E001034

EXHIBIT 6

PROGRAM DOCUMENTATION

BASIC AGREEMENTS

1. Documentation according to objectives.
2. Can document effort
3. Do not expect to measure outcome other than by numbers.
4. Documentation at end of one year is of value primarily with reference to future planning.

The processer identified as being measurable by numbers and amenable to cost analysis were:

1. Training persons
2. Personnel trained
3. Centers established
4. Patients treated

It was emphazied that most programs were designed to expand services by education and outreach. Therefore, documentation will be numerative, and not intended to provide conclusion regarding training effectiveness and quality of care.

Documentation should be prepared so the following elements can be identified:

1. Effort
2. Performance
3. Adequacy
4. Efficiency
5. Process

Workshop Recommendations

1. RMP should provide common data collecting system for uniform documentation.

2. Documentation should be reviewed and evaluated by sub-units of: RMP, AF, and AAOS.

3. Summaries should be made available to all interested parties.

In addressing ourselves to the charges given to us, we would philosophize the stree on reporting the achievements of the arthritis RMP initiatives were to place emphasis on primary patient care--- NOW. That majority of the projects are now doing this is reflected in their activity reports. This concept of responding to the needs of patients == of doing something for them now-- should be protected for fostered in the realization of the National Arthritis Act which in its language places stress upon research.

In all of the 29 projects, education is either a major or a minor outcome. Education should really not be aimed at any one group; it should, rather, enchance the activities of all concerned, i.e. physicians, allied health professionals, patients, their families and the public. Because of the multiplicity of efforts to design good educational materials, it i s suggested that a national clearing be established. This, it is emphatically suggested, should be the Arthritis Foundation-- this is reflective of the decisions make in the AHP and Physicians Educational Workshops. It is suggested that educational materials be designed in response to documented patient, physician and alliebd haealth professional wants, needs and demands. Ths educational clearing house should actively seek out and maintain relationships with other pertinent organization dealing in the divilopment of educational materials.

In this workshop eight out of the 12 projects Represented were actively seek out and maintain relationships with other pertinent organizations dealing in the development of educational materials.

In this workshop eight out of the 12 projects represented were actively collecting "data". We encourage these activities in the light of the establishment of a national arthritis data base. We demand that the responsibility for data generated in the arthritis initatives be in a repositary accessible and responsive to meet the needs of the field. It is recommended, because of lack of uniformity in reporting, that each project immediately remipt copies

of their data collecting instrument to Dr. William Campbell associated with the Tennessee Regional Medical Program arthritis project. He will only assemble and disseminate the instruments as information to the project people. It is also recommended that central collection and dispersion of data be undertaken by the public accounting system (PAR) or some other appropriate entity but under the specifications of arthritis as delineated, for instance, by Dr. Hess and her committee.

In the future it is recommended that high priority be assigned to evaluation of: (1) long term efficacy of comprehensive (optimal) arthritis management versus episodic care, i.e. the usual type of clinical care; (2) the effectivenss of the nurse practicioner versus the physician. A cooperative report based upon the contributions of everyone involved in the training of nurse practicioners in arthritis is desirable.

Third party reimbursement of alliedhealth professionals should be explored in a copperative report with the hope including allied health professional care serveces as a reimbursable item.

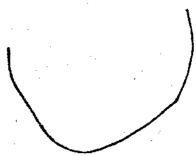
It is recommended that likages be established between the various levels of care providers: this will optimize their utilization.

Among special studies that should be reported we list: (1) Arthritis in Industry; (2) Alabama's Medical Information Service by Telephone, i.e. the MIST program modified to the needs of practicioners with arthritis patient problems; (2) the Western Pennsylvanaia Regional Medical Program which defines the lack of knowledge, gearing of their educational efforts thereby, and providing follow-up evaluation of their efforts.

Through out this conference very little has been said about the methods and problems of outreach into the community. We wish to inform that this is what the RMP is all about. A cooperative report based upon our individual

experiences is certainly in order so that methologies used, the solution the problems which we have encountered are not to be lost.

In conclusion, we are all agreed that experiences from this initative should form a basis for activities to be sponsored by the National Arthritis Act.



RECOMMENDATIONS

1. Establishment of a national clearing house for educational materials, efforts and methodologies. This office is to actively seek out and maintain contact with other pertinent organizations dealing in the development of educational material.
2. Because of lack of uniformity in data collection, each project should immediately remit copies of their data collecting instruments to Dr. William Campbell, Bioengineering Medical Program, Department of Engineering, Science and Mechanics, University of Tennessee, Knoxville.
3. The central collection and dispersion of data is to be undertaken by the public accounting system (PAR) or some other appropriate entity, but under the specifications and guidance of Dr. Evelyn Hess.
4. Eventrually, high priority must be assigned to (1) definement of the long term effectiveness of different modes of health service delivery employed in the important types of arthritis and (2) the effectiveness of the nurse practicioner versus the physician. A cooperative report based upon the contributions of everyone involved in the training of nurse practicioners is desirable.
5. Third party reimbursement should be explored in a cooperative effort.
6. The final recommendation is to establish a cooperative report, reflecting outreach experiences in the arthritis project.

