



E001029

A-1 PHYSICIAN EDUCATION

How can family physician resistance to education in arthritis be reduced?

A. Services

1. Make back up more available.
2. Emphasize team approach; include practitioner.
3. Don't take away his patient.
4. Access to peer review to assess care effectiveness.
5. Assure reports back to physician of what center did, found, recommends.
6. One-to-one contact.
7. Help locate allied health personnel in their offices.
8. Help establish 2-way referral.
9. See patients together.
10. Increase assistance opportunities from centers.

B. Education

1. Through professional societies.
2. Use simpler educational tools; eg; cassettes.
3. Distribute bulletins and journals.
4. Devise more appropriate motivational methods.
5. Teach on their home ground .
6. Center-office interaction improvement.
7. Make continuing education available to TV at convenient times.
8. Strong programs such as state symposiums.
9. Educate patients to seek care wisely.
10. Identify the prospective ratio of arthritis patients.

C. General

1. AF work with AMA
2. Financial incentives, other incentives.
3. Don't talk down to local physician.
4. Patient feedback.
5. Solicit private physician participation.
6. Differential fees (higher) for arthritis Rx/
7. Establish need in community for practitioners services in arthritis.
8. PSRO controls for quality care.
9. Direct patient (consumer) demands.
10. Public pressure.
11. Start low key development of trust, and give local physician credit for delivery role played.

A-1 Physician Education

How can arthritis physicians achieve optimal utilization of their skills?

1. Through education of Primary Care Physicians.
2. Conducting workshops in Rheumatology.
3. Give clinics to instruct other medical and para-medical personnel.
4. Learn about knowledgeable needs of local practicing physicians.
5. Prepare a broad base of consultation systems to Primary Care Physicians
6. Delegation of responsibility to others within their field of accomplishments.
7. By consulting with non-professional personnel especially trained in arthritis.
8. Restrict practice to Rheumatology only.
9. Computerize patient records.
10. . .PATient Compliance
11. Well planned patient presentations.
12. Desimination of known activities.

A-2 ALLIED HEALTH EDUCATION

How can the allied health role as service extenders be improved or expanded?

By delegating total responsibility for screening reserve fellowship programs.

Have Allied Health personnel do more rheumatism reports.

The Allied Health personnel need to know more about arthritis care problems.

By designing and providing the organization's framework.

By using Allied Health personnel to help screen patients.

Use Allied Health personnel as members of the team.

Improve Allied Health personnel training and use of quantitative measurement devices.

Education of physician as to role that Allied Health and how they can assist the physician.

Physicians should accept their quality and not feel that M.D.'s are the only real professionals.

Get third party for all health personnel skills by using all health personnel to help screen patients to determine when arthritis treatment is needed.

Increased instruction in home programming health development of home followers.

Include patients as part of the health team.

Circuit writing "screen nurses" to find rheumatic arthritis in the physicians offices.

Increase credibility of all health professionals.

A-2 ALLIED HEALTH EDUCATION

How can continuing education in arthritis be maintained for practicing allied health personnel?

1. By working programs in conjunction with continuing education programs which will involve allied health professional schools.
2. Through hospital in-service programs.
3. Keep continuing education in arthritis to licensing requirements--pay people to come for courses and hold courses in attractive places.
4. One to one with physicians.
5. Development of allied health experts to conduct continuing education programs.
6. Active participants in allied health professional chapters of national allied health professional sections of arthritis foundations.
7. Appropriate and sufficient funds for continuing education programs--not merely leftovers from physician's programs.
8. Utilize team approach which include patients as part of the team.
9. Avoid duplication, that is, coordinate existing educational efforts.
10. Contact and coordinate with state boards of nursing, OT, PT, home health agencies and other allied health professional organizations.
11. Inclusion of arthritis in allied health licensure examinations.
12. Change in state licensing laws may be needed with medical schools offering the necessary leadership.

A-3 PATIENT EDUCATION

How can patients be motivated to follow prescribed regimens?

