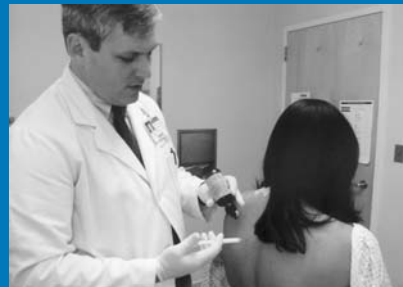


TEXAS TASK FORCE ON  
**ARTHRITIS**



**2003  
ACTION  
PLAN**



**ProtectTexas™**  
Texas Department of Health

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## Foreword

We all know someone with arthritis. In fact, arthritis is such a common condition that many people take it for granted. "It's just part of getting older." "Something that happens to everyone eventually." "Can't do much about it." Not only are these statements wrong, but they also tend to diminish the true impact that arthritis and chronic musculoskeletal conditions have on individuals, the public health, and our economy.

Arthritis affects a large and increasing part of the population. The Centers for Disease Control and Prevention estimates that one-third of all Americans, including 4.6 million Texans, have symptoms of arthritis. It is the leading cause of disability in this country, and results in nearly \$51 billion in medical costs per year. This does not include the lost wages, time off to visit doctors, and other indirect costs of illness.

Arthritis affects every part of the population, from babies and children to the elderly. Medical professionals list over one hundred different conditions that can be related to arthritis or other musculoskeletal disorders. The most common is osteoarthritis, also known as degenerative joint disease. Over 10 percent of the population has this problem, primarily people over the age of 50. In the next 25 years, our aging Baby Boomers will double the population with osteoarthritis. This is projected to lead to over 200,000 hip replacement surgeries and over 450,000 knee replacements per year. This results in costs of almost \$10 billion per year, as well as significant non-medical costs. However, this disease is not inevitable. While all the factors are not yet known, it is clear that maintaining an appropriate weight, exercising safely and often, and avoiding joint injuries at work and at play can prevent a large fraction of future osteoarthritis. These are behaviors and activities that must be started at an early age and maintained throughout life to prevent later disease.

Other types of arthritis affect other age groups. For

example, rheumatoid arthritis is an autoimmune disease that can rapidly lead to joint destruction and permanent disability. It affects about 1 percent of the population. Its symptoms usually start during young adulthood, causing maximal disruption of education, employment, parenting and family life. Fortunately, there are several new drugs to treat this form of arthritis. These drugs must be used early to prevent crippling joint destruction, can have serious side effects, and cost between \$2,000 and \$20,000 per year. Therefore, early and accurate diagnosis, and proper selection of therapy is essential for these patients.

Fibromyalgia and other chronic pain conditions affect about 2% of the population, mainly women. These conditions are poorly understood by patients and their families, physicians, employers, and insurance providers. While joint destruction is not seen in these conditions, they result in decreased quality of life, reduced workplace productivity, and increased use of medical resources.

Addressing the needs of Texans with arthritis represents a significant challenge. Primary and secondary prevention strategies need to be developed that will significantly reduce the impact of osteoarthritis. Conditions such as rheumatoid arthritis, juvenile arthritis and systemic lupus erythematosus need to be recognized early so that patients can get the proper joint- and life-saving care. Scientifically valid strategies for treating patients with all forms of arthritis need to be available throughout the state, and benchmarks for their implementation identified and used. Healthcare providers need to learn the best ways to care for patients with arthritis and more arthritis specialists should be trained and employed in Texas. All of this needs to be done in ways that serve the diverse population of Texas from large cities and rural towns; from the Rio Grande Valley to the Panhandle.

## Introduction

In 1998, the Centers for Disease Control and Prevention, in association with the National Institutes of Health and the Arthritis Foundation, released the *National Arthritis Action Plan*. This was a comprehensive “blueprint” that defined the broad steps that we as a nation must take to reduce the public health impact of arthritis. Part of that plan was to provide funding for states to develop and begin to implement their own arthritis action plans. The Texas Task Force on Arthritis convened in December 2002 to draft this Texas Arthritis Action Plan. It tells us where we are with the information available about arthritis in Texas. It suggests information we need to have, partnerships that need to be formed, and both short- and long-term strategies to lessen the burden of arthritis in Texas and improve the quality of life for all Texans with these diseases. This plan is just the first step, however. I urge all concerned Texans – patients, healthcare professionals, employers, advocacy groups, insurers, state and local governments, and elected officials – to understand the seriousness of arthritis in our state and work for improved health for all.

