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REMARKS:

Report on Arthritis Conference

Dr. Pohl has copies

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To

From Matt Speas

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FORM HEW-30 REV. 11/56 **ROUTE SLIP** GPO : 1973 O - 517-326

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
BUREAU OF HEALTH RESOURCES DEVELOPMENT

TO : Acting Director
Division of Regional Medical Programs

DATE: January 23, 1975

FROM : Matthew Spear
Public Health Advisor

SUBJECT: Trip report; Arthritis Conference, Kansas City, Missouri, Jan. 19-20,1975

This an interim report on the conference. There is to be a Conference Report, but that will not be available earlier than late February. The conference expressed its desire that the traveller undertake to draft the arthritis report. I acceded to this request by indicating that I had made preliminary arrangements with Mr. David Shobe for the writer staff of the Arthritis Foundation to assume this task if circumstances prohibited my ability to effectively carry out this responsibility.

The Arthritis Conference was Chaired by Dr. Roger D. Mason, Senior Vice President for Health Affairs, Blue Cross/Blue Shield, Omaha, Nebraska. More than 100 persons participated in the conference, representing arthritis program and project directors, and some of their staff, RMP Coordinators and arthritis program administrators, and some of their staff, the writer (DRMP), and Dr. Lawrence M. Petrocelli, Director of Arthritis Activities, NIAMDD. The above participating groups included representatives from the conference sponsoring, and host organizations. Dr. Gordon R. Engebretson, Director Florida RMP, participated in the conference proceedings as the representative of the Program Accountability and Reporting (PAR) group of the NARMPC.

The conference was organized to devote attention on the first day primarily to substantive aspects of the pilot arthritis program to identify its characteristics, and associated needs and opportunities. The output from these discussions was presented to the conference orally, and in written form at the end of the first day as background for the second day's deliberations.

The first day's material was developed through short talks on five (5) selected program areas, a luncheon talk by Dr. Engebretson, a dinner talk by Mr. David Shobe, on the new arthritis law (PL93-640), and six (6) workshops. These workshops addressed pilot program aspects of physician, allied health, and patient education, demographic factors, and arthritis services, and service deployment.

The focus of the second conference day is most succinctly characterized by the question, "Where do we go from here?" A panel discussion wa s presented first to explicate overall arthritis program documentation and assessment, vs. project evaluation. Four (4) workshops followed to discuss, and bring back to plenary session recommended conference perspectives, positions, and proposals regarding Program Documentation, Care Delivery Initiatives, Special Report Opportunities, and Program Continuity. The afternoon was devoted to hearing the workshop reports, and conference action on workshop recommendations.

All of the materials needed to prepare an accurate and comprehensive conference report are not yet at hand. However, there are enclosed materialsabout and from the conference which elaborates on this brief report. These are:

Exhibit 1. Conference Program
Exhibit 2. Roster of workshop Co-Moderators
1/Exhibit 3. Responses to Program Interrogatory 1/
Exhibit 4. Summary of "A Workshop" reports (first day, A-1 through A-6).
Exhibit 5. Instructions to Evaluation Panel
Exhibit 6. Summary of "B Workshop"reports (2nd day, B-1, through B-4), including recommendations.

All of the second day workshop recommendations were supported by a majority vote of the conference. However, there were a number of modifications which cannot be accurately reflected until the writer receives a transcript of the Monday, January 20, plenary session.

1/The Program Interrogatory was a simplified application of a brainstorming technique. The objectives were to obtain overall conference participant input to the respective A workshops, and to quickly involve the participants in (a) thinking about mutual concerns, and (b) stimulating thought processes about matters which would be addressed in the workshops. The extent to which these objectives were met is moot; minimally, the conferees obtained insight about the spectrum of viewpoints shared by their colleagues and associates on the question subjects.

