

CHAPTER 1

Community Rheumatology: Delivering Care Across Boundaries

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OVERVIEW

- The importance of a multidisciplinary care pathway in the management of musculoskeletal patients is now well recognized globally.
- The need to provide a whole-community approach to the management of these patients is also being increasingly recognized globally.
- The shared-care monitoring of rheumatology patients on disease-modifying drugs between primary and secondary care is an example of a successful model using this approach.
- A community-wide approach encompassing the involvement and education of both patient and primary care physician will lead to earlier diagnosis, speedier and more appropriate secondary care referrals, quicker treatment and ultimately improved clinical outcomes.
- A community-wide approach will ensure that psychosocial factors are not overlooked and that “red flags” for regional pain syndromes are not missed.
- This approach will also ensure that evidence-based primary care treatments for musculoskeletal problems are developed and implemented.

The ever-increasing demand upon the acute hospitals to deliver emergency medicine, together with technological (but time-consuming and expensive) advances means that in the UK and elsewhere follow-up of many chronic conditions has been squeezed out of the acute setting and, by default, delegated to primary care. Unfortunately this shift in activity has not always been mirrored by an appropriate shift in resources and skills. This chapter discusses new ways of working to try to ensure that patients with musculoskeletal conditions receive timely, appropriate treatments within the limitations imposed by restricted resources.

Shared care—how to make it work

With hospital services running at full (or over) capacity, one way

forwards is to develop models of shared care appropriate to local need, responsive to local demands and in the patients’ best interests. Simply transferring the workload from rheumatologists to general practitioners (GPs) will not work—primary care is also bursting at the seams. One way of transferring rheumatological expertise to the community, without increasing the burden on the primary care team, is to develop the roles of health professionals such as nurses, physiotherapists and occupational therapists. Such practitioners, working in an extended role, operate at a high level of clinical practice and cross traditional professional boundaries. Their expertise includes assessment (of the disease and psychosocial factors), follow-up and management of patients with musculoskeletal conditions and inflammatory arthritis. Their roles and responsibilities have recently been defined (Carr, 2001).

What is the role of the specialist nurse?

Specialist nurses are highly skilled and provide holistic care for patients and their significant others by addressing their physical, psychological and social needs. They can play a pivotal role in the management of people with musculoskeletal conditions, acting as effective communicators between the patient, their GP and hospital consultant. Like GPs, they tend to stay in post for many years and become a “constant presence” in the patient’s illness journey, thus ensuring the continuity of care that those with a chronic disease value so highly. The role of the specialist nurse is essentially to provide care management, education and support for patients and their families, and to act as an educator and resource for other health professionals. The role includes those activities shown in Box 1.1. Some nurse specialists also undertake advanced practices such as intra-articular injections (Meadows and Sheehan, 2005). This can be particularly useful to GPs, who may be inexperienced in this procedure. After specialist training these nurses can also prescribe drug therapy (Carr, 2001). Of all these activities, patient education remains one of the priorities of the specialist nurse (Department of Health, 2006).

Why educate patients?

Patient education enables people with complex chronic diseases to care for themselves, bringing benefits for everyone. Supporting

patients to self care has been shown to reduce their GP visits by 40–69% (Schillinger *et al.*, 2003). Patient education is not a treatment in itself but a treatment enhancer, magnifying the effects of standard treatments by persuading patients to adhere to them more closely, or to adopt actions that are believed to be beneficial. To do this, patients must be active collaborators in their care and believe in their ability to perform a specific task or achieve a certain objective. This is known as “self-efficacy”. For changes to occur patients must acquire knowledge and skills, and so patient education involves the multidisciplinary team and the patient and their partner/carers in both primary and secondary care. Every consultation is an opportunity to educate and provide information. In order to care for themselves, patients will need to know about the topics shown in Box 1.2.

Patients should be given both verbal and written explanations. The Arthritis Research Campaign (arc), Arthritis Care, and the National Rheumatoid Arthritis Society are good reliable sources of the latter.

Skill enhancement can be gained from attendance at an Expert Patients Programme, and giving the patient the address of local and national community support networks offers great benefits.

It is important to remember that simply because information has been provided does not mean that it has been understood or acted upon. One quick and easy method to ensure assimilation is the “teach me back” method (Schillinger *et al.*, 2003), which involves the patient being asked to “teach me” or “show me” as if the professional does not understand the problem. This quickly identifies any misunderstandings and allows purposeful correction.

