
E000526

D R A F T

PROCESS AND BASIS FOR FUNDING PILOT ARTHRITIS PROGRAMS

Summary Statement

Pilot arthritis grant programs have been authorized to be carried out in 31 Regional Medical Programs during 1975. While program activities up to a level of $4,737,360 have been approved, the actual cost of the programs which will be conducted will not be known until all of the awardees have affirmed that they will undertake the program approved in their Regions.

The new program was made possible by a special Congressional earmark in the 1974 RMP appropriation of $4,500,000. Under special guidelines, the RMP's were permitted to apply for pilot arthritis program grants in addition to their regular RMP program applications. Arthritis grant applications were received from 43 RMP's, in the amount of nearly $15,900,000. In the review and approval process, the Arthritis Ad Hoc Committee, and the National Advisory Council on Regional Medical Programs developed guides on program priorities to govern the review and approval of the arthritis grant applications. The guides advocated outreach activities from centers, and constrained approval of activities which, while otherwise meritorious, appeared to reviewers to be high cost or collateral activities unlikely to achieve fruition in the grant year, or not contributory to patient care delivery improvements.

The arthritis grant review process, conducted in May and June, 1974, resulted in recommendations for approval and funding of the 31 RMP applications at approximately $4,800,000. In recognition of country-wide needs on arthritis, and that their recommended approvals exceeded available earmarked funds, both the Ad Hoc Committee, and the National Advisory Council requested that the Division of Regional Medical Programs seek identification of other funds so that all approved grant programs could be supported.

The review bodies ranked all of the approved programs on quality and achievability factors to provide specificity with regard to programs approved for funding with earmarked funds, and those for which additional funds should be sought. Of the 31 approved programs, the 27 higher ranked programs can be funded with the earmarked fund. The remaining 4 have been authorized to allocate other RMP funds in their possession to pilot arthritis activities if they identify arthritis as a high priority, but only up to the amounts approved, and only for the approved activities.

Modification downward of requested amounts of most arthritis grant applications was imposed by the review bodies in order to achieve outreach characteristics and development of patient services, obtain a more cohesive National pilot effort, and achieve optimal outcome with limited, one-year pilot arthritis funds. The modification of some of the grant requests was

extensive, and in some instances may result in regional decisions to abandon the pilot arthritis activity as a priority activity. For this reason, all letters of award advised recipients that they cannot spend the grant funds until they accept in writing to the DRMP the modified programs approved. The DRMP is waiting for these acceptance letters.

PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
BUREAU OF HEALTH RESOURCES DEVELOPMENT

Arthritis Ad Hoc Review Committee
Summary of Committee Recommendations
(By Rank Score)

Region	Rank Score 1/	Total Requested	Recommended Total
Kansas	85	390,013	242,400
Texas	85	356,559	244,200
Arizona	80	241,638	215,000
California	80	726,343	397,250
Georgia	80	595,000	200,000
Hawaii	80	461,820	216,000
Mississippi	80	862,409	58,000
Tri-State	80	844,775	213,370
Wisconsin	80	267,857	62,000
West Pa.	78	281,051	140,400
Inter-Mntn.	75	385,463	169,500
Michigan	75	823,413	194,700
N. Dakota	75	340,800	111,000
Arkansas	73	260,011	100,000
New Mexico	73	272,765	163,600
Alabama	70	272,360	228,400
Grtr Del Val	70	385,001	247,500
Ohio Valley	70	711,166	46,500
Iowa	65	87,554	87,550
N. Carolina	65	433,962	211,500
Oklahoma	65	157,526	66,050
Central N.Y.	60	92,492	70,200
Metro D.C.	60	845,301	176,900
Virginia	60	188,857	80,000
Colo-Wyo.	52	362,621	174,240
Albany	40	175,975	130,940
Puerto Rico	40	122,541	92,160
Susquehanna	33	254,901	139,500
Lakes Area	30	602,500	45,000
Wash/Alaska	21	361,167	75,000
Tenn Mid-So.	20	420,401	138,500
		($12,584,242)	$4,737,360

Earmark Funds

Discretionary RMP Funds

Disapproved	
Bi-State	164,442
Connecticut	328,183
Florida	115,700
Illinois	449,000
Louisiana	335,528
Maine	74,346
Maryland	351,759
Missouri	693,362
Nassau-Suffolk	332,190
New Jersey	200,000
N.Y. Metro	227,829
No. New Eng.	10,000
	$15.866.581

1/ NOTE: Rank Scores relate to the modified program, and not to the original request.

DIVISION OF REGIONAL MEDICAL PROGRAMS

Review of Pilot Arthritis Program Grants

Review bodies were confronted with 43 applications which requested a total of $15.9 million against available earmarked funds of $4,275.000. Reviewers deliberated on ways to extend support for work which would be most creative and productive within the one-year funding period, and which would also provide cohesiveness of effort across the country. The result was a number of Resolutions and Guides to govern program recommendations. Reviewers recognized that in the context of widespread arthritis program needs, the necessity to prioritize within available funds required the disapproval of otherwise meritorious programs and activities. The review Resolutions and Guides are:

I. OUTREACH

Resolution: The major thrust of approved pilot arthritis programs shall be outreach.

Background: Examples of requests for personnel, equipment, and other support for centers were noted which appeared to represent an "overwhelming emphasis on the further development of an on-going center." This was characterized as "inreach." It was recognized that some support of centers is in order to conduct an outreach program. The center is often the source of reaching out, and upgrading of center resources to the degree necessary to initiate and conduct outreach is appropriate. The main thrust, however, should be the improvement of patient access to the health system, and the respective levels of care which it can provide. Facilitation of patient access and entry into the system should be emphasized. The intended thrust of the pilot arthritis program cannot be fulfilled if centers only keep bringing patients into the centers. While much should be expected of the larger, established programs, equal or greater needs and lessons are present in lesser developed areas.

II. DATA COLLECTION, AND AUTOMATED REGISTRIES AND DATA BANKS

Resolution: Separate arthritis data banks and registries should not be funded. Program statistics should conform to American Rheumatism Association (ARA) standards as these are developed.

Background: While it is recognized that specific data is required to plan, conduct, and evaluate pilot arthritis programs, the expenditure of relatively large sums for a variety of data gathering and analysis activities, especially those proposed to be automated at many sites, and in different ways was opposed. It was noted that the ARA is conducting a study to develop standardized nomenclature and reporting, and these will be published.

The support of automated data programs with the limited pilot arthritis funds appears to be premature, and unduly costly in view of the uniform approach to these needs which is being developed. State Health Agencies were considered more appropriately responsible for morbidity and prevalence data. There is pending Federal legislation which, if enacted, would more adequately address arthritis data needs.

III. FILM/TAPE DEVELOPMENT, AND PRODUCTION FOR PUBLIC AND PATIENT EDUCATION. AND OTHER INFORMATION PURPOSES

Resolution: Those portions of arthritis program applications which request support for the purchase of hardware for film and tape production should not be funded. Consent might be given to the support of software costs if the program is otherwise approvable. The widespread development of such materials is not considered wise when superior products can be obtained through qualified sources. It was suggested that DRMP and the concerned RMP's cooperate to provide coordinated identification and procurement from central, qualified sources of widely needed film and video tape materials.

Background: While reviewers were personally aware of the capabilities of films and cassettes for patient and other educational activities, it was not considered wise to support the volume and diversity of requests made for these purposes. The needs for such materials is Nation-wide, and considerable expertise is required to efficiently produce high quality products. The high cost reflected in the applications does not appear to be a productive way to employ the limited RMP funds. Previous RMP experience in this area has demonstrated that extraordinary administrative problems are encountered in obtaining first-rate products, even in facilities with sophisticated equipment and expertise. There are a number of institutions which operate high quality audio-visual facilities where equipment presently exists (Michigan was noted). It was proposed that the DRMP might cooperate through concerned RMP's to produce selected video tapes, on subject matter widely sought, through one or two experienced centers.

