Background: Advanced practice refers to a registered nurse, educated to master’s degree level, with the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice beyond that of the first level nurse. Advanced practice characteristics are shaped by the specialty, local context and/or country of practice. Countries, as well as specialty areas are at different stages in the development of legislation, scope of practice, roles, responsibilities, education and clinical preparation. Rheumatology nursing development continues apace internationally.

Objectives: To bring rheumatology advanced nurse practitioners (ANPs) to the forefront in the delivery of quality patient-centered care, working to enhance patient outcomes and reduce the personal and societal burden of rheumatic musculoskeletal diseases.

Methods: The Irish Rheumatology Nursing Forum proposed a business case for the development of advanced nurse practitioner posts to implement, as a standardised approach to care nationally, the therapeutic strategy of treat to target for patients with inflammatory arthritis. This was endorsed by the Irish Society for Rheumatology and approved by the Rheumatology National Clinical Programme in 2015. Subsequently this proposal was chosen by the Chief Nursing Office as a demonstrator project for the Department of Health (DOH) draft policy to raise the critical mass of ANPs in healthcare delivery.

Results: In late 2017, the DOH allocated 22 new ANP posts to rheumatology services countrywide, aligned to the national integrated care programme for the prevention and management of chronic disease. These 22 candidate ANPs are now completing advanced practice education at MSc level run by a consortium of Irish universities (University College Dublin, Cork, Galway, and Trinity College Dublin). Supervision of the requisite 500 clinical hours at advanced practice level is being provided by local consultant rheumatologist in partnership with the universities. Local teams of key service, nursing, medical, and academic personnel have been established across all centres to oversee project development; implementation; utilisation of robust evaluation criteria to capture clinical impact and cost-effectiveness. Initial evaluation will focus on key performance indicators related to patient and staff satisfaction as i) rate of non-attended appointments, ii) return attendance ratio, iii) percentage of referrals seen within three months, iv) percentage of non-attended appointments. Intermediate-long-term evaluation will encompasses patient care and health care outcome through evaluation of all nursing interventions such as health assessments; medication prescribing and optimisation; patient education; health promotion; comorbidity screening; referral to other professionals; ordering of investigations; patient and staff satisfaction surveys. Quality of care will be evaluated guided by published quality care indicators. Patient outcome will be evaluated using appropriate nursing sensitive and validated disease activity scores and patient reported outcome measures. Real-time data collection using a specifically commissioned epr will ensure cANPs are supported by the appropriate technology to treat to target.

Conclusions: ANP-led care underpinned by evidenced practice based and guidelines, continues to grow as a model of care delivery in rheumatology.

Disclosure of Interest: None declared


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HPR Professional education, training and competencies

THE CONCEPT OF PATIENT CENTERED CARE IN SPONDYLOARTHRITIS BASED ON A MULTIDISCIPLINARY MODEL

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Background: Spondylarthritides (SpA) is one of the most prevalent musculoskeletal disease in the Americas, with an estimated prevalence of 0.5%. This group of patients present a number of unmet needs for accessibility to the consultation, diagnosis and adequate treatments. That for this reason it is necessary to develop a program of Centers of Excellence (CoE), which allows answer to these needs and at the same time to add values for our health systems.

Objectives: The aim was to create a program with pilot SpA centers initially in some countries that operate under the scheme of CoE, as they are already delineated in projects like REAL-PANLAR for rheumatoid arthritis. In a second phase and under the auspices of PANLAR (Panamerican League of associations for rheumatology) create a Pan American Network of Centers of Excellence in SpA (CESPA).

Methods: We performed a systematic review of the literature in global and regional databases (PubMed, Medline, Scopus, Lilacs), in order to search information on this research question-hypothesis. Subsequently and under a Delphi-modified methodology and consensus of involved rheumatologists lay the conceptual bases on this particular subject – the Centers of Excellence in SpA (CESPA). As a result of the above was defined as should be a CESPA.

Results: In accordance with the principles of creation and operation of the CoE in particular, specific themes were developed by a coordinator who, after a review of the literature, presented a specific proposal on every particular topic that was discussed and then voted on and implemented within the CESPA concepts. A CoE-SPA must have: 1. Screening Clinic and Early Diagnosis of SpA: the purpose is to rule out false positives of disease and to diagnose early SpA; 2. Model of patient-centered care: a model of frequencies of care should be implemented for SpA patients from the perspective of the different specialties involved in the multidisciplinary team; 3. Laboratories and images: conventional laboratory tests as having a minimum of 3–4 times a year and each patient will have conventional X-ray images of cervical and lumbosacral column at the beginning and then once a year; Ultrasound of entheses: upon admission to the program and then with a certain periodicity (annual) or depending of sensitivity to change (OMERACT). The same applies to subject of MRI of sacroiliac joints and column for both diagnosis and follow-up; 4. Clinical guideline on SpA should be adapted and customized to the particular realities of some of our countries; 5. There must be a management (disease management) program that must include Structure, Process and Result Indicators to define CESPA as Standard, Optimal and Model; 6. There must be standardized education and research programs for patients and physicians at the center.

Conclusions: There is a global need to develop CESPAs, in order to define treatment targets type T2T-SPA, which would improve clinical outcomes and avoid so much disability and health economic costs.

REFERENCES: