estimate is expected to have a five per cent reserve for bidding variations above the original cost estimate. Two per cent of the total eligible costs of alterations and renovations may be retained as a contingency fund after the contract is awarded.

9. Cash Allowances

The use of cash allowances is not recommended; however, at certain times it may be necessary to include them in the specifications for special items of construction or fixed equipment. Only special items should be considered as cash allowances. Common materials and equipment that are regularly manufactured (such as, brick and hardware) should not be considered as special items. These items should be described in the technical sections of the specifications. Only items of a special nature should be considered under a cash allowance, and then only when circumstances do not permit the preparation of a complete description in the specifications. If cash allowances are used, the following procedures must be followed:

a. competitive quotations or bids, based on complete specifications, must be solicited from three or more manufacturers or suppliers, and the award must be made to the responsible bidder submitting the lowest acceptable bid;

b. the difference in cost between the amount of the allowance and the actual bid must be adjusted by a contract modification.

10. Documents Required of Successful Bidder

The successful bidder is to provide the grantee the following:

a. Performance bond in the amount of 100 per cent of the bid price. No contractor may be required to purchase bonds from a specified agent or company.

b. Labor and material payment bond in the amount of 100 per cent of the bid price. No contractor may be required to purchase bonds from a specified agent or company.

c. Adequate fire, workmen's compensation, public liability, and property damage insurance during the life of the contract. No contractor may be required to purchase insurance from a specified agent or company.

d. Assurance that no subcontractor will be employed on the project who is on the U.S. Comptroller General's list of ineligible bidders.

e. A one-year warranty covering materials and workmanship.

IV. Guidelines on Cost Estimating and Eligible Costs

The calculation of the amount of an RMP remodeling grant award is based on the allocation of costs to the space that will be assigned to the approved RMP project. If alterations and renovations involve more than the RMP project site, the eligible costs of RMP are determined by allocating a proportional amount of the total remodeling costs to the RMP project.

A. Definitions

1. The Grant Participation Percentage (G.P.P.)

   This is the proportion of necessary costs allocated to the RMP area which will be paid by RMP grant funds. This amount cannot exceed 90 percent of RMP funded facilities.

2. The Cost Allocation Ratio (C.A.R.)

   This is the ratio used to allocate a portion of the total eligible costs of construction to the RMP space which the grant will support.

3. Net Assignable Area

   The sum of all areas of a building assigned to, or available for assignment to, an occupant, including every type of space functionally usable by an occupant.

The cost allocation ratio is calculated by dividing the RMP net (assignable) area by the total net area being remodeled. In general, the construction costs within a building are allocated to the RMP grant by this ratio.

B. Calculation of the Amount of the Grant

The necessary construction costs for the remodeling and utility lines within the building to a point five feet outside the building are multiplied by the cost allocation ratio. Then, the necessary costs for utility lines beyond the five foot line and approved in the grant award are determined, and allocated to the RMP grant by the cost allocation ratio or other methods and added; the final total is multiplied by the grant participation percentage (not to exceed 90%) to determine the remodeling costs to be funded by the grant.

C. Costs Chargeable to RMP Space by the Cost Allocation Ratio

1. Structural and Architectural Costs

   All remodeling work within the building

2. Mechanical Costs

   All costs incidental to mechanical work within a perimeter of five feet outside the building.

3. Electrical Costs

Costs incidental to such work within a perimeter of five feet outside the building.

4. Professional Fees

All professional, technical, and consultation costs in 1, 2, and 3 above, incident to the design and execution of the project from its inception to final completion and acceptance of the facility by the contracting institution. These fees may cover architectural and special consultation, site investigation, fees (e.g., permits, tests, printing). and inspection fees incidental to the execution of the contract documents.

5. Fixed Equipment

Equipment usually included in the construction contract, including scientific or electrical equipment and building equipment without which the RMP space would be nonfunctional for the work specified. in the Program of Requirements.

6. Sales Tax

The nonrefundable sales tax and Federal excise tax, which a grantee pays in connection with constructing and equipping an approved project, are allowable costs for grant funds.