The Interrogatory process required a question to be asked orally, and respondents were given one (1) minute to record their responses on 3" X 5" slips of paper. These slips were immediately collected, and later reviewed for categorization in written pages referred back to the respective workshops. Questions 13, 14, and 15 (not here available), were posed later as a reflection of conference enthusiasm; No. 13 from the floor during the Interrogatory, and Nos. 14, and 15, by Dr. Engebretson in connection with the panel discussion on Program Evaluation, January 20.

The 13 questions were posed in between the five opening session speakers on January 19. The questions were:

Affected Workshop	Question Sequence	Question
A-1	1	How can arthritis physicians achieve optimal utilization of their skills?
A-6	2	How can arthritis services deployment be defined, or characterized?
A-2	3	How can the allied health role as service extenders be improved, or expanded?
A-5	4	How can the arthritis capabilities of several provider institutions be coordinated for better care delivvery? (The responses to this question were lost in the mass of generated paper slips, and could not be reported.)
A-3	5	How can patient vulnerability to non-prescribed medications and devices be reduced?
A-4	6	How can existing, or proposed, arthritis services be made more responsive to demographic characteristics of the locality?
A-1	7	How can family physician resistance to education in arthritis be reduced?
A-6	8	How can the deployment of arthritis services improve the integration of local resources?
A-2	9	How can continuing education in arthritis be maintained for practicing allied health personnel?
A-5	10	How can an arthritis center best support, or back up community services?
A-3	11	How can patients be motivated to follow prescribed regimens?
A-4	12	How can demographic information be accumulated through current program activities?
General	13	How can special needs of children be addressed by arthritis resources?
Panel	14	How can the approach used to evaluate drugs be used to evaluate education, training, and services?

As suggested above, a speaker was scheduled for each meal period. At the Sunday luncheon, Dr. Gordon R. Engebretson, Coordinator, Florida RMP, discussed the adaptability of a PAR-developed cancer program evaluation procedure to the arthritis program. He also offered PAR assistance in reporting, and assessing this program. At the Sunday buffet dinner, Mr. David Shobe, Director of Government and Community Affairs, Arthritis Foundation, described and discussed the "National Arthritis Act of 1974", P.L. 93-640. At the Monday luncheon, Dr. Evelyn V. Hess, University of Cincinnati Medical Center, discussed the standard nomenclature and data base for arthritis developed by her staff under the auspices of the American Rheumatism Association.

Administrative arrangements for the conference were superbly organized and directed by Mr. Charles Hine, Kansas RMP, and Mr. Gordon Waller, Executive Director, Kansas City Division, Arthritis Foundation. For instance, plenary sessions and workshop reports were performed by a team of Court Reporter students made available at no cost by a Kansas City business school; workshop Co-Moderators were able to dictate all reports.

All sections of the conference proceeded on schedule, and participants generally satisfaction with the meeting. A number of noteworthy results may result, all of which cannot be reported at this time. For instance, it appears that PAR will organize and execute overall program documentation; PIMA Health Systems, Tucson, Arizona, has funds and resources to support evaluation of many, if not all projects; and the allied health participants proposed to organize a special arthritis program session at their annual meeting this year at New Orleans in June.

Enclosures

EXHIBIT 1 EXHIBIT 1

ARTHRITIS CONFERENCE

Kansas City, Missouri

January 19 -- 20, 1975

Sponsors	Hosts
Amer. Acad. Orthopaedic Surgeons	KC Div., Arthritis Foundation
Arthritis Foundation	Kansas RMP
Participating RMP's	

CHAIRMAN Roger D. Mason, M.D.

PROGRAM

Sunday, January 19

8:00 a.m. Registration. Mezzanine Floor, Ballroom Assembly Room

8:45 a.m. Conference Convention — Colonial Ballroom

- Welcome
- Conference Charge
- Introduction of Chairman

9:30 a.m. Program Interrogatory — Mr. Matt Spear

10:20 a.m. Coffee Break

10:30 a.m. Program Presentations

Cost Evaluation of Patient Care System	E. R. Convery, M.D.
Developing Rural Services	Elam Toone Jr., M.D.
Enlarging Allied Health Roles	Paul Young, M.D.
Developing Pediatric Services	Balu Athreya, M.D.
Nursing Outcome Criteria	Janice Pigg, R.N.