IV. PUBLIC EDUCATION (and fund raising)

Resolution: Activities geared solely to public education will not be supported.

Background: A number of the arthritis grant applications requested support for audio-visual equipment, vehicles, printing, publications, and items related to mailing, etc, for purposes of public education. Distinctions were drawn between patient and family education, and professional and para-professional training, viewed as meritorious and appropriate in the pilot program, and public education. Reviewers determined that public education was not an appropriate use of the limited RMP funds. Such activities appear to be more appropriate for support by Chapters of the Arthritis Foundation, local departments of health, and medical societies. Reviewers drew a distinction between undesirable public education, and other desirable types of education by noting the use of vans and other equipment used in British Columbia to provide services to patients, and their families, and local medical and health personnel about arthritis disease treatment. Another example is the

dissemination of information about diagnosis and treatment of gout, an eminently treatable disease for which appropriate diagnosis and treatment is not always made available outside of centers. Such activities are appropriate elements of the pilot arthritis grant program.

Specific note was taken of requests for support of overt, or implied fund-raising activities. Use of Federal funds for this purpose is prohibited.

V. EQUIPMENT (including vehicles)

Guide: In view of the one-year availability of the RMP arthritis funds, lease or rental of expensive items of equipment should be seriously considered before commitments are made to purchase.

Background: Activities without firm continuation support may unnecessarily commit limited funds to equipment which cannot be effectively utilized when program support ends.

VI. RESIDENCIES AND FELLOWSHIPS

Guide: Reviewers emphasized compliance with RMP policies with respect to professional training and education.

Background: Various applications included requests for support of residencies, fellowships, and other education activities which cannot be supported under RMP policies.

DRAFT (7/12/74)

A NATIONAL PILOT ARTHRITIS PROGRAM TO BE CARRIED OUT IN THE REGIONAL MEDICAL PROGRAMS

A National pilot arthritis program has been initiated through one-year grants provided to 31 Regional Medical Programs by the Division of Regional Medical Programs, Bureau of Health Resources Development, Health Resources Administration, PHS. These grants were made possible by a Congressional earmark of pilot arthritis funds in the 1974 RMP appropriation. It is anticipated that approximately $4,500,000 will be expended this year for the special arthritis program.

Indicative of the widespread needs which exist in the arthritis field is the fact that RMP grant applications for pilot arthritis program support totalled nearly $15,900,000, or approximately 4 times the available earmarked funds. These applications were reviewed and analyzed by a technical peer review body, the Arthritis Ad Hoc Review Committee, and the RMP policy advisory body, the National Advisory Council on Regional Medical Programs. These review bodies formulated an arthritis grant review perspective to provide a uniform analysis of the grant applications so as to determine activity approvals within available fund limits. In addition to weighing general application merits, the review perspective, or guides, provided definition of high priority activities which appeared to be innovative, practical, achievable, or a combi-

nation of these qualities, and which would result in a Nationally cohesive pilot arthritis thrust. The review guides advocated outreach services from established medical facilities, and disparaged support for high-cost, collateral activities less likely to achieve fruition in the grant year, or not clearly contributing to patient care delivery improvements. Activities proposed which ~~revies~~ reviewers recommended for disapproval included production of educational films and video tapes, diversified approaches to automated registries and data banks, development of publications, expenditures for high-cost equipment, and requests related to development of medical center capabilities beyond the level required to support outreach activities.

The emphasis of the approved pilot program is the extension of present knowledge in arthritis diagnosis, treatment, and care through coordinated services which demonstrate improved patient access to care, and extension of professional services through expanded utilization of allied health personnel, and existing community resources. Arthritis clinics will be established in medical centers, community hospitals, and family health facilities. Educational programs will increase the arthritis handling capabilities of hospital and private physicians, and will equip larger numbers of allied health personnel to support services in hospitals, clinics, and home care settings. Increased patient self-care will be demonstrated through the development of patient/family training

activities. Seminars and workshops will be conducted at many sites for improved utilization of community medical and health personnel in arthritis services. Existing health department personnel and facilities, and health groups such as the Visiting Nurse Association, local councils on aging, and operating community health worker training programs, are cooperating in demonstrations of improved arthritis health care delivery. Several modest studies to develop criteria for quality care through provider performance standards are being conducted. An industry survey is planned in one Region, and and employee/employer education program will be developed in concert with better organized occupational therapy services. Another Region will investigate the utilization of sheltered workshops in support of patient restoration to productive activies. A number of programs are focusing on the problems of low income rural groups, and others are developing demonstrations of care delivery to economically disadvantaged inner city residents. Localities which presently have little, or no rheumatological resources are being supported in the initiation of medical school arthritis departments. Across the country, Chapters of the Arthritis Foundation are providing program coordination, dissemination of publications, and increased numbers of volunteer workers in support of services and increased patient referrals to local clinics, and physicians.

The constraints imposed by one-year limited funds were keenly appreciated by the review bodies. It was recognized that

while much valuable work could be accomplished with the earmarked funds, many otherwise meritorious concepts and activities could not be approved. In this respect, the Arthritis Ad Hoc Review Committee noted, "... we consider this a very meager effort toward a tremendous problem, and it in no way reaches a point of beginning to provide a solution of any definitive kind ..."

SUMMARY OF ARTHRITIS PROGRAM

ALABAMA: Request - $273,360 Outreach from U.A. Birmingham, to 3 areas with no rh. services: @ UA Huntsville; UA Tuscaloosa, Coll. of Med. Methods: patient consultation with teams; trng. PH Nurses to identify & refer patients; mo'ly conferences to train PH Nurses, psychotherepists, and phy's asst's: and molig pat. care conf's for practicing physicians.

Reduction - $43,960 In'out/ pat. study of Spain Rehab. Center. Reduced equipment/supplies, so as to do more outreach.

Approved - $228,400

ALBANY: Request - $175,975 Strengthen Alban Med. Coll. via lab and more people, and provide educational programs. Develop 3 sat. clinics, staffed part-time with local phys's. Develop computerized record system.

Reduction - $45,035 Computer system and related personnel; 1 satellite out. Possibly cut personnel and lab in order to do more outreach.

Approved - $130,940

ARIZONA: Request - $241,638 Develop diagnostic treatment & rehab in 6 counties around Tucson, building 3 selected communities. Develop a Tucson Interagency Committee, and a local Committee in each of 3. Develop consulting teams, with PT backup in each area. Public ed. In-service ed - 6 didactic conferences. Improve pat. transportation.

Reduction - $26,638 Public ed, and patient transport.

Approved - $215,000

ARKANSAS: Request - $260,011 Establish 12 clinics in larger communities staffed by local physicians. Employ and train 5 part-time District Health Ed. Coordinators to work with local committees; 6th PH Educator in Little Rock. Employ and train 2 new PT's, and provide 73 working PT's a 2-day workshop. Public ed. via a PR firm, and develop an automated registry, 24-hr "What's Your Arthritis Problem" answering service.

Reduction - $96,411 Excessive central RMP administrative funds, public education, patient registry, and related costs. Reduce clinics to 6, and commensurate reduction in District Coordinators, and PT training. Social services should be given larger role.