7. Insurance

The cost of insurance coverage during the construction is an allowable cost for a RMP grant, including:

a. Grantee's liability insurance.

b. Fire insurance covering construction in the event the insurance is carried by the grantee rather than by the contractor.

c. The cost of insurance carried by the grantee to protect against the loss of equipment.

8. Salary

Salaries paid architects, engineers, draftsmen, and inspectors, employed specifically by the grantee for the grant project is an allowable cost, if based on documented actual time-and-wage rates.

D. Equipment Costs

The equipment for RMP space involves two types, scientific and building fixed equipment which is usually purchased as part of

the construction contract, and program equipment which can be purchased separately from the RMP program funds.

1. Scientific Fixed Equipment

   Fixed scientific equipment is that which requires modification of the facility for satisfactory installation or removal. This equipment usually requires connections to utility services (such as water, gas, air, steam or to the building ventilation system) by other than simple joining by such devices as a union. Also, the removal of a partition may be required, or the installation of a special structural provision (such as, reinforcing the floor, shielding against radiation, electrostatic shielding, soundproofing, or insulation). The simple connection of electric power, by plugging the equipment power cord into the building electrical system or temporary attachment to a utility system, does not qualify the item as scientific fixed equipment.

2. Building Fixed Equipment

   Fixed building equipment is defined as that required for the general public use of the facility. Circulation equipment (elevators) and refrigeration equipment (compression) are examples.

   It is necessary that a careful distinction is made between types of equipment. At final inspection, fixed equipment purchased in the construction contract must be in place and be capable of operation. Other equipment chargeable to the grant must have been purchased and immediately available when the facility is completed and inspected. This must be in accord with minimal needs. Additional equipment can be purchased at a later date when the facility is fully staffed, if previously approved by the DRMP.

   The costs involved in purchasing, shipping, and installing new equipment are allowable but the cost of moving equipment from one building to another or for storing existing equipment during construction are not eligible for support by grant funds.

E. Costs which are Negotiable (may be Allocated by the Cost Allocation Ratio or Another Method)

1. Exterior Utility Costs on the Approved Contract Site

   These include costs for repairing or replacing utilities adjacent to the building where the RMP space is located. Since eligible costs of these items is subject to negotiation, they must be supported by separate justification, computation, and cost data.

2. Mechanical (beyond five feet of the building and on the approved site)

   These costs include utility systems adjacent to the RMP space. Water and sewer line connections to a public main, in an adjacent

street, usually qualify for support. Other costs may include the prorated share of centralized power plants and chilled and condenser water, water supply and sewage treatment facilities. The RMP portion of these costs is calculated on a demand basis (e.g., British Thermal Units per day). These costs, also, must be supported by separate justification, computation, and cost data.

3. Electrical (Beyond five feet of the building and on the approved contract site)

These include utility elements, such as switch-gear and power transformers. They must be supported by separate justification, computation and cost data and, as in 2 above, the DRMP portion of the costs is calculated on a demand basis.

F. Contract Modification ("Change Orders") and Contingency Funds

If contract modifications are proposed because of significant changes in the approved grant program, approval must be obtained from the DRMP before such modifications are authorized. Otherwise there is a possibility of disallowance of costs at the time of final inspection. The disallowance would occur because the completed facility failed to meet provisions described in the application and in the grant award.

Changes in design details or program functions after the final plans are reviewed and approved should be considered as "change orders" and in no case may they exceed 2% of the total alteration and renovation cost for RMP participation.

It should be noted that grant funds, upon approved application, can be used for participation in design costs incident to the preparation of construction drawings and specifications (for RMP portions of new construction and for remodeling). They may be approved for use during the actual construction phase for payment (for that portion which represent the RMP) of construction inspection fees or salaries to those who represent the interests of the grantee (e.g., architect or a clerk of the works).

V. Bidding Procedures and Construction Administration

A. Construction Administration

As a rule, the responsibility for managing the bid advertising and opening, and the construction contract, is delegated to the grantee, by the terms of the grant award and the applicable regulations. The Division of Regional Medical Programs is available for assistance, upon request, and conducts a final inspection of the project when necessary.