12:00 Noon LUNCH — Grand Ballroom

SPEAKER

1:30 p.m. Workshops

Physician Education	Music Room
Allied Health Education	Tower 22
Patient Education	Private Dining Room 4
Demographic Factors	Private Dining Room 3
Arthritis Services	Junior Ballroom
Service Deployment	Private Dining Room 1

3:45 p.m. Coffee Break

4:00 p.m.	Plenary Session Colonial Ballroom	Roger D. Mason, M.D.
	Workshops Reports	
	Adjourn	
6:00 p.m.	Cocktails	Cash Bar
7:00 p.m.	Buffett Dinner	Grand Ballroom

Monday, January 20

8:00 a.m.	Colonial Ballroom Call to Order	Roger D. Mason, M.D.
	Panel Discussion - Program Evaluation	
	Gordon R. Engebretson, Ph.D., Moderator O. Lynn Deniston, M.P.H. Evelyn V. Hess, M.D. Carl W. Schwartz, Pima Health Systems	
9:45 a.m.	Coffee Break	
10:00 a.m.	Workshops	
	Care Delivery Initiatives Program Documentation Special Report Opportunities Program Continuity	Private Dining Room 4 Music Room ~~Private Dining Room 2~~ Colonial Room Tower 22
12:00 Noon	LUNCH	Grand Ballroom
	Speaker	
1:30 p.m.	Plenary Session, Colonial Ballroom	Roger D. Mason, M.D.
	Workshops Reports Recommendations Plenary Deliberations	
	Adjourn	

EXHIBIT 2

ARTHRITIS CONFERENCE

Meuhlebach Hotel
Kansas City, Kansas
January 19 - 20, 1975

Workshop Co-Moderators

Sunday, Jan. 19

A - 1	Physician Education	Charles Tourtellotte, M.D. ~~Warren Katz, M.D.~~ Russell T. Schultz, M.D.
A - 2	Allied Health Education	Marjorie C. Becker, Ph.D. Robert Godfrey, M.D.
A - 3	Patient Education	Frank E. Emery, M.D. William G. Sale, M.D.
A - 4	Demographic Factors	O. Lynn Deniston E. L. Angie Hebbeler
A - 5	Arthritis Services	Gene V. Ball. M.D. John L. Magness, M.D.
A - 6	Service Deployment	Raymond E. H. Partridge, M.D. Donald L. Riggin

Monday, Jan. 20

B - 1	Program Documentation	F. Richard Convery, M.D. Carl H. Eisenbeis, M.D.
B - 2	Special Report Opportunities	Ivan F. Duff, M.D. John L. Kline
B - 3	Care Delivery Initiatives	Roy L. Cleere, M.D. C. H. Wilson, Jr., M.D.
B - 4	Program Continuity	Ephraim P. Engleman, M.D. ~~Paul D. Ward~~ David Shobe

EXHIBIT 3

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 practioner.
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 refferal.
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 insentives, other incentives.
3. Don't talk down to local physician.
4. Patient feedback.
5. Solicit private physiciam 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 expecially trained in arthritis.
8. Restrict practice to Rheumatology only.
9. Computerize patient records.
10. PAtient Compliance
11. Well planned patient presentations.
12. Desimmation 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 rhuematism 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 physcian as to role that Allied Health and how they can assist the physcian.

Physcians 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 rhuematic arthritis in the physcians 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 fourms; 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. Prefessional [illegible] 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 specefic areas to be served, i.e., culture, language, financial needs and services available.
10. Organize committee as a feed dash in mecahnism.
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. Laboratonatory 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. Laison 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 algorythms 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 linkeages.
10. By carefully developing arthritis services around existing services as a catylist 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.

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 questionaire.

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.

