



E001030

PHYSICIAN EDUCATION

A-1

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-assessment and programmed 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 insufficient 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 among local physicians for continuing education effort. Distance also creates a teaching resource 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 consensus 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 effectiveness of various teaching techniques. This data could be of great value to those responsible for continued funding. It might also be pertinent 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 existance of less than 2.5 rheumatologists 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 implemented. 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

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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 adjunct 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 clarifications 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 Referral Patterns

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 development. 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

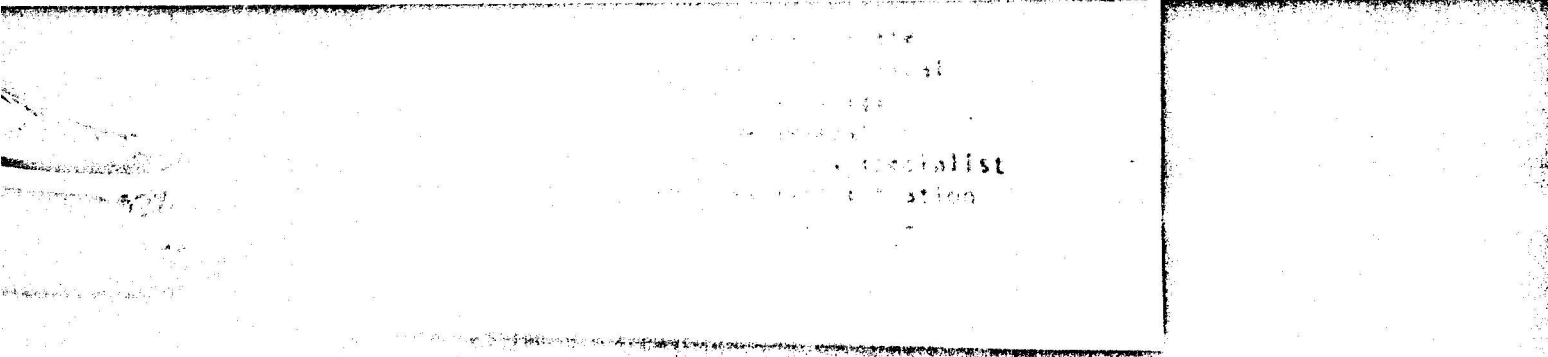
1. The arthritic services workshop began by a review of the activities of the participants in the workshop in their particular units. There seemed to be general concensus that an important part of the arthritis service program was decentralization of present services from medical centers and medical 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 variability existed among the members of the workshops among the constituents of such a team. These varied from 1) The use of specialized physicians, orthopedists, rheumatologists, physiatics, 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 serologic 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 to support the arthritic in job placements.

4. A discussion was held on the role of Allied Health personnel in the arthritis treatment and service programs. Considerable 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 arthritic.

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 physicians 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 patients 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.