Box 1.1 Role of the specialist nurse

- Supervise treatment safety—e.g. monitoring disease-modifying antirheumatic drugs (DMARDs)
- Review treatment effectiveness
- Coordinate the multidisciplinary team
- Provide a communication channel between the patient and the team
- Act as the patient’s advocate
- Promote continuity of care
- Identify and address psychosocial patients’ issues
- Man telephone advice lines
- Facilitate education for patients, carers and health professionals

Box 1.2 Knowledge necessary for self care

- Disease aetiology and progress
- Drugs and how to take them; what the side effects are and what to do if they occur
- How to exercise
- How to protect joints and acquire appropriate devices and home changes
- How to control pain
- Coping strategies

Who should be referred to secondary care?

Waiting times for new rheumatology appointments vary widely and depend on local resources but also, to some extent, on how clinicians triage referrals from GPs. To make the system work effectively, care pathways need to be developed in which the patient is a partner, and which take psychosocial as well as biomechanical factors into consideration. The outcome, in terms of whether the patient is given an appropriate priority with an appropriate health-care professional, depends largely upon the information contained within the referral letter. Standardized referral forms may help but have the disadvantages that they are time-consuming to complete and rather impersonal. Helpful information to include in a referral letter is shown in Box 1.3.

It has been estimated that 15–30% of all GP consultations are for musculoskeletal conditions. Most of these are for osteoarthritis in the over 50s age group and back pain in the under 50s. One challenge for the GP is how to spot the small number of patients with early inflammatory arthritis among this caseload who will benefit from early referral to hospital and prompt treatment with DMARDs. There are no specific clinical, radiological or immunological markers for rheumatoid arthritis (RA). Normal blood test results and X-rays do not exclude RA, but equally a positive rheumatoid factor does not clinch the diagnosis. Most rheumatology departments encourage an “inclusive approach” to referral and encourage GPs to maintain a high index of suspicion and not delay patients with possible inflammatory arthritis. Ideally, patients suspected of having inflammatory problems will be fast-tracked to secondary care. Box 1.4 highlights certain features thought to be indicative of early RA.

Box 1.3 Important information to include in a rheumatology referral letter

- Length of history
- Pattern of joint involvement
- Presence of joint swelling
- Presence of early morning stiffness
- Previous treatments and response
- Level of distress/disability
- Results of investigations
- Other relevant medical or psychosocial factors

Box 1.4 Symptoms and signs suggestive of early inflammatory arthritis

- Symmetrical soft-tissue swelling (synovitis) of wrists and/or metacarpophalangeal joints and/or proximal interphalangeal joints
- Joint stiffness a significant problem—especially in the early mornings for >30 minutes
- Soft-tissue swelling of any joints
- Good response to a trial of non-steroidal anti-inflammatory drugs

Primary care management of musculoskeletal problems

Clearly, the majority of patients presenting to GPs will not have inflammatory arthritis. Indeed, often a precise pathological diagnosis based on symptoms and signs and results of investigations will not be possible, and may not be the most appropriate approach to management. This “medical model” of care often fails to address other important influences on pain perception, such as emotional and behavioural factors, and may encourage chronicity by using terms such as “arthritis”, “wear and tear” or “degeneration”, which emphasise the unchanging nature of the condition. Doctors are trained to diagnose “disease”, whereas the patient’s concern is what to do about their musculoskeletal pain, not just what to call it.

An alternative approach, which may be more useful in primary care, limits the diagnostic process to identifying potentially serious pathology—the so-called “red flag” disorders—and other specific diseases or disorders. This system was initially developed for back pain, and has been effective in changing the primary care management of this condition. It is equally applicable to other widespread or regional pain disorders, however (Box 1.5) (reviewed in Carr, 2001). Patients with “red flags” and certain other patients with specific diagnoses, including inflammatory arthropathies and connective-tissue disorders, should be considered for referral to secondary care for further investigation and management.

Having excluded and dealt with the small proportion of patients with potential serious pathology and specific diagnoses, the next step is to decide how best to manage the remainder. Two areas need to be addressed: how to deal with the presenting pain and distress (discussed below), and how to prevent future disability. Guidelines for the management of low back pain highlight the importance of identifying factors that predict chronicity. It is important to give positive messages about likely recovery and lack of long-term

Box 1.5 “Red flags” for regional pain syndromes

History of significant trauma

- Fracture
- Major soft-tissue injury

Localized joint swelling and/or redness

- Septic arthritis
- Inflammatory arthritis
- Haemarthrosis

Unremitting night pain

- Malignancy
- Inflammation/infection

Bone tenderness

- Fracture
- Malignancy
- Infection

Systemic disturbance

Significant co-morbidity

harm, taking particular account of psychosocial barriers to recovery (“yellow flags”). These principles have been described elsewhere (Department of Health, 2007) and are summarized in Box 1.6.