TECHNIQUES

The workshop identified the following main techniques being employed by the Arthritis Program funded through R.M.P.:

1. PRECEPTORSHIP- Such efforts involve medical students participating in local health care deliveries as well as physicians returning to medical schools for specialized rheumatoid training.
2. CLINIC PARTICIPATION- Through these techniques difficult patients are presented to consultate physicians and others in the local community. The medical problem is discussed in some detail and treatment recommendations made.
3. CONSULTATION- Conventional consultation contacts have evolved from out-reach efforts.
4. WEEKLY LECTIVE SERIES- Some programs have employed regular lecture series on specific problems of the treatment or diagnosis of rheumatic diseases.
5. REGIONAL DAY LONG SEMINARS- These seminars are usually conducted at a local site by a panel of rheumatologists of the areas medical centers.
6. MEDICAL CENTER SYMPOSIUMS- These are more formalized presentations using out of the area experts of some renown and are usually one or two days in duration.
7. SELF OR PROGRAMMED INSTRUCTION- A few programs have developed self-assesment and programed instruction instruments. This technique is available to individual physicians to apply at their own time and pace.
8. MEDICAL STUDENTS AND HOUSE STAFF PROGRAMS- There is a conscious attempt in many projects to involve medical students and house staff in the rheumatic disease educational programs.

PROBLEMS

The following list of problems related to physicians education was enunciated by the workshop group:

1. Local physicians are over-worked and claim no time to participate in programs conducted in medical centers.

2. Treatment of the arthritic patient is a team effort, therefore, training should realistically be conducted on a team basis (several team teaching programs are being conducted with reasonable success).

3. Programs should be planned to meet the individual need of the particular community. Without some degree of tailoring rapport between medical center and community can be lost.

4. There seem to be a insufficiant number of trained rheumatologists in the medical teaching institutions to meet the demands of an extensive out-reach program.

5. Evaluation of the effectiveness of out-reach teaching is at best difficult, no suggestions were offered.

6. If out-reach programs are too serviced orientated and patients begin to circumvent the local health care system, rapport will be lost.

The attempt should be to emphasize education rather than patient service.

7. In areas where distances between population centers are great, experience shows a lethargy amoung local physicians for continuing education effort. Distance also creates a teaching resourse problem.

8. Medical school faculty are not all enthusiastic about participating in out-reach clinics. Many feel their responsibilities lie elsewhere, such as research and institutional instruction.

EVALUATION

The workshop discussed evaluation in broad terms. No concensus was achieved on the best ways to evaluate the programs discussed. In fact, it was generally agreed that such short term efforts could not be evaluated in terms of their effect on patient treatment and physician behavior.

It was suggested that where possible all programs maintain and compile cost and "students reached" data. From this information it may be possible at the end of the R.M.P. program to make judgement concerning the cost effectness of various teaching techniques. This data could be of great value to those responsible for continued funding. It might also be pertiant to an evaluation of the cost of basic medical education in rheumatoid as apposed to continuing education in rheumatoid.

The workshop participants heard a report of an assessment of professional education conducted by the A.R.A. and national Arthritis Foundation. Dr. Evelyn Hess presented some preliminary information which indicates a potential shortage of physicians trained in rheumatology. Their survey indicated few house staff and medical students involved in arthritis centers. It also pointed to the relatively number of post-doctoral fellowships available in rheumatology. Numerically the data would indicate the exsistance of less than 2.5 rheumatoligists per institution surveyed. (The survey covered 120 teaching and private treatment institutions.)

Final results from this survey are expected to be available at the national meeting in June 1975.

RECOMMENDATIONS

Many suggestions were offered for improvement of physician education by program basis, but several recommendations were offered which relate to the over all task of educating physicians in the area of rheumatic diseases.

1. Educational programs should be aimed at the need of the patient and address the physicians problem related to patient need.

2. The guide lines for funding of the R.M.P. Arthritis Initiative were quite restrictive. It is recommended that future funding allow more latitude for program emphasis between out-reach education and education of medical students and house staff.