Approved - $163,600

BI-STATE: Request - $164,442 (Eastern Missouri - Southern Ill., centering on St. Louis) Washington University, St. Louis University, and the AF Chapter. Send roving consultant team to 12 sites twice a year. Expand capabilities of Wash U. lab., & provide St. Louis U. with a complete lab. equal to WU's. Provide patient, physician, and public ed. Develop a long range plan.

Reduction: - 0 Question direct benefits to patients of WU lab. expansion which appears research-oriented. Cooperative services would obviate need for St. LU lab. Question about commitment and coordination of roving teams.

Approved - $164,442

CALIFORNIA: Request - $726,343 2 major thrusts involve 12 projects: (a) Statewide data base; and (b) develop quality care, and criteria. Components (projects):

154A Central Admin. - compile demograph data with facilities of resources; 1-2 demonstration sites to develop quality of care criteria, and test.

154B Cal. Med Assn, San Fran. - Statewide patient ed. program, exhibit for State Med meeting, and provide translation of leaflets.

154C UC, Davis-extend limited rheumatologist resources to JRA population in N.E. Cal on a referral basis; extend info and training to local practitioners.

154D UC, San Fran - add RA services to existing hospital resources in 11 central Cal. hospitals via roving consultation teams. Develop teaching program.

154E St Mary's Hosp., San Fran - demonstrate comprehensive care to RA at single institution level using allied health personnel; encourage pat. referral, and physician consultations.

154F Stanford U. - work with 3 hosp's in Palo Alto area to develop a data base, and demonstrate automated clinical diagnosis. Info & computer to be made available to interested hospitals.

154G O'Connor Hosp. San Jose - out-patient demonstration project. Develop a library. Provide consultation and referral services for mid-coast area where there are no rheumatoligists.

154H Cedars-Sinai Hosp., LA - evaluation of needs in their catchment area, develop program, & then fit it in new hospital now building.

154I USC, LA - develop an automated patient registry so as to have data for epidemiological studies & planning for a system of clinics in L.A. County. Also identify existing resources.

154J Orange Co. Med. Center - Employ a PT, OT, and Nurse practitioner, and extend services in County. A second clinic will be established and patient and physician education developed. Provide physician and allied health conferences.

154K Loma Linda U. - extend services in San Bernadine/Riverside communities, and coordinate with 2 new RA clinics.

154L Scripps Clinic/Res. Fudn, Ed Center - U.C. San Diego, & Scripps will cooperate to initiate and operate 2 RA clinics in the Imperial Valley, demonstrating a comprehensive team approach.

154M UC, San Diego - Cooperate with Scripps, above. Particularly armed at low income population. Make home, and follow-up visits.

Reduction - $329,093 154F, G, and H. disapproved. Cut 154B to $5,000 excluding RMP support of public education. 154I approved in view of ARA study support. General reductions of equipment and personnel to foster cost-sharing.

Approved - $397,250

CENTRAL N. Y.: Request - $92,492 Employ a PT, OT, Voc. Counsellor, & 2 Nurse clinicians, increase clinic sessions from 2, to 3/wk, train 2 Nurses, to upgrade quality of care, improve operation of the Clinic at Upstate Medical Center, and provide consultation & referral for primary physicians. Adopt POMR in hospitals. Add bi-monthly clinics at Binghampton, and Johnson City.

Reduction - $22,292 Delete 1 sec'y, and 1 nurse, cut voc. counsellor to 50%, and inject social services. Arrange more frequent clinic visits, such as by visiting each monthly for 1/2 day.

Approved - $70,200

COLO.-WYO.: Request - $362,621 The Arthritis Chapter will establish a small, separate office to provide coordination and administration. UC Med. Center will bring in local physicians from the 2-State area for instruction, and work in the UC clinic. Additional personnel will permit UC to increase consultative visits into 8 small community hospitals. Install latest testing capabilities in the UC Lab. Expand the present 1/Mo juvenile clinic to 2/mo. General Rose Memorial Hospital would add staff to expand capabilities, and share teaching and consultative work with U.C. Ewuipment needed in Gottsche Rehab. Hospital. Data collecting program proposed to standardize medical records, and to support care cost analysis

Reduction - $188,381 Relatively high "inreach" should be converted to increased outreach. Data and registry activities deleted, and some teaching audio-visual costs. Personnel $ reduced to induce cost sharing.

Approved - $174,240

GEORGIA: Request - $595,000 Proposal described GRMP's "Umbrella" system: a central coordinating point, 2 Regiona, 4 Areas, and identified community programs. Future contracts will provide teaching, consultation, and quality of care improvements in all Areas.

Reduction - $395,000 Program should be developed in 2 Areas in accordance with review guidelines, and reported to DRMP.

Approved - $200,000

GREATER DEL. VALLEY: Request - $385,001 Six institutions are involved: Temple U. will attempt to upgrade 17 community centers. U.P. will do the teaching including production of 12 films. Hahneman Med. Sch. will provide pat/fam. workshops, and Children Seashore House will upgrade juvenile clinics. Thomas Jefferson U. will develop educational capabilities (physician self-assessment). Albert Einstein will train allied health personnel. Established evaluation criteria will be applied, and statistical retrieval from uniform records will be pursued.

Reduction - $137,501 Automated data, general visual aids production, and public education activities disallowed. Temple upgrading activities reduced 50%. U.P. visual aids and self-teaching aids deleted. Cautioned not to let visiting teams supercede development of local practitioners.

Approved - $247,500

HAWAII: Request - $461,820 Develop a center at H.U., develop a pat. education program, develope a rhuematological assistant program (Nurses), and evaluate changes in quality of care. Audio-visual materials will be developed, and some translated. A good deal of tape and film equipment, and office equipment is requested. Multidisciplinary teams will visit the islands - 45 trips, plus 6 trips to the Trust Territory. Clinical services are based at Queens Hospital.

Reduction - $245,820 Support the base structure of an arthritis program. Delete $150,000 in audio visual production salaries and equipment; cost-share personnel, and cost-share approved equipment. Reduce outside Consultant costs. Delete $20,000 subsidy to patient care costs.

Approved - $216,000

INTERMOUNTAIN RMP: Request - $385,463 Univ. Utah will develop 6 primary and 5 secondary facilities in the Region. Consultation services will be bolstered by a relatively large amount of extra-regional people on services contracts. A "Home and Midway Care Program" involves multidisciplinary personnel in both patient, and services evaluation at $20,000 for each of 3 States. Professional education will be provided at U.U., especially to upgrade primary and secondary providers, to reduce the existing patient backlog, and to extend better care. Duplicate patient testing will be reduced by employment diagnostic and treatment standards distributed to all providers with reference to RA, osteo., gout, and SLE.

Reduction - $215,963 Personnel costs to be cost-shared, and data processing costs deleted. Reduce equipment costs 40% (cost share), and reduce travel, and outside consultant costs.

Approved - $169,500

IOWA: Request - $87,554 Outreach clinics will be established by UI at Des Moines, and Muscatine. Des Moines is basically a service clinic, while the Muscatine facility is a patient care demonstration program. A multidisciplinary team will be developed at each site, and a single professional education conference will be held using one or two outside experts.

Reduction - None

Approved - All

KANSAS: Request - $390,013 KU-VA in KC will develop professional/pat. info. and ed. units in KC, Topeaka, Salina, and Wichita under local sponsorship to provide diagnosis, assessments, and referrals of patients. Laboratory equipment is requested for the center, and automated data operations are proposed in connecton with center review and counselling on local diagnosis and treatment. Professional training will be conducted.