In conclusion, we are all agreed that experience from this initiative should form a basis for activities to be sponsored, in the future, by The National Arthritis Act.

Summary

Room: 4
Monday, Jan. 20, 1975

Dr. Roy Cleery
Denver, Colorado

Dr. C. H. Wilson
Atlanta, Georgia

The workshop explored the prevailing pattern of Arthritis Care Delivery in the past which has been a primary care physician, 1 on 1 delivery system. A number of weaknesses of this system where pointed out:

1. A lack of property utilization of allied health discipline in the care of the patient with arthritis.
2. Since all care and patient education in this system is derived primarily through the physician, this requires an inordinate amount of time and often is less effective than using experts in the allied health disciplines.
3. This prevailing concept has inhibited full functioning of some of the allied health disciplines because of the ambiguity of legal systems based on this with regard to legal liability.
4. Frequently the physician is of innated in delivering primary care, that he is unable to participate in continuing education activities.

Only one strength of this system was pointed out and that was the very significant rapport developed between patient and primary care physician. It was felt that this could be transfered and shared with other members of the health team without decreasing any effectiveness of care.

In exploring the impact of the regional medical program on the health system a number of project discriptions were explored and discussed, varying from a traveling clinic concept over large areas to deliver care and for screening and diagnostic processes, to a more stable perminant clinic development program in community hospitals. It was felt that all of these had had a significant impact as demonstration projects fitting the demographic situations for which they were designed. The major effect is in the demonstration of the team approach to the delivery of services, as well as educational opportunities for those involved in the care of the arthritic patient.

It was felt that these projects are significant enough that they need to be continued for a longer period of time to effect proper evaluation of their impact, as well as for continued delivery of primary health services. It was felt that if there was a gap period in which there is a loss of funds before proper evaluation can occur much ob the potential impact of these systems will be lost, due to the collapse for lack of support. Therefore, it was felt that every effort should be made to continue interm support of these projects. It was the concensus of the workshop that a number of recommendations should be made:

CARE DELIVERY INITIATIVE

Resolutions of workshop:

1. It is recommended that as many as possible of the Care Delivery Project of the Arthritis Program be continued beyond the present grant period by asking that immediate funding be made available, effective July 1, 1975 to keep these programs going during the time period from close of RMP to grant of the Arthritis Funds through the National Arthritis Act.

2. The Arthritis Initiative Project should be extended, where there is a promise of learning from them, until such time as this learning can be demonstrated. Potential sources are Unexpended Project Funds, other RMP resources, Industries, etc.

3. Another source of continuing funds would be through extending contract benefits with health insurance organizations such as Blue Cross and Blue Shield.

4. That this conference request the National Arthritis Act Task Force to consider extending funding care delivery into areas where there are not now centers.

5. That personel in the Arthritis Programs contact the governors in their states for input into the composition of the health councils. That contact with the council then be continued to seek funding through the National Health Services Planning and Delivery Act.

The discussion was opend by listing the variety of funds being utilized by the arthritis projects which includes arthritis chapter funds, some private sources, certain support from The National Institutes of Health, as well as fees for services. In the latter category it was indicated that in most cases, these are currently being paid by patients but that project directors have applied, or are applying, for reimbursement of these fees by Medicare, Medicade, or other third party payers.

Dr. Mason said that the Federal government is now directing a variety of mechanisms that pay for nearly one-half of all medical care, but third party payers are responsible for another major part but the amount and type of payment is a negotiated factor.

The question was asked as to which A.H.P.'s are reimbursed and how third party payments are made. Dr. Mason stated that if they are reimbursed, it is usually limited to in-patient services and that the rates are often at the same rate that those paid to physicians. In some states, however, rates have been reduced by law to a lower fee schedule. Patient education services are also reimbursed on an in-patient basis.

No participants indicated that they were receiving any state funding for their projects.

The question of future funding revolved around four central issues:

1. The possibility of additional RMP funds which may either be in the balance of 29 regional programs or being held by O.M. Matt Spear stated that there is also the Continuing Resolution which provides up to 78 million dollars during fiscal 1975, but which specifies that these funds should be used only for transition.

2. The second and third points concerned new authorizations. The new regional health planning, development and resources act was reviewed. It was pointed out that project funds were unlikely to be available until in late 1976.

3. The National Arthritis Act was also discussed particularly the section dealing with screening and detection

It was pointed out that if funds are made available to implement this section, that it is possible they could be applied to some of the current RMP Programs.

4. The fourth area of future funding discussed was the possibility of approaching governors and state legislators to authroize continuance of specific programs in which local persons would not otherwise be benefited.

The discussion ended with the recommendation that all Arthritis Foundation Chapters in areas where RMP programs are currently in existence insure publicity for these programs, and, where possible, try to secure continuing funding for those projects for which public funding will no longer be available.