3. A coordinate attempt to gather assess and evaluate data on the various education techniques employed, R.M.P. Arthritis program should be implimented. Perhaps the P.A.R. group in coordination in D.R.M.P. could assimilate the appropriate information for such an analysis.

4. The workshop supports continued funding of the Arthritis Center approach and other programs designed for the continuing education of the practicing physician.

ALLIED HEALTH EDUCATION

Summary

Workshop: A-2
Room: Tower 22
Sunday, Jan. 19, 1975

Edited By:

Marjorie C. Becker, R.P.T., Ph.D.
University Hospital
Ann Arbor, Michigan

Robert Godfrey, M.D.
Univ. of Kansas School
of Medicine
Kansas City, Kansas

Each project summarized their activities, including educational A.H.P. activities.

The potential under the grant initiative, and in any other way, is essentially untapped. The primary method and technique for strengthening the effect of A.H.P. education can most rapidly and efficiently be obtained by a massive A.H.P. training program.

We do not want to let rigid certification or licensure to take place so that it precludes using manpower and talent at a level that is presently available. We want to encourage the earliest possible educational interaction between all health occupations. We need to correlate or to include the A.H.P. contribution within the A.R.A. central health data basis.

Recommendations for future A.H.P. educational activities are:

1. To support Allied Health Professional Section of the Arthritis Foundation

2. Set up a national meeting of Allied Health professionals to share their R.M.P. project outcomes and methodologies, and it was suggested that this might be held in New Orleans, preceding the June meetings, in conjunction with the National Arthritis Foundation meetings.

3. Have each of the twenty-nine project directors assign an A.H.P. coordinator to report specifically on the Allied Health involvement in their projects. This information could be forwarded to the Allied Health Education Workshop participants for some sort of generalization or compilation and distribution.

Anticipated outcomes of greater Allied Health Professional Education:

1. We could better assure greater numbers of rheumatic patients receiving services from appropriate levels of health professionals.

2. Therefore, we can increase the total volume of patients serviced.

3. We would enhance better the level of sophistication of the patient so that the patient utilizes the physicians' time and vice versa, which also overcomes physicians' resistance to his professional education.

Unresolved issues that might provide agenda items for future meetings:

1. Who should be doing Allied Health Professional Education? Should discipline train discipline?

2. Who should define criteria for competency, training, and performance?

3. How should we approach third-party payers for coverage of Allied Health Professional services; and identify other sources of funding for continuing current and proposed projects?

4. How should we utilize non-physician-Allied Health resources, such as the Arthritis Foundation and other national and local community health resources,for provision of complementary public education, patient education, or simple secretarial services?

The Allied Health Education group strongly recommends that Allied Health training, recruitment, and research should be an extremely high priority item when the National Arthritis Act is being considered.

A-3

PATIENT EDUCATION

The participants in this workshop consisted of orthopedics, R.N.s, Arthritis Foundation personnel and R.M.P. administrators. The expenses and needs for education of all varied considerably and it was enlightening to some to know that they were ahead of others. The problems viewed were:

1. dissemination of educational information and who is responsible or should be for local arthritis centers.

2. The geographical, social, and economical needs of various groups as far as education and how they would feed it to the programs.

3. Is there a method to evaluate effect of patient education?

4. Participants need list to answer patient needs and discuss patient problems.

5. Arthritis Foundation would like to find if anything is available in the way of education for the problems.

DEMOGRAPHIC FACTORS

Summary

Workshop: A-4
Room: 3
Sunday, Jan. 19, 1975

General discussion pursued definition of Demographic data. Basic distinction was made between what should be termed classical Demographic data, e.g., age, race, income, etc., and a broader definition which should include any statistics collected which further programmatic goals, e.g., physical profile, 3rd party payers, community resources, etc. Conclusion was reached that should be termed Classical Demographic Data, which should be used as an adjuncted to the broader definition of data. By this is meant that the initial data is used to augment and facilitate the planning process in general.