Reduction - $147,613 Laboratory, IEU, office rental, and office equipment costs deleted as more appropriate for coverage through local sponsors' earning services. Automated data costs deleted

Approved - $242,400

LAKES AREA: Request - $602,500 - 2 year support to establish 3 clinics, two in Buffalo (7 Hospitals involved), and one in Erie, Pa. (4 Hospitals involved). provide monthly consultation in each of 8 outer Counties. 3 Clinics will institute continuing education in the 9 Counties. A Central registry of patients and resources will be established. The 3 clinics would be directed primarily by a Fellow.

Reduction - $557,500 - delete second year request, plus 2/3rds of clinics, plus Fellows. Program not deemed viable on a 1-year basis, and Fellows, depended on for full time manning of clinics, inappropriate for RMP support and for effective teaching relationships with experienced local physicians.

Approved - $45,000 to establish one clinic with part-time rheumatological direction, and/or trained nurse direction.

METROPOLITAN D.C. Request - $845,301 - The D.C. Dept. of Human Resources (DHR) will provide public education, with some multi-disciplinary team surveying and consultation regarding treatment, and home care (VNA). Incidence will be studied. Freedmen's Hospital (FH) will significantly beef up its services by training callied health people , and organized inpatient, and outpatient care for the inner city population. Patients not attending clinics will be identified and brought in. Home visits and care will expand, as will pat./fam. education. In additionto multidisciplinary care and home visits, the team will hold monthly team conferences. Washington Hospital Center (WHC) will cooperate with Shaw Community Health Center to improve care through increased multi-disciplinary diagnosis and treatment. An RN will be fully trained for continuity operation of the Shaw Clinic, and an SW will be trained to improve intake and screening for referral to WHC. The National Orthopaedic and Rehab. Hospital (NORH) will stimulate local patient referral, perform outpatient diagnosis and treatment, and seek to improve care quality and continuity. Several short-term professional and public educational conferences and seminars are planned. A "Regional Arthritis Directory" of services and facilities will be compiled. Georgetown Univ. Hosp. (GU) will develop 21 slide and video tape teaching/self-teaching programs of 20 min. each on 15 selected subjects aimed at both physicain, and allied health users. Programs will be provided free to local hospitals, and libraries. The Arthritis Rehab. Center (ARC) a privately-owned facility, will establish 2 new community clinics in addition to 3 now operated.

Reduction - $668,401 Projects from DHR, NORH, GU, and ARC are disapprove as duplicatory, and/or low priority. FH reduced by pat. transport costs and 1/2 Admin. Asst. WHC reduced by pat. trans. costs, and $27,000 in personnel (cost-sharing).

Approved - $176,900 community outreach clinics and services at FH, and WHC

MICHIGAN: Request - $823,413 UM will establish a geriatric arthritis center with both inpatient, and outpatient services for persons over 55 in Weshentaw County, and coordinated with an on going gerontology program. Also evaluate present status, and post-care status to assess comprehensive care results. Professional and patient education will be performed. Wayne Univ. will develop and improve mechanisms for health care for RA, and degenerative joint disease, The care will rest primarily on the nurse clinician, and is essentially a care evaluation project. Expanded Lab. facilities are requested. Medical College of Toledo will support the Northwest Ohio AF proposal with establishment of a clinic at MCT to provide professional training, support the establishment of a Div. of Rheumatology, and to stimulate patient referral.

Reduction - $628,713 Wayne State and Toledo components deleted as inreach. UM proposal reduced in personnel costs through both position reductions, and cost-sharing, and deletion of automated data and visual aid production costs.

Approved - $194,700 - for core staff support and development of the demonstration and educational components which are coordinated with the Council on Aging, and various local public and voluntary agencies all of whom will refer patients. Primarily, treating and care personnel in existing nursing homes and day-care centers will be identified, and provided training. Most of the patients involved is the project are recent releasees from hospital care.

MISSISSIPPI: Request $862,409 A new hospital Mississippi Methodist Hospital and Rehab. Center, adjacent to MU will allocate 15 beds to arthritis. There will be a clinic at each, MU, and MHRC, 4 community clinics around the State. Patients will be classified by ARA standards and progress analyzed; patient-oriented records will be employed, and a cost effectiveness study will be conducted. A large education program includes professional, patient, and public emphases, and there is a telephone consultation service. Community clinics will be headed by local internists who will be trained.Audio-visual aids will be produced.

Reduction - $804,409 covers items of cost related to the 15 beds, and other hospital costs, general supplies, a van, audio-visual production.

Approved - $58,000 covers satellite clinics' budget, and professional education activities.

NEW MEXICO: Requested - $272,765 The UM and NMAF will cooperate in the establishment of clinics at Las Cruces, Roswell, and Taos to provide care, and serve as prof./pat./pub education centers. State and voluntary agencies, and community hospitals are cooperating. UM will send multidisciplinary teams to the clinics monthly, and increased local support/assumption of work will be fostered. Three existing clinics in Albuquerque are under murse practioner supervision, and will be upgraned by professional consultations on patients, and training of personnal at UM and other hospitals. These clinics will expand patient and public education activities. A Juvenile RA clinic will be developed in the UM Dept. of Pediatrics. A multidisciplinary medical team drawn from the Arthritis Foundation Medical Council will visit all clinic sites, and will organize and help support greater involvement of local physician, and allied health people, and volunteer individuals, Pat./Fam. seminars will be conducted. Special pamphlets and audio-visual materials will be produced, and/or translated for Indian and Spanish-speaking people.

Reduction - $109,165 Audio-visual production is deleted, one of the 3 clinics, and the juvenile clinic as a separate clinic (apart from adult services). Automated data activities are excluded.

Approved - $163,600 To establish 2 clinics, one of which may incorporate juvenile RA Capabilities, the multidisciplinary teams, and professional and pat./fam. education, as well as the development of greater experstise in local communities.

NORTH CAROLINA: Requested - $433,962 The AF will provide coordination, organize professional education programs and provide volunteers' assistance, and conduct a detection program at Burlington Industries plants. At Asheville Orthopedic Hospital and Rehab. Center train RN's, and other allied health personnel to monitor drug toxicity, perform patient screening, serve (RN's) as physician assistants for followup, and to train patients. A station outside OHRC will be established to conduct retinal function evaluation, and retinal toxicity monitoring of anti-malarial drugs. UNC School of Medicine, Chapel Hill, will expand its clinic operations (100%), provide a multidisciplinary team to visit and assist AHEC hospitals to develop model clinics, and develop video tape educational programs. The Central Piedmont Community Hospital at Charlotte will establish a paramedical patient teaching program. Local physician "centers" will be set up with one or more paramedical personnel working under the local physician. Duke University School of Medicine will establish outreach clinics, and a series of seminars for physicians and allied health personnel. Local physicians will be invited to attend referral clinics with their patients. A State-wide symposium will be conducted. Training materials will be produced. Bowman Gray School of Medicine will send multidisciplinary teams regularly to 3 existing Clinics to improve and expand their capabilities (N.C. Baptist Hospital, and East Bend Community Family Physician Assistant Clinic, and the Farmington Nurse Practitioner Clinic).

Reduction - $222,462 - a reduction of positions, and cost-sharing of the remainder. The AF request is reduced, reflecting excessive "coordination" proposed. OHRC, Asheville, is reduced to exclude audio-visual, and support a more achievable coordination effort. UNC, Chapel Hill reduced to exclude video tape production, and tighten program. CPCH, Charlotte, disapproved as the scope of utilization was undetermined, and sintability of some paramedical activities questioned. Duke U. seminars were halved in cost. Bowman Gray reduced 50% as the effectiveness of the proposed activities were questioned.

Approved- $211,500 - The AF will provide coordination especially with respect to patient referrals, and will provide patients and physicians with educational literature. In An industrial complex will be surveyed and employee/employer education developed. Professional personnel will be trained, multidisciplinary teams will work with existing and new clinics, and increased utilization of allied health and local physicians should occur.