1. Through patient education which assures the patient that results will be beneficial with less pain and suffering if regimes are followed.
2. Through family and peer pressure--general public education that can be understood.
3. Education of the disease, treatment and resources for each step carefully explained.
4. Better education from physician's and orthopedic organizations--effective use of A.H.P.'s.
5. Motivation through group therapy coordinated by arthritis treatment centers.
6. Give patient adequate time to learn about disease, treatment and results that may be obtained.
7. Frequent monitoring of all patients in the beginning of regime.
8. By demonstrations "seeing success of others."
9. Let the patient know with documented details that dosages taken now and then and not regular will not help and will possibly cause harm.
10. Free medication with "easy to understand" education material.
11. Follow up by telephone to patient, "Are you taking your pills," "How do you feel?" Develop the "we care" attitude, (team approach.)
12. Make the patient a part of the team.

A-3 PATIENT EDUCATION

How can patient vulnerability to non-prescribed medications and devices be reduced?

A. General

1. Monitoring by consumer advocate groups.
2. Peer review on recommendations for commonly accepted Rx.
3. Central audit of reinbursements.
4. Tax the non-prescribed medications and devices higher.
5. Reduce cost of prescribed medication.
6. FDA Regulations
7. Prove their "worth" .
8. Advertising regulations.
9. Greater publicity on "quackery".
10. Concerted pressures on the media; expose imposters.
11. Expand certification requirements.
12. Officially investigate effectiveness of available medications and devices.

B. Education

1. More, better, faster, more intensive, better planned/developed patient education.
2. Physicians give patients more attention as an educational measure; educate from physician's office.
3. Specific instruction by allied health personnel of the patient's treatment requirements.
4. Media seminars.
5. Public forums; clearinghouse information.
6. Consumer education in schools, media, and physician's offices.
7. Intensive mass media education.
8. Educate the children.
9. Educate the adults.
10. Patient group session education.
11. Use patients to help educate other patients.

C. Providers

1. Professional observing ethical approaches.
2. Professional ~~XXXX~~ counseling, be sure it occurs.
3. Good care will reduce patient interest in quackery.
4. Make care more available.
5. Physicians advise patients.
6. Get feed back on patient functional assessments.
7. Abstain from criticism to gain patient's trust.
8. Better patient followup.
9. PSRO activities.
10. Maintain central inquiring point for patients to check reliability of claims.
11. Research.

A-4 DEMOGRAPHIC FACTORS

How can demographic information be accumulated through current program activities?

1. Set up national or regional standards of demography information and seek universal consent for data use.
2. Establish special projects using expertise already existant outside your areas if not within your area.
3. Using uniform case sheets and reporting systems through the established RMP Centers.
4. Collection of specified data, which are centerally analyzed by a computer system.
5. Use data base for standardization of evaluation and treatment regimes.
6. Initiate national criteria for data collection, computer analysis, and standardization of publication.
7. Set up arthritis registry in uniform system on national basis.
8. Use RMP Centers for collecting uniform data with central computer to analyze and publish.

A-4 DEMOGRAPHIC FACTORS

How can existing or proposed arthritis services be made more responsive to demographic characteristics of the locality?

1. Consumer participation on Advisory Committee
2. Inclusion of consumer on planning committee.
3. Inclusion of consumers on implementation review.
4. Moving away from hospital based programs to outside screening.
5. By moving personnel to patients.
6. Involvement of mobile teams.
7. Refine existing demographic data.
8. Frequent review of data.
9. Awareness of specific areas to be served, i.e., culture, language, financial needs and services available.
10. Organize committee as a feed dash in mechanism.
11. Aggressive public relation program.

A-5 ARTHRITIS SERVICES

HOW CAN AN ARTHRITIS CENTER BEST SUPPORT OR BACK UP COMMUNITY SERVICES?