The group as a whole developed a set of classifications and generated a laundry list under each one. The list will appear below with clearifications being given subsequently.

I. Population Data
What is normally available through the use of census data and any related national or local resources.

II. Patient Data
- Age
- Sex
- Income
- Occupation
- Health Insurance
- Weight
- Family History
  - -family rheumatoid
  - -personal history
- Smoking Patterns
- Level of Education
- Race
- Urban-Rural
- Language Spoken
- Living Arrangement
- Functional Capacity
  - -diagnosis rheumatoid
  - -diagnosis other
- Other Health Care
  - -traditional
  - -nontraditional
- Mobility
- Transportation

III. Provider Data: both physician and AHP's
- Practice Arrangements
- Professional Profile
  - -age
  - -training-speciality
  - -place of education
  - -place of residency
  - -involvement of allied health professionals
- Physicians Referal Patterns

DEMOGRAPHIC FACTORS

Summary

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Room: 3
Sunday, Jan. 19, 1975

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III. Provider Data: both physician and AHP's

- Practice Arrangements
- Professional Profile
  - -age
  - -training-speciality
  - -place of education
  - -place of residency

III. Provider Data
American Hospital Guide Issue
AMA Directory
State and Local Directories
State Licenser Boards
PSRO's

If the above prove unsatisfactory or inadequate it may be desirable to interview the providers themselves. It is recommended that this be done in only selective situations and as a last recourse.

IV. Institutions Data
Medical Care Standards, State Agencies
State Institutional Licenser Regulatory Authorities

V. Community Data
Center for National Health Statistics

It is suggested that local volunteer resources be explored.

Long Term Program Goals

In light of the scope of the current projects and recently enacted and hoped for legislation, it is suggested that collective action be taken in order to answer the following three areas.

1. What appropriate mechanism be devised in order to facilitate uniform data collection.
2. The present arthritis programs, coupled with new legislation which mandates arthritis initiative suggest collective evaluation of all the funded arthritis projects through a central mechanism.
3. The present public accounting system (PAR) of the regional medical programs provides a resource for centrally collecting and dispersing project data. Further, this activity for PAR is appropriate and consistant with the responsibilities delegated regional medical programs to evaluate operational projects. Consistant with new legislation for help planning and resources developement. This data will be incorporated into national and regional HEW and NIAMMD when appropriate. This will serve as the basis for an ongoing long term evaluation of the arthritis initiative.

ARTHRITIC SERVICES

1. The arthritic services workshop began by a review of the activities of the participants in the workshop in their particular units. There seemed to be general concensus that an important part of the arthritis service program was decentralization of present services from medical centers and medical clinics out into the respective communities. This was perhaps brought out by 30 per cent of the workshop participants. The exact type of arthritis service was divided into three areas:

    a. An area of physical treatment.
    b. An area of social and emotional treatment.
    c. An area of economic, vocational and educational treatment.

2. A discussion of what constitutes comprehensive arthritis service was held. There seemed to be a wide spectrum as in physician's use of community resources. A discussion was held concerning the use of volunteer organizations, charitable organizations, including the Arthritis Foundation, available community resources such as the Public Health nurse, in order to provide service for the arthritic, fixed or mobile evaluation and follow-up teams. Considerable variabilty exsisted among the members of the workshops among the constituents of such a team. These varied from 1) The use of specialized physicians, orthopedists, rheumotologists, physiatrics, and pediatricians with the Allied personnel fulfilling a constructive role; 2) teams comprised primarily of Allied Health personnel utilizing a nurse, arthritist specialist, physical therapist, occupational therapist, social service worker and psychologist and nutrition specialists. The teams varied in thrust from teams that were designed primarily to act as demonstration or teaching teams, to teams designed primarily to engage in diagnosis and treatment, community resources, fixed or mobile.