NORTH Dakota; Request - $340,800 No. Dakota Medical Research Foundation will assist and coordinate the establishment of arthritis treatment programs in Bismark, Grand Forks, Fargo, and Minot which are also AHEC centers. Participating personnel, and program planning will be selected, assisted and coordinated by special committee of public and private persons. Expansion of patient care services will be accompanied by standardized patient assessment, treatment, and evaluation reporting. A POMR system will be incorporated into and automated data to be processed in the Dakota Hospital at Fargo. At Grand Forks, Fargo, and Minot, a multidisciplinary team will conduct twice-monthly clinics; itinerant services will be extended to homes, and physicians offices, and clinics. Ambulatory patients will be brought out of centers by extended services. Public and professional education will be provided.

Reduction: - $229,800 - Reduced program from State-wide, 4 centers, to pilot 2 centers. Costs reduced accordingly, plus publication and computer costs. Travel, and consultant costs reduced, as are personnel, to foster cost-sharing.

Approved - $111,000 to develop 2 centers, with accompanying services and trials indicated above.

OHIO VALLEY: Requested - $711,166 Request includes 1 from OV/RMP, and 3 from State of Ohio. U. Louisville will establish a comprehensive treatment program for low income residents, based at Louisville Gen. Hosp. Centralized specialist services will be made available here and through community and VA referrals. Paramedical and lab. backup services will be increased, as well as home care services through VNA. At Cincinnatti, the AF Clinical Research Center, UC, VA, Drake Hospital, Good Sam. and Christ Hospitals and local physicians have large back-logs of untreated cases, mostly minor conditions. "Arthritis Assistants" (mostly nurses) will be trained patient evaluation and followup, and

will comprise part of multidisciplinary teams to provide weekly visits to 4 existing clinics in Hamilton County. Capability for specialized lab. tests will be added to the AFCRC, and "assistants" will be trained to do urinalysis and blood tests for outpatients under fold salts treatment. A standard patient info system will be developed per ARA system. The Central Ohio AF will improve capabilities ar 7 hospitals in and around Columbus through professional education, doubling clinic frequencies, establishing 3 new clinics outside Columbus, improving lab. backup services, ann developing a uniform clinic referral and reporting system. Case Western Reserve at Cleveland will expand juvenile RA and Lupus services at Abington House Locomotor Unit. Referral and education will be increased, and a study conducted on the effectiveness of patient education.

Reduction - $664,666 Louisville, all lab and related costs, consumable supplies, and patient transportation costs ($67,560), Cincinnatti, Columbus, and Cleveland programs.

Approved - $46,500 - all Louisville coordination, planning and operating staff involved in service development training, and outreach.

OKLAHOMA: Requested - $157,526 - UO has no rheumatology division. A new orthopaedist in coming. Clinics staffed by 1 internist/rheumatologist recently started at each OU Hlth. Sc. Center, VA hospital. Want 2 full-time rheumatologists in the clinics and expand referral, treatment, and Physician and Physician Associate training. Referral services will be developed RA clinics at OUHSC will increase from 2 to 3 times weekly, and clinics will be initiated at OCVAH. Activities will be related to 10 south-central counties where an Health Development Area Program is operational.

Reduction - $91,476 - supporting staff, supplies and equipment which should be borne by sponsoring facilities.

Approved - $66,050 to support rheumotologic salaries.

PUERTO RICO: Requested - $122,541 to develop a model clinic at PR Med. Center, and local clinic at Cagues, or Bayamon. Public and professional education will be initiated, clinic services will be planned and initiated, and data collected.

Reduction - $30,381 - to delete duplicatory planning activities, publications, lab. equipment, and rental costs.

Approved - $92,160 - to organize and operate clinics, and training cativities.

SUSQUEHANNA VALLEY Requested - $254,901 Central Pa. AF will coordinate activities to develop patient and family education, physician and allied health education, and clinical services. Education at 2 Northern clinics, and 4 southern towns. Visual-aid materials will be produced. Patient education will also be developed in the centers. The AF will establish clinical services at Williamsport Hospital, with satellites at Lock Haven Hospital, and Blossburg Family Health Center. Services will be expanded at Geisinger Med. Center, Danville.

Reduction - $115,401 - High proportion of salaries raised concern re. continuity. $21,000 deleted, and cost-sharing of remainder advocated. Audio-visual costs deleted, and other cost categories reduced.

Approved - $139,500 to proceed with clinics, training and outreach activities. Inreach to be reduced.

TENNESSEE MID-SOUTH Requested - $420,401 - Vanderbilt U. will be site of new, and first, arthritis center and clinic in the region in cooperation with the VA, and Nashville-Metropolitan GH. Outreach clinics will be developed, and public, patient and professional education. Both a juvenile, and adult clinic will be established at East Tennessee Childrens Hospital, Knoxville. A uniform patient record will be employed. Audio visual, vehicles, and large equipment costs are indicated.

Reduction - $281,901 - vehicles, lab. equipment, hospitalization costs, and automated costs deleted. Personnel costs to be cost-shared.

Approved - $138,500 - to undertake a more modest, achievable program in an area which has few arthritis capabilities at present. Clinics, training and outreach to be pursued.

TEXAS: Requested - $356,559 - Feve Med. Schools and the AF are cooperating in a State-wide program. A Governor's Conference is planned. Public and professional education will be conducted in 48 communities, including regular clinics. Public forums will be conducted in 40% of all towns of under 10,000 pop. and will involve local physicians and hospitals in arrangements, and production. A demonstration van will be developed &employed in south central Texas. Lab capabilities will be upgraded, & a technician employed at each of the 5 schools, and practitioner and allied health refresher sessions held at Texas Tech U. (El Paso, Amarillo). Regional arthritis workshops will be held at 3 schools for all allied health people. Outreach clinics will be augmented by physician conferences (1 at each of 3 schools), and bi-weekly seminars at T. Med Sch., San Antonio. A minimal-care facility will be developed and operated at Galveston to treat and train seriously handicapped patients.

Reduction - $112,359 - deleted support for the Governor's Conference,

public education, lab. upgrading, demonstration vehicle, and automated data, and required cost-sharing of patient-treating personnel at Galveston.

Approved - $244,200 - provide professional education, expanded services, and outreach. The Galveston minimal-care unit strongly advocated for support.

TRI-STATE: Request - $844,775 - the Robert Bent Brigham Hospital will develop public and professional educational materials, and seek acceptance of POMR by practicing physicians and local hospitals. Boston City Hospital will develop a multidisciplinary team to improve care, and provide outreach to inner city patients. Emphasis is development of allied health personnel, and services, including physician assistants. A standardized data reporting system will be developed. At Tufts New England Medical Center, 8 new community clinics will be initiated, and 4 existing ones expanded. 12 Nurse clinicians will be trained; Tufts pediatric services will be improved. Mass. General Hospital will initiate in Essex County Pilot Program emphasizing physician education, case comsultations, coordinated community services, and demorgraphic studies. RBBH, and Boston U. Med. Center will participate. The New England Rehab. Hospital (for profit) in cooperation with UM Sch. Med., and Worcester City Hospital, will develop the clinics at 6 community hospitals, increase professional, and pat./fam. training, and stimulate exchange of research and therapeutic information

Reduction - $631,405 - Robert B. Brigham Center, Mass. G.H., and New England Rehab. Hospital programs disapproved. Others reduced to delete library and visual aid costs, and reduce personnel and equipment costs.

Approved - $213,370 -training, clinics and outreach activities proposed at Boston City Hospital, and Tufts New England Medical Center (Maine and Mass. satellite clinics).

