Development of future practice – multidisciplinary

HP0036 MULTIDISCIPLINARY CARE IN OUTPATIENT CLINICS: THE CLINICAL NURSE SPECIALIST'S INPUT

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Rationale In The Netherlands multidisciplinary care for inpatients with rheumatic diseases is quite common. It is generally recognised that this kind of care is necessary to fulfil the treatment goals. Within the University Medical Centre Nijmegen the multidisciplinary meetings are not only scheduled for inpatients, but also for outpatients. This way the continuity of treatment and care will be positively influenced.

Objective In order to propagate and let more patients benefit from this kind of care, we will describe the role and input of the nurse practitioner in the multidisciplinary team.

Patients and methods At our outpatient clinic the multidisciplinary meetings are scheduled once a month. The team consists of rheumatologists, social workers, occupational therapists, and the clinical nurse specialists. All team members have the possibility to add their case (s) to the agenda for discussion. Generally these are patients with more complex problems, necessitating optimal co-ordination of treatment and care.

The discussion and decision making process take place on the 'base of equality'. In our team, each member's knowledge and experience are respected and applied. This equality of disciplines is required to guarantee optimal quality of the multidisciplinary care.

The role of the clinical nurse specialist consists of:

- representing the patients by clearly explaining their questions and problems
- input of her expert opinion to the multidisciplinary treatment approach
- advising the colleagues in the clinic as well as the primary health care
- making a working schedule and point out priorities, based on the planned treatment approach.

Conclusion The clinical nurse specialist is more and more an expert with a crucial role in patient care. Within the multidisciplinary team, an open relationship between physicians and health professionals is an important condition for good quality of the decision making process.

Patient centred health care

HP0037 ESTABLISHING A ONE-STOP DIRECT-ACCESS JOINT INJECTION CLINIC

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Background All intra-articular and soft tissue injections were previously carried out at the general rheumatology clinic however due to the increasing patient referrals we developed a direct access, one-stop intra-articular and soft tissue injection clinic.

Plan Training of the rheumatology nurse specialist (RNS) in intra-articular and soft tissue injection using corticosteroids took place prior to notifying general practitioners of the rapid access clinic. Local general practices were informed of the service and guidelines for referral were developed outlining the appropriate patients to refer.

Action Twelve months consecutive referrals were seen at a specialist joint injection clinic. 8 patients were appointed for each clinic, allowing adequate time for assessment, education and, if required, injection. Patients were sent the Arthritis and Rheumatism Council information leaflet on intra-articular injection with their appointment and are encouraged to ask questions regarding their treatment.

269 consecutive patients were seen, assessed and treated. All were sent a questionnaire 3 months after their appointment.

Referring general practitioners were also questioned to assess their impressions of the service.

Results Of the 269 questionnaires sent to patients, 189 (71%) were returned. 253 (94%) patients felt that they received sufficient information prior to their appointment. Response duration (as determined by patient) was as follows;

- three months: 61 patients (32.2%)
- 172 (91%) patients stated that they would be willing to receive a further injection if required and 185 (98%) patients rated the service overall as good or very good.

The survey of general practitioners, carried out six months after the clinic had commenced, returned 65 of 80 questionnaires (81%). 59 (90.8%) stated that they were aware of the clinic, 35 (53.8%) stated that they referred patients directly to the joint injection clinic, 21 (32.3%) had not required to refer patients and 9 (13.8%) continued to refer to the General Rheumatology clinic. 62 (95.4%) thought it was a valuable resource and were satisfied with the service provided.

Conclusions It can be concluded from the results of the patient questionnaire that overall the joint injection clinic is a well-accepted effective method of organising joint injections, both for patients and referring doctors. This has been achieved through no need for additional funds. Importantly, it reduces pressures on the standard rheumatology clinic and provides an additional educational role, which has proved a valuable resource to health care professionals. Maximum waiting time is two weeks from referral.

We are planning to introduce an electronic appointment system, whereby general practitioners can book patients appointments directly via the GPASS desktop system, with emailing of the referral letter to the clinic.

SP0145 DEVELOPMENT AND PRESENT STATE OF THE CZECH LEAGUE AGAINST RHEMATISM

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The Czech League against Rheumatism (CLAR) was founded in 1991 and accepted as a member of EULAR in 1999. Since 2000 CLAR participates in activities within the framework of Bone and Joint Decade 2000–2010 and of European Manifesto for People with Arthritis/Rheumatism for the third Millennium as well. The central CLAR branch is located in Prague and the second one was instituted recently in Moravia.