3. Medical center or clinic programs. It was emphasized that there was a need for a centralized resource center, with sophisticated seralogic laboratory support in order to provide the resource and research data necessary to handle complicated patients and often with specialized clinics for juvenile rheumatoid arthritics, geriatric, lupus. 4) Educational programs. It was felt that patient para-medical and post grant education were all the important parts of the arthritis service program, but are being discussed under other specific sessions. 5) Vocational need. It was felt that vocational assistants, ranging from home-bound or sheltered workshops to specialized employment opportunities would be necessary in order tosupport the arthritic in job placements.

4. A discussion was held on the role of Allied Health personnel in the arthritis treatment and service programs. Consideralbe philosophical differences existed as to what the responsibilities of the nurses practioners and Allied Health personnel should be. Some general concensus was reached that there is need for a nurse arthritis specialist to be involved in an evaluation,data collection and treatment situation under the supervision of the physician in charge of the care of the

5. Considerable discussion hinged on obtaining funds for a continuation of arthritis services that are begun under the R.M.P. Grant Program. It was felt that some help would be obtained from charitable, federal and state sources but a majority of the support of the individual programs would very likely come from fee-for-service charges from both physicisns and Allied Health personnel.

A-6 SERVICE DEPLOYMENT

As regards the general program of existing arthritis services, the first question that was raised was how the majority of care of arthritis patients is provided, and it was quite clear that this was with the private physician, particularly with the local medical practitioners. The question was raised as to whether physicians have any idea as what is available to arthritis patients in the area. Many services may be available that the physician is unaware of. It was also apparent that many services that are available compete rather than cooperate with one another. The need here appears to be directory of resources. The question was raised as to whose responsibility it is to oversee this directory of resources, and, of course, the question was also raised as to ultimately who organizes the deployment of the arthritis services that are available.

Circumstances that effectively inhibit services deployment and use were discussed. Some of these are: one, the physicians are conservative by nature; two, a fear that referring patients to other clinics or facilities, that these patients will be lost to them; three, poor educational physicians as to what an arthritis service can offer; and four, suspicion of government finance services.

Other inhibiting factors of deployment and utilization of services are financial ones, particularly on the part of the patient and the ability of the patient to pay. It was felt that more use should be made of insurance carriers to pay out-patient fees, and since this is undeveloped, this could be a further factor that should be developed.

It was noted that with the National Health Act being discussed in Congress, greater propaganda emphasis in the next six months should be put on the financing and methods of financing in the arthritis field. All areas of concern for arthritis patients should be covered. The role of the present region or medical program in adding to or changing attitudes of local physicians and patents or referrals given, it was felt, particularly by physicians in rural areas, that there was a marked impact and that these physicians were becoming much more familiar with arthritis problems and handling them with greater ease. There was also a better utilization of services. The use of para-medical personnel was discussed, who directs them, what is their role linking the local physician and patient, and the Rheumatologist and patient.

The need for early diagnosis and the development of diagnostic centers was emphasized, utilizing peripheral facilities for continuation of the program. It was clear that there was a great need for physicians and patient education as to what can be provided. Some discussion was achieved of the priorities, whether one should concentrate on quality versus quantity of care, and it was generally felt that the first priority was to increase the available access to medical care by arthritis patients.

EXHIBIT 5

PROGRAM EVALUATION

Panel Discussion

Monday 8:00 a.m.
January 20, 1975

Moderator:

Gordon R. Engebretson, Ph.D.
Deputy Director, Florida RMP
Telephone: 813/253-0931
Member: Program Accountability Reporting
A cooperative group from the RMP's formed to develop national descriptive and evaluative information about RMP programs.