VIRGINIA Request - $188,857 - satellite clinics will be conducted in Richmond, Norgolk, and the Appalachian area of southwest Va. Each will be visited every 4-6 weeks by a team of: a physician, a PT, and a nurse. Assistance will be given on record keeping, as well as with patients. Plan to hold these at 8 family practice training centers, and offices of 15 physicians. There will also be 5 regional workshops. Allied health personnel will be invited to serve in-service training periods in the program. It is also planned to test the benefits of early intensive care. A full-time PT, and nurse practitioner will carry out activities -- home visits, clinical therapy, patient education. Controls will be developed from existing patient records. A controlled study on Acupuncture is proposed. Vocational rehab. services will be incorporated into the pilot program.

Reduction - $100,857 - The studies are deleted and clinics are reduced.

Approved - $88,000 to develop 1/2 the proposed clinics

WASHINGTON-ALASKA: Request - $361,167 - 13 components are presented covering: administration and coordination; public education; production of a resource book; a patient transportation system; a telephone consultation system; PT/OT home services to patients released from hospitalization; traveling multidisciplinary consultant teams; expand the training capabilities of Mason House Residential Facility; short-term, in-service PT/OT training at Virginia Mason Medical Center, and at the Western Washington AF Chapter; a pediatric clinic; establish an RA reference laboratory at UW Med. Sch.; development of a physicians assistant training program; and continuing education for physicians.

Reduction - $285,167 - deletes all but the 2 OT/PT components, and the vans for traveling PT/OT's.

Approved - $75,000 to conduct PT/OT outreach and PT/OT training.

WESTERN PENNSYLVANIA: Request - $281,051 - 2 yr's support requested. A coordinated network of 6 centers will be developed, with monthly consultation visits, and employing a demonstration van. Short-term professional training courses will be conducted. A regional directory of services will be produced. Referrals to sheltered workshops will be developed. Public education, and a uniform reporting system will be developed. A van will be employed for patient and physician training.

Reduction - $140,651 - to delete public education, and automated data activities.

Approved - $140,400 - to establish centers, conduct training, develop consultative and referral activities, and develop the directory. The van should be leased.

WISCONSIN: Requested - $267,857 - the Wisconsin AF will administer and coordinate the program. It will collect State-wide data and compile a directory of services. This will be done by a SW/Nurse team. A Health Educator will assist and coordinate patient education at treatment units. Nursing standards will be developed after a study of nursing care on 2 well-defined groups of patients. A committee of physicians, with other professional participation, will develop standards on Medical, Surgical, and physical care of 2 or 3 common diseases. A multidisciplinary teaching team will be formed to provide 1-2 day training sessions at local hospitals. Public education will be developed. A study on patient education will be conducted to develop a model program to (a) establish education quidelines, (b) identfy outcome criteria, and (c) disseminate the model.

Reduction - $205,857 - activities which appear to be more traditional, or suitable for AF support.

Approved - $62,000 - to carry out the Quality Assurance of Nursing Care study, the patient education study and to support the multidisciplinary teaching team.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
ROCKVILLE, MARYLAND 20852

February 21, 1974

BUREAU OF HEALTH
RESOURCES DEVELOPMENT

TO ALL RMP COORDINATORS, NATIONAL ADVISORY COUNCIL MEMBERS, AND REGIONAL HEALTH ADMINISTRATORS, PHS

SUBJECT: RMP Arthritis Initiative Under the 1974 Appropriation Earmark of $4,500,000

Guidelines relating to applications for arthritis funds "earmarked" in the RMP 1974 appropriations, and a brief background statement on arthritis, are enclosed. Included in the guidelines are application instructions and review criteria. These materials were developed with two audiences in mind --- the RMP's which must apply for the funds, and individuals or groups who may be interested in developing project proposals.

Our distribution of these materials is to the 53 RMP's, the Arthritis Foundation Headquarters, and other interested agencies. These agencies will send an announcement about the availability of the application materials and a list of RMP Coordinators and addresses from which interested parties should obtain specific information.

Since the arthritis "earmark" is from FY 1974 funds, the review of applications and the award of grant funds must be completed by June 30, 1974. Thus, we are all under severe time constraints. Applications are due in DRMP, Room 11A-18 by close of business on May 6. No applications received after that date will be considered. Please note that the room number for the receipt of arthritis applications is different from the room number to which regular RMP program applications are to be sent.

Several points from the attached materials need immediate highlighting:

1. Regional Medical Programs will submit the application for arthritis "earmark" funds, incorporating those project proposals which have undergone CHP review and comment and have received Regional Advisory Group approval, as is normal for other activities proposed for RMP funding, i.e., the normal review process applies.

2. The applications for "arthritis" funds, however, should be submitted as a separate application to the Division of Regional Medical Programs. The arthritis applications will compete for the earmarked arthritis funds, only.

3. Applications will receive technical review at the national level by consultants assembled in May by the Division of Regional Medical Programs for this specific purpose.

4. The National Advisory Council on Regional Medical Programs will review the applications during its June, 1974 meeting; the Council will approve or disapprove the applications and recommend funding levels to the Director, DRMP.

5. The Director, DRMP, will inform, in writing, each RMP of Council recommendations concerning its application and the amount of supplemental funds that will be awarded from the "earmark".

6. The "earmark" supplemental awards will be effective July 1, 1974.

Should you have questions, please call the Operations Officer assigned to your Regional Medical Program.

Sincerely yours,

Cleveland R. Chambliss
Acting Director
Division of Regional Medical
Programs

ANNOUNCEMENT REGARDING APPLICATIONS FOR ARTHRITIS FUNDING

The Division of Regional Medical Programs has announced that $4.5 million will be awarded in FY 1974 to Regional Medical Programs for one year program development in the arthritis field.

Applications for the special arthritis funds are due in the Division of Regional Medical Programs by close of business May 6, 1974. All applications will receive technical review by an ad hoc panel of consultants in mid-May, 1974, and by the National Advisory Council on Regional Medical Programs during its June 1974 meeting. Awards will be made prior to June 30, 1974 for the period July 1, 1974 - June 30, 1975.

All applications must be submitted to CHP (a) and/or (b) agencies for review and comment. Anyone interested in applying for these funds should contact the Regional Medical Program serving the geographic area for information regarding guidelines, and the RMP's schedule for submission of project proposals for review and Regional Advisory Group consideration.

Further information may be obtained from Mr. Matthew Spear, Division of Regional Medical Programs, Parklawn Building, Rockville, Maryland 20852, telephone 301/443-4385.

GUIDELINES AND REVIEW PROCEDURES FOR ARTHRITIS PROGRAMS

A. BACKGROUND

Under P.L. 93-192, Congress appropriated up to $4,500,000 for planning and development of pilot arthritis centers in 1974. This document sets forth the governing RMP arthritis program guidelines and related information for activities to be carried out with these funds. In developing the guidelines, the Division of Regional Medical Programs has had the benefit of consultation and advice from RMP coordinators, the National Institute of Arthritis, Metabolic, and Digestive Diseases, members of the American Rheumatism Association, and the National Advisory Council for Regional Medical Programs.

B. PROGRAM EMPHASIS AND DEFINITION

The term "pilot arthritis centers" is defined for purposes of this RMP initiative as organized pilot programs to develop optimal delivery of care to arthritis patients in a defined population. The goal of the arthritis program is to develop, strengthen, and improve arthritis care delivery in order to obtain more accessible, efficient, and high quality care for victims of the arthritis diseases. In this perspective, the traditional view of a center is broadened to include the medical service area. Improved extension of advanced treatment and care methods, and improved patient referral practices, should be facilitated by coordination of the collective health and medical care provider system of the area. Linkages of these elements of the system should bridge the gap between research and clinical investigations, and the care which is made accessible to arthritis patients.