Some data characterising the development and activity of CLAR were followed up during last ten years. Thus an increasing number of members of CLAR were noted. This number doubled during the last year, i.e. to 203 persons. The number of issues of the CLAR Bulletin edited every three months increased in the same extent. The interest of patients to participate in rehabilitation and in yoga meditation expanded too/to about 40 patients every week/.

These encouraging facts should be considered as consequence of CLAR activities mentioned above and of enhanced public awareness of rheumatic conditions too.

The majority of CLAR actions are organised with the help of the Institute of Rheumatology in Prague and with the support of pharmaceutical industry.

Improving the health professional/patient relationship

SP0174 PATIENTS' INFLUENCE ON HEALTH CARE, AND SOCIAL CARE

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A short presentation of how a Rheumatism NGO can work on a local level together with the County Council, the Health Care Employment Service Agency and the Social Insurance Office. Together with the health professionals we have produced education material, which is possible to use for health professionals, patients, the Employment Service Agency, the Social Insurance Office and the County Council. This material is called "For whom (it may concern)". The book has 12 chapters which contains these subjects: Humanity, quality of life, for whom, whose goals, meeting people, to take responsibility – right to self-determination, to make demands, who has the authority, rehabilitation economy, following up and evaluation, conventions, laws and regulations. The material contains four parts in each chapter, the first part is sayings, the second part is a factual part, the third part is a case example, the fourth part is a number of questions which are solutions orientated. Everyone can use this material, alone or in groups.

We are functioning, as patient experts on matters like, rehabilitation, education and how to approach the patient. My experience is from a region in the middle of Sweden called Jamtland. Jamtland has a big area on 49 500 km² with a population of 129 000 people, which means 2,6 persons per square kilometre.

Patient priorities in medical and social research

HP0038 PREFERENCES FOR IMPROVEMENT IN HEALTH: A COMPARISON BETWEEN AGE, SEX AND EDUCATION-MATCHED PATIENTS WITH OSTEOARTHRITIS (OA) AND RHEUMATOID ARTHRITIS (RA)

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Background Awareness of patients' preferences are of salient importance for health professionals in today's health care system. Preferences both on an individual and on a group level form the premises for the provision of an effective and efficient health care service.

Objective The aim of this study was to examine in which areas of health a group of patients with OA would most like to see improvement, and to compare their preferences with the preferences reported by matched RA patients.

Materials and methods Fifty-one patients (mean (SD) age 66 (4) years, 4 (8%) males, mean (SD) years of education 12 (3)) with generalised OA including hand OA, previously referred to a rheumatology outpatient department, underwent a comprehensive clinical examination including completion of several self-reported health status questionnaires. Among these were AIMS2, MHAQ, SF36 and joint pain VAS and fatigue VAS. These OA patients were compared with 51 RA patients matched for age, gender and level of education who were recruited from the Oslo RA register and had previously responded to identical questionnaires. All patients were asked to check three out of twelve health areas in which they would most like to see improvement (AIMS2, question 60). Scores of health status were computed from the different scales of health status questionnaires. Comparisons between the two matched patients groups were performed by McNemar tests (categorical variables) and paired analyses (continuous variables).

Results Out of the OA patients 82.4% reported priority for improvement in pain, compared to 58.8% of the RA patients ($p = 0.02$, McNemar test). Other health areas had lower priorities in both groups without any significant group difference and were distributed as follows among the OA/RA patients: Mobility level 5.9/17.6%, walking and bending 31.4/25.5%, hand and finger function 45.1/52.9%, arm function 9.8/23.5%, self-care 11.8/21.6%, household tasks 39.2/31.4%, social activity 2.0/11.8%, support from family 3.9/3.9%, work level 3.9/5.9%, tension 11.8/7.8%, mood 25.5/17.6%. Across different instruments OA patients also reported numerically more severe pain and mental health scores than RA patients whereas RA patients had significantly worse scores within the dimension of physical disability.

Conclusion Although being a preliminary study with only 51 patients in each group, these findings indicate that pain is the area where both OA and RA patients would most like to see improvement, and that patients with OA have pain as an even higher preference for improvement than patients with RA. Consequently, pain is the area of health that deserves increased attention in clinical practice, both for patients with OA and RA.