B. Bidding Methods

In obtaining competitive bids, either of the following methods is acceptable:

1. Open Bidding

Public advertisement is to be made in suitable newspapers and trade journals. Advertisements must appear prior to the release of bidding material to any bidder.

2. Selective Bidding

Three or more competent bidders may be selected and invited to submit bids.

C. Unacceptable Bidders

Prospective bidders should be advised that bids submitted by contractors currently on the Federal list of unacceptable bidders will not be certified for Federal grant fund participation. This notice should be included in the bidding documents.

Anyone furnishing design and/or supervisory services on a project must be disqualified as a bidder on such project. The acceptance of such a bid would be in violation of the requirements of competitive bidding since the firm or individual providing such service is in a preferred position.

D. Bid Openings

Bids are to be opened publicly in the presence of the bidders or their representatives at the time and place stated in the invitation for bids. The applicant must furnish the Division of Regional Medical Programs with a copy of an abstract or tabulation of all the bids.

E. Inspection of Bids

Original bids are to be made available by the grantee for inspection by authorized representatives of the PHS.

F. Administration after Bids are Received

1. Preparation and Submission of Information after Construction Bids are Received

The first action is to submit Construction Cost and Contract Information to the Division of Regional Medical Programs

This information should show the final estimated cost of construction, based upon the cumulative bids, and indicate the proposed selection of the lowest acceptable bidder.

2. Low Bid Exceeds Cost Estimate on which Award is Based

When the bids received are higher than the estimated cost on which the grant award was based, the grantee may:

a. Proceed to pay the increased cost from his own resources.
b. elect to revise the plans and specifications and readvertise the project, or revise the plans and obtain revised bids from the original bidders. Revised plans must be approved by the Division of Regional Medical Programs before rebidding.
c. negotiate, within reasonable limits (i.e., approximately five percent) with the low bidder on specific items of construction. The negotiations can be at the discretion of the contractor and the applicant. However, the DRMP must approve all such negotiations since they could change the project concept.
d. elect to request supplemental construction grant funds from the RMP. Such a request will be considered, if the following conditions have been met:

(1) the scope of the project has not been increased since the grant application was reviewed by the RMP Advisory Council;
(2) the amount of RMP net space has not been increased;
(3) the total area of the remodeling and extension costs have not increased significantly, and
(4) the architect's final cost estimate delineates the basic trade specialties (i.e., structure, plumbing, ventilating, air conditioning, heating, electrical) and bidding documents show comparisons between the estimated cost and the bid cost for each.

3. Contract Award

The contract should be awarded to the responsible bidder who submits the lowest acceptable bid. Alternates must be selected in the order prescribed in the invitation to bid. Contract awards are subject to the approval of the DRMP.

VI. Preconstruction Conference

When deemed advisable by the Division of Regional Medical Programs, immediately after all building construction contracts have been signed, the applicant may be requested to arrange a meeting of DRMP staff with the applicant and such persons as the architect, clerk of the works, consultant, prime contractor, and principal subcontractors. This discussion of the responsibilities of the various parties is intended to avoid misunderstandings and problems which may arise during construction. On joint projects, representatives of other agencies may wish to attend the meeting and an invitation to them may be extended.

VII. Mandatory Labor Standards

All construction contracts financed with Federal grant-in-aid funds under Title VII, PHS Act, as amended, must conform with the Copeland Act (Anti-Kickback), the Equal Employment Opportunity Executive Orders, the Davis-Bacon Act, the Contract Work Hours Standards Act and the Civil Rights Act of 1964. Grantee institutions are responsible for insuring that grant-supported construction contracts are managed in conformance with these Acts and Orders, and for insuring that

monthly or final payrolls, covering the period in question, have been received. Failure to comply with these Acts and Orders may lead to the withholding or withdrawal of PHS grant funds.

VIII. Inspection

The grantee institution is responsible for providing adequate inspection and management of the construction contract. The Government will not participate in costs for work that does not conform with the contract documents, or for correction of excessive errors contained in the final working drawings and specifications.