Programs will be developed and processed through the local RMP's in order that Regional expertise and assistance will be available to applicants. Arthritis programs should benefit from and contribute to the health care delivery experience and resources existing in the Regions.

C. TYPES OF ARTHRITIS PROGRAM ACTIVITIES

Activities developed should contribute to organized programs of arthritis patient services. Existing and expanded skills and resources at all community levels should be united in the provision of care to arthritis patients in the population served. Programs approved for support should display coordinated courses of actions which can result in exemplary demonstrations of community health resource mobilization to meet the treatment needs of the community's arthritis patients.

Both care providers (physicians, nurses, and allied health professionals), and consumers should be involved in planning and developing proposed pilot programs. Characteristic activities contemplated within pilot arthritis programs include, but are in no way limited to the following examples:

1. Improvement of community arthritis clinics to broaden the care delivery base (especially outpatient care), as well as to augment multidisciplinary diagnosis and treatment of adult and pediatric arthritis patients.

2. Home, and "mid-way" care programs to improve care access, and reduce long term or chronic treatment workloads on hospitals and clinics.

3. Center-to-center, and center-to-clinic linkages of services which expand the specialty base of patient services, and accelerates the dissemination of advanced care, especially restorative and rehabilitative methods and techniques. Particular note should be taken of opportunities to relate to Veterans Administration facilities, vocational rehabilitation programs and other private and public operating health services. Maximum utilization of existing care delivery resources should be obtained.

4. Community advisory bodies representing provider and consumer interests to maintain surveillance and evaluation of activities, and facilitate the development and coordination of community services for arthritis. Such groups might also establish liaison with other arthritis and chronic disease programs, as well as undertake studies of arthritis care delivery problems.

5. Alternative sources of service funding to sustain program viability when RMP funding ends. In this respect, it would also be useful to determine the magnitude of the arthritis problem, and the costs of different modes of care delivery.

6. Program-wide reporting system to aid patient referral, prevent patient loss from the system, improve continuity of care, reflect program progress and indicate program deficiencies to program authorities, and provide the base for program evaluation.

7. Standards of quality care for different categories of arthritis, and for effective utilization of different levels of care provider personnel and facilities.

8. Public education programs to motivate patients to seek qualified provider services, and to formulate more positive public attitudes toward arthritis and its crippling effects.

9. Professional education to refresh or expand the responsibilities of physicians, nurses, and allied health personnel in arthritis therapy, and to motivate united action against arthritis disease. Existing seminars, and health service/education consortiums should be utilized to determine manpower needs, develop curricula, and improve education and training.

D. OBJECTIVES OF PILOT ARTHRITIS ACTIVITIES

1. Patient Care

a. Improve patient access to high quality care, including multi-disciplinary treatment planning, and including conservative management to prevent, delay, or reduce pain and loss of function.

b. Expedite referral of patients to appropriate care in the least care-intensive setting.

c. Improve diagnosis and treatment.

d. Reduce loss of work caused by arthritis.

e. Reduce pain and disability due to arthritis.

2. Facilities and Services

a. Integrate arthritis services with existing health care services.

b. Provide optimal utilization of available health personnel.

c. Develop new care delivery methods responsive to special community or patient needs.

d. Accelerate exchange of advanced technical and semi-technical information.

e. Develop an effective program evaluation system.

E. FINANCING

Awards for approved pilot arthritis programs will be in addition to the regular RMP grant award. The amount allocated for arthritis will be indicated under "Remarks" of the Notice of Grant Award (Form HSM-457). Arthritis funds may not be rebudgeted to other activities without prior written approval by the Division of Regional Medical Programs.

To avoid misunderstanding, applicants should be clearly advised that the arthritis funds provided in PL 93-192 are available in FY 1974, only, and these will be one-time grants. They should also be made aware that the earmarked arthritis funds must cover both direct and indirect costs of their arthritis program requests. The funded programs should include development of third-party payment mechanisms, and rigorously seek recovery of costs for services to maintain program viability. Existing restrictions on the use of RMP funds apply to these grants; e.g., direct patient care costs, basic education and training, research, construction, etc. RMP staff counsel to applicants should go beyond discrete fund restrictions to include advice about known Advisory Council preferences, and previous activity approaches which have proved impractical.

F. APPLICATION REQUIREMENTS

Applications for support of pilot arthritis programs should be submitted separately (not included as a section) from applications for regular RMP program support. However, discrete or different arthritis programs within the same RMP may be presented in a single application.

For each application (Form RMP-34-1), only one Face Page (Page 1), and one set of Assurances and Certification (Page 2) are required. The Face Page should show the entire amount, both direct and indirect costs, if the application includes several discrete program proposals. Each discrete pilot arthritis program proposal involving different local sponsors (or applicants) must have a separate Page 3 and Page 16 for each separately sponsored program component, or activity.

The Form 15 should be employed as the first, or face page of a complete Program Description as noted below. After the appropriate boxes are completed, the Program Description should be started in Item 11, entitled "Proposal", continuing on additional pages to describe the essential points or elements noted below. Descriptions of each component, or element of the overall arthritis application should normally be less than 20 pages.

G. PROGRAM DESCRIPTION

In presenting the arthritis Program Description, applicants should be responsive to the four pre-printed questions in Item 11, on the Form 15. As a categorical, earmarked program, arthritis proposals must provide a comprehensive program description, as distinct from the summary of ongoing program for which the Form 15 is normally used.

A description of the substantive nature and activities of each component of a pilot arthritis program is required (component examples: establishment of clinics; patient services standards; home care delivery, etc). The description should include the following specific information:

1. Activity: What is planned to be done.

2. Plan: What is the sequence, or schedule of salient events, and how do they relate.

3. Location: Where the activity will be conducted geographically, or organizationally (hospitals, clinics, rural areas, named suburbs, etc).

4. Responsibility: Name, title, and location of person responsible to conduct or monitor the work, if different from the Director named in Item 7, Form 15. This person's authority, and the manner in which directive action can be taken to maintain momentum should be indicated.

5. Objective: The end result to be achieved should be stated in quantitative measures, insofar as possible; e.g., increased # of patients to be brought into treatment, increased # of categorical professional

personnel to be activated in the referral/treatment system, increased population to be served by a clinic or coordinated services operation, new methods to deliver care, etc. It may be useful to differentiate immediate impact under the grant supported program from post-grant momentum.

6. Benefit: (May be identical to No. 5, Objective) What quality or quantity of the service area's arthritis problem will be ameliorated, or controlled?

7. Resources: Identify both new and existing personnel, equipment, supplies and facilities required to carry out the program. Item 2, Plan, and Item 10, Budget, may be related to this discussion. It is useful to show how the capabilities of existing services and facilities are being improved, or expanded. New services should be clearly identified.

8. Continuity: Foreseen needs and prospects to maintain program viability after the grant period should be identified so that their further attention during the grant period will be an integral part of the program development activity.

9. Evaluation: A formal plan should be developed with appropriate criteria and schedulled "pulse-taking" to measure progress, identify problems, and permit early action on any program deficiencies.

10. Budget: In addition to the budget summary (Page 16, or Form 34-1), a detailed budget should be prepared which itemizes personnel positions and costs, and identifies specific equipment and supply purchases proposed. Full-time, and part-time personnel effort should be indicated. Care should be exercised to exclude furniture and supply items which are normally covered by indirect cost allowances. Non-RMP program support should be indicated in all cost categories. RMP grant funds cannot be used to supplant existing arthritis support.