Participants:

O. Lynn Deniston, M.P.H.
Program in Health Behavior, SPH 2
University of Michigan
Telephone: 313/764-9494
Evaluation of Michigan program, and others

Evelyn V. Hess, M.D., F.A.C.P.
Professor of Medicine
University of Cincinnati Medical Center
Telephone: 513/872-4701
Developer ARA standard data program

Carl W. Schwartz
PIMA Health Systems
Telephone: 602/881-4770
Evaluation of Arizona program and others

This will confirm our telephone conversations regarding the need for a panel discussion on program evaluation at the arthritis conference in Kansas City, January 19 - 20. The panel is scheduled on the enclosed program for 8:00 a.m. Monday morning, January 20. This timing is poor with respect to the assistance with program evaluation factors which may be needed in the Sunday workshops. It is suitable, however, with respect to the crucial conference workshops schedulled immediately after the panel discussion. The experiences you individually encounter on Sunday may permit specific commentary during the panel discussion with regard to substantive project evaluation, as distinct from overall arthritis program evaluation, or assessment limits.

Background: The pressures under which the arthritis grant applications were developed contributed to a generally poor response to program evaluation requirements. Lack of staff at DRMP prevents development of this program element. The rapid phase-out of DRMP, and the transitory position of the RMP's makes followup of arthritis program evaluation impossible. A meeting last November with representatives of the organizations which are sponsoring the conference resulted in consensus and agreement to convene the conference, seek to assure that the experiences of the grant program are documented, and reinforce the evaluation/assessment forces which exist.

Panel Problems: What scale or intensity of evaluation is appropriate with regard to the various kinds of projects being undertaken? What scale, or intensity of assessment is appropriate with respect to the total program, or identifiable segments of it? How should these tasks be accomplished? What resources are available to undertake them? How reasonable are the costs involved?

Commentary: I am enclosing for background two of the better suggestions for evaluation which were received in response to our call for suggestions last Fall (No. Carolina, and Colorado-Wyoming). If any of you have material which might be helpful to project and program heads, you may wish to bring handouts (150 copies). We will have reproduction facilities at the conference, and the Kansas RMP will make its facilities available if you cannot bring copies.

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.

CARE DELIVERY INITIATIVE B-3

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.

Draft of Arthritis Conference Resolutions

Kansas City, Missouri, January 20, 1975

Workshop B-1: Program Documentation

Approved 1. RMP should provide a common data collection system for uniform documentation of the present projects.

Approved 2. Documentation should be reviewed and evaluated by sub-units of RMP, AF, AAOS, and other concerned professional organizations, and they should develop a plan for future documentation of arthritis activities.

Approved 3. (Same)

Workshop B-2: Special Report Opportunities

Approved 1. A national clearinghouse should be established for educational materials, efforts, and methodologies through the Division of Long Term Care, or the Arthritis Foundation, and these agencies should seek out and maintain contact with other organizations with educational materials.

Approved 2. (Same) Clarified: request for followup support is to be issued, and procedure determined by responses.

Approved 3. Central collection and dispersion of data should be undertaken by the PAR, or some other appropriate entity, under the specifications and guidance of the AF Computer Committee.

Approved 4. (Same) Clarified to be a comparison of comprehensive arthritis care to episodic care.

Approved 5. Third party reimbursement should be explored in a cooperative effort by this (conference) group.

Approved 6. (Same)

Workshop B-3: Care Delivery Initiatives

Approved 1. It is recommended that as many as possible of the care delivery projects of the arthritis program be continued beyond the present grant period (June 30, 1975), by availability of RMP funds, or requesting Congress for a supplementary appropriation, to keep these programs going during the interim period between the close of RMP and the time that funds become available under P.L. 93-640, so as to be able to complete and evaluate present activities with regard to their effectiveness, and potential association with future arthritis programs.

Approved 2. (Same)

Approved 3. (Same)

Approved 4. That this conference request the Commission to be established under P.L. 93-640 to investigate areas where there are not now arthritis centers which might nevertheless be determined appropriate sites for allocation of P.L. 93-640 grant or contract funds.

(This resolution received strong vocal dissent with respect to (a) possible duplication of existing P.L. 93-640 terms, and (b) appropriateness with respect to the perceived main thrust of P.L. 93-640.)

Approved 5. (Same)

Workshop B-4: Program Continuity

Approved 1. (Notes do not elaborate on the written summary report).