Evidence-based primary care treatments for musculoskeletal problems

The shift in emphasis towards self-management of musculoskeletal problems means that the primary health-care team is of central importance. There is a growing evidence base supporting the effectiveness of a number of simple primary care interventions for musculoskeletal problems (reviewed in Schillinger *et al.*, 2003). Direct access physiotherapy reduces wait times and costs for treatment and is one way to facilitate the use of exercise and self-management regimes. These have been demonstrated to be beneficial for patients with a variety of regional and widespread musculoskeletal conditions, including osteoarthritis, back pain, fibromyalgia and shoulder problems. Prescribed exercise need not be the province of the physiotherapist alone. Often, wait times to see a physiotherapist are excessively long, and many self-limiting musculoskeletal conditions can be managed with sensible exercise regimes undertaken outside the hospital setting. This has the advantage of promoting self-help and “demedicalizing” common musculoskeletal problems. arc publishes a wide range of patient information leaflets and booklets, which are useful adjuncts to advice and education provided by health-care professionals (Box 1.7).

Local steroid injections are effective for reducing pain from soft-tissue problems such as tennis elbow and shoulder problems in the short term but do not improve long-term outcome. They should be reserved for patients in whom pain is restricting rehabilitation

Box 1.6 Psychosocial factors that predict chronicity

- Belief that pain is due to progressive pathology
- Belief that pain represents harm or injury
- Belief that avoiding activity will speed up recovery
- Tendency to social isolation
- Tendency to anxiety/depression
- Expectation that passive treatments rather than self-help programmes will be of benefit

Box 1.7 arc publications

Arthritis Research Campaign (arc) leaflets, booklets and other publications are available from:

Dept RD
arc Trading Ltd
Brunel Drive
Northern Road Industrial Estate
Newark
Notts. NG24 2DE
www.arc.org.uk

Box 1.8 Contraindications to local steroid injections

Absolute

- Suspected septic arthritis
- Local skin disorders or sepsis
- Active systemic infection
- Prosthetic joint

Relative

- Poorly controlled diabetes mellitus
- Osteoporosis

with the measures discussed above. Although the risks from local steroid injections are minimal, certain precautions need to be adhered to (Box 1.8).

Non-steroidal anti-inflammatory drugs may be beneficial for the short-term treatment of osteoarthritis but have a worrying side-effect profile in the patient group most likely to be prescribed them (elderly females). Simple analgesics are the preferred option where possible.

Global issues

The issues discussed in this chapter have global application, as the burden of illness from musculoskeletal conditions is high in both the developed world and developing countries alike, particularly with an ever-increasing elderly population worldwide. In developing countries, it is essential to involve local community leaders and community health workers in the management of patients with these conditions. Awareness of the importance of musculoskeletal conditions, in terms of morbidity but also mortality, needs to be raised among all health-care workers, governments and members of the public. With increasing travel and migration, knowledge of the global spectrum of musculoskeletal conditions is important. There also needs to be an increasing emphasis on prevention through encouraging healthy lifestyles and joint protection and by tackling modifiable risk factors such as falls prevention. Whether in primary or secondary care, or whether in a developing or developed country, what is key is not where musculoskeletal care takes place, but that it is appropriately given.

Conclusion

Over the last 10 years there has been a shift in thinking about how best to care for patients with rheumatological disorders (Box 1.9). For those with inflammatory arthritis the emphasis is on prompt referral to secondary care so that treatment with potentially disease-modifying agents can be instituted early, before irreversible joint damage has occurred. For patients with non-inflammatory

Box 1.9 Evidence-based summary

- Early aggressive treatment of rheumatoid arthritis with disease-modifying drugs improves clinical outcome and slows radiological progression (O'Dell, 2001)
- Psychosocial factors are the main predictors of chronic pain disability (Linton, 2000)
- Local steroid injections provide effective short-term relief for soft-tissue problems but do not improve long-term outcome (Smidt *et al.*, 2002)

conditions, such as osteoarthritis and regional or widespread musculoskeletal pain, optimal management depends on developing an efficient triage system that can identify those with “red flags” who will benefit from referral to secondary care for further investigation and management. The first-line management for the remainder should be by health-care professionals in primary care, using the strategies outlined above.

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Further reading

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