ORGANIZATION

1. Having coordinator who is available to everyone.
2. Organize secondary-primary linkages
3. Medical Society support to education
4. Center-outreach programs which provide "credit" to participants
5. Establish coordinated referral system
6. Coordinate arthritis services
7. Support development of missing services
8. Joint community planning
9. Cooperate in coordinating services

COMMUNICATION

1. Improving all community relationships
2. Communicate with local health professionals; personal links
3. Cooperate in educational activities between centers and center-clinics
4. Jointly sharing ideas on needs
5. Make information listings available
6. Disseminating useful information; exchange information locally
7. Assisting/facilitating conferences, workshops, consultations
8. Develop innovative educational programs
9. Visit community hospitals and clinics
10. Involve local practitioners in treatment of local patients
11. Serve as an info-educational clearinghouse
12. Have community agencies attend conferences/seminars
13. "Inreach" training for outside groups

SERVICES

1. Continuing education programs
2. By best of all being service-oriented
3. Finding out what is needed and help coordinate development
4. Provide excellence at professional levels
5. Assure consultation services
6. Assure non-duplication of services
7. Laboratory support
8. Provide outreach services
9. Include community services and resources as an element of professional training
10. Use them! Take referrals to and from them
11. Provide a community liaison coordination person

A-6 ARTHRITIS SERVICE DEPLOYMENT

How can arthritis services deployment be defined or characterized?

I. General

- a. By regional or local needs.
- b. By available facilities.
- c. New outreach to communities.
- d. Liaison between provider and teaching institutions.
- e. Use of many personnel backgrounds, and skills.
- f. By relationships of physician, allied health, and patient education activities and patient services (functions.)
- g. Groups of specialists taking care of patients.
- h. Structured use of allied health and physician skills.
- i. Reaching people not reached before.
- j. Defining service goals, and expected outcomes.
- k. Objectifying sets of variables and components.
- l. By cost benefit.

II. Education

- a. Improved professional education.
- b. Increased public education.
- c. Organizing medical schools in alliance with local professional personnel.
- d. Consumer education.
- e. By teaching value.
- f. New disciplines to meet new needs.
- g. Must obtain a multi-disciplinary approach.
- h. Consultant services to outlying areas.

III. Services

- a. Services and needs of given areas.
- b. Documenting number and type of services delivered.
- c. Efficient delivery.
- d. Patient services on all levels.
- e. Patient self-care teaching.
- f. By the scope of treatment services.
- g. Documenting services.
- h. Age and function demands of environment.
- i. Developing good algorithms for documentation.
- j. Comprehensive care plan.
- k. Referral pattern networks.
- l. Institutional vs. private practice orientation.
- m. Inadequate.

A-6 SERVICE DEPLOYMENT

How can the deployment of arthritis services improve the integration of local resources?

1. Educational programs of all persons involved, using the team approach.
2. Create a local officer as Committee as a structure on which to build, with periodic review of results.
3. Consider the need and involve the Community in the development of service capabilities through a referral agency, (local arthritis chapter.)
4. By giving the lay organizations a medical unit that is recognized as their resource center.
5. Improving communications between providers of care and educating the consumer of existing services.
6. Establish referral programs through physician education.
7. By personal contacts in the communities.
8. By drawing together systems of services with like objectives.
9. Utilization of all existing local services plus manpower in setting up local linkages.
10. By carefully developing arthritis services around existing services as a catalyst to improve services in general.
11. Make sure area of deployment is large enough to encompass a population sufficient to utilize and be able to access resources which are to be integrated.
12. Let local arthritis centers coordinate multiple in-patient/out-patient services through a referral system.

#13

How can special needs of children be addressed by arthritic resources?

No difference between needs of children and adults.

Identify special needs and then provide services to meet them.
Use screening questionnaire.

Include pediatrician in all levels of planning and care.

Training AHP in meeting identified special needs.

Training physicians in diagnostic (awareness) and treatment capabilities in
Med School and continuing education programs.

Increase communication between primary physician and specializing physician
or clinic.

Educate public to be aware of the disease

Use existing resources to refer ie: Public Health and school nurses.

Regional facilities to serve wide geographical area.

Include patients own environmental influences in planning care.
Physician, Orthopedist, School, Parent, Family

Educate and involve patient and family in planning and care.

Increase number of MD & AHP specialists.

Establish more Pediatric Arthritis Clinics.