H. APPLICATION SUBMISSION REQUIREMENTS

Arthritis program applications must be received by the Division of Regional Medical Programs (DRMP) by May 6, 1974. Applicants should be provided a clear understanding of the submittal deadline required by the servicing RMP in order to meet this schedule. The RMP must conduct a review process which includes review and approval by the Regional Advisory Group (RAG), and the (a) and/or (b) agencies of Comprehensive Health Planning Service (CHP). The Regional Office of the Department of Health, Education, and Welfare, (RO, DHEW) serving the applicant's area must be advised of RAG-approved applications forwarded to DRMP.

The number of copies of approved arthritis programs required at DRMP is 26. This is the original, signature copy, and 25 additional copies of the completed application. Complete applications include, in addition to necessary forms, and Program Description noted above, a transmittal letter, a report of RAG comments and approval, CHP comments, and program-

related letters and other written communications, such as cooperation affirmations, or agreements.

The arthritis grant applications must be postpaid by the sending RMP. They should be addressed to:

Mrs. Sarah J. Silsbee
Division of Regional Medical Programs
Parklawn Building, Room 11A-18,
5600 Fishers Lane,
Rockville, Maryland 20852

I. APPLICATION PROCESSING AT DRMP

Processing of arthritis program proposals at headquarters requires four steps which must be completed by mid-June:

1. Staff review of each proposal to assure completeness, and compliance with DRMP policies.
2. Technical review by selected arthritis and health administration professionals.
3. Review and approval by the National Advisory Council for Regional Medical Programs.
4. Notification to RMP's of Council decisions.

J. DRMP REVIEW CRITERIA

The criteria by which arthritis programs will be evaluated at headquarters are indicated above: i.e., B. Program Emphasis and Definition (see "goal" statement); D. Objectives of Pilot Arthritis Activities; and G. Program Description. To summarize the major points in these Sections:

1. Programs must comply with RMP, and CHP policies and requirements.
2. Programs must clearly contribute to improved patient access, and quality of care.
3. Programs must build on existing health care services, thereby improving health care delivery efficiency.
4. Programs must display efficient utilization of personnel and facilities.
5. Program activities aimed at increasing numbers of patients, professionals, or services, must show why the numbers are necessary, or desirable, and the basis of their computation, or estimation. 1/

1/Where firm evidence or documentation is not immediately available, it is appropriate to describe how it will be obtained. However, planning, or negotiations should not normally comprise the totality of the grant-supported activity.

6. Programs purporting to benefit some professional, or patient group, or locality, must reflect the beneficiary's approval or willingness to participate in the proposed activity. 1/
7. Programs involving more than one group, institution, or community must be accompanied by signed statements of the nature, extent, and commitment to cooperative work. 1/
8. Programs must be professionally acceptable.
9. Program end-results must be feasible within the grant period, or show liklihood of continued non-RMP support to their planned completion.
10. There must be an effective program evaluation activity which will be applied, and which is capable of providing meaningful information (feedback) to responsible officials who are empowered to take necessary action.

1/ Where firm evidence or documentation is not immediately available, it is appropriate to describe how it will be obtained. However, planning, or negotiations should not normally comprise the totality of the grant-supported activity.

BACKGROUND ON ARTHRITIS

This is a summary statement about arthritis to provide staff with a basic understanding of the disease, and salient problems. More complete information can be obtained from local chapters of the Arthritis Foundation, and local rheumatologists, orthopedists, and allied health professional personnel engaged in arthritis therapy, and care.

The term "arthritis" literally means inflammation of a joint. It is generally used, however, in reference to 80 - 100 different conditions which cause aching and pain in body joints, and connective tissues. The major forms of arthritis are chronic diseases.

Arthritis is the major cause of crippling, and among the chronic diseases, is second only to heart conditions in limiting activity, and causing days of bedtdisability. Systemic forms of arthritis damage organs, including the eyes, heart, lungs, and kidneys. The causes of arthritis are unknown, but medical capability exists to reduce pain, and prevent, delay, or reduce crippling in up to 70% of the patients.

The most recent information on arthritis disease prevalence was obtained in the 1969 National Health Interview Survey:

20,230,000	Americans suffer arthritis, rheumatism, gout, and other arthritis-like conditions.
18,315,000	suffer arthritis (pyogenic and nonpyogenic acute arthritis, adult and juvenile rheumatoid arthritis, spondylitis, osteoarthritis, and allied conditions).
992,000	suffer rheumatism (polymiositis, dermatomyositis, fibrositis, lumbago, torticollis, and other unspecified rheumatisms).
753,000	suffer gout exclusively (data indicated 968,000, including 215,000 persons counted with other complications).
170,000	suffer "arthritis-like" conditions (mostly psoriatic arthritis).
---	(an estimated 100,000 - 400,000 patients, not included in the data, suffer systemic lupus erythematosus, progressive systemic sclerosis, polyarteritis, and periarteritis).

While in the aggregate, arthritis is most common among the elderly (everyone gets it as age progresses), all age groups and both sexes are respectively the principal risk groups for various arthritis diseases. The prevalence of arthritis in women (44.9 %) approaches twice the rate for men (28.7 %). Gout is twice as prevalent among men, as it is among women. It appears that rheumatic disease is more prevalent among nonwhite males than white males after age 65. The nonwhite prevalence is less in the under-45 age group. In the U.S., there is no marked variation in the prevalence of the three principal disease categories on the basis of geographic region, or place of residence. However, while the highest

patient numbers appear in SMSA areas, arthritis prevalence rates are higher outside metropolitan areas, peaking in the farm population. The prevalence of arthritis and rheumatism is higher among individuals with family income of less than $4,000 per year, than it is in other income groups.

Osteoarthritis is the most common form of arthritis. It is associated with aging, and degeneration of joint tissues, and is most frequently observed in active men. Rheumatoid arthritis is the second largest category of arthritis diseases, and occurs most frequently in women under age 50. Gout occurs most frequently in men, increasing with age, and is the only arthritic disease which can be medically controlled. Systemic Lupus Erythematosus, a disease of the connective tissues producing changes in the structure and function of the skin, joints, and internal organs, is more prevalent in young women. A serious pediatric disease is Juvenile Rheumatoid Arthritis, occurring in children under 16 (also suffered by adults), which can stunt growth, blind, cripple, deform, disable, and can kill in its systemic forms.

Although acceptable programs of comprehensive care for arthritis patients are available, they are not generally offered to a large portion of the arthritic population. Arthritis clinics are not numerous, and the Arthritis Foundation reports less than 50 university-affiliated "centers of excellence". The primary interest in most centers is clinical investigation; care is oriented to patients with acute crippling, or fatal disease entities.

Citing the Arthritis Foundation, and Federally-supported reports:

1. Only about 20% of persons reported with some form of arthritis in the 1969 National Health Interview Survey were under physician's care for their disease.
2. Only 3.1% of the people who know they have arthritis were reported to be under the care of rheumatologists.
3. Physicians are reluctant to refer their arthritic patients to rheumatologists.
4. Rheumatologists, orthopedists, and physical therapists are not being utilized to the fullest potential.
5. There is a general lack of knowledge among physicians and surgeons treating the arthritides about the existence, functions, and capacities of community health agencies and facilities.
6. There is a shortage of physical and occupational therapists, and social workers in arthritis service.
7. Rehabilitation services are not adequately utilized in the care of arthritis patients.
8. Third-party payers are not actively seeking to support arthritis patient care.
9. There is widespread apathy and resignation about arthritis therapy capabilities among both practicioners, and patients.
10. The annual economic cost of arthritis in the United States, according to the Arthritis Foundation, is $9.2 billions.