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David R. Karp, M.D., Ph.D.  
Chief, Rheumatic Diseases Division  
The University of Texas  
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Dallas, Texas  
2003

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Photo Credit: Arthritis Foundation

Texas is a diverse and growing population. In 2000 the total population for Texas was 20,851,820. The projected population for 2010 is 24,178,507. The senior population aged 65 and older is currently 9.9 percent of the Texas population. According to Texas Department on Aging projections, the proportion of the Texas population aged 65 and older is projected to increase from 10.4 percent in 2010 to 18 percent in 2040. Chronic diseases, which affect older adults disproportionately, contribute to disability, diminished quality of life, and increased health and long-term care costs. Public health programs are called upon to respond now by including health promotion for older adults, prevention of disability, maintenance of capacity of those with frailties and disabilities, and enhancement of quality of life. Public health should support healthy behaviors throughout a person’s lifetime.

According to 2001 Behavioral Risk Factor Surveillance System data, 30 percent of Texans aged 18 and older reported arthritis/chronic joint symptoms, compared to the national average of 33 percent. The percent of Texans aged 18 and older with chronic joint symptoms having never been seen by a health-care provider was 28.2 percent. The projected number of Texans aged 65 and older with arthritis or chronic joint symptoms in the year 2025 is 57.9 percent. Clearly this presents a problem for the public health, medical and economic systems. Arthritis contributes substantially to disability, poor health-related quality of life, and increased direct and indirect medical costs. Decreasing this impact will require effective public health interventions that improve function, decrease pain and delay disability among persons with arthritis.

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# I. The Impact of Arthritis: National and State Data

# The Impact of Arthritis: National and State Data

## Arthritis in the U.S.

According to the Centers for Disease Control and Prevention, arthritis and chronic joint symptoms affect about 70 million (33%) of Americans, or about one of every three adults, making it one of the most prevalent diseases in the United States.<sup>1,2</sup>

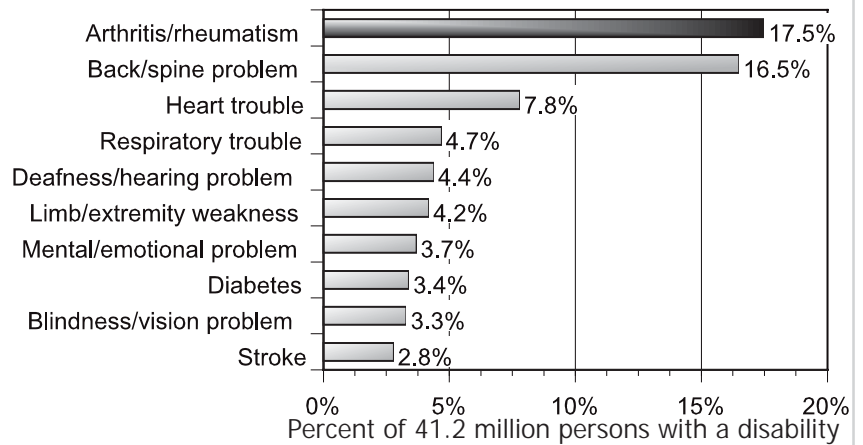
Arthritis is the nation's leading cause of disability among individuals ages 18 years and older. Direct costs for arthritis are estimated at \$51 billion, with indirect costs (lost earnings) reaching \$65 billion for total costs of \$116 billion. Texas' share of these costs amounts to about \$7 billion (\$3 billion in direct costs and \$4 billion in indirect costs).<sup>3</sup>

## Arthritis in Texas

### Background - BRFSS

Texas Behavioral Risk Factor Surveillance System (BRFSS) prevalence data are used to estimate how many persons in the state of Texas currently have arthritis, or arthritic symptoms. The Texas BRFSS completes about 500 surveys of randomly selected adult Texans (aged 18 and older) each month to collect data on lifestyle risk factors contributing to the leading causes of death and chronic diseases. Because the BRFSS is used nationwide, comparisons can be made to other states and the national average. The BRFSS provides a mechanism that states can use to collect data on health issues of special interest to their population. BRFSS data can also be analyzed with other demographics and risk factors that are related.

Leading Causes of Disability Among U.S. Adults, 1999



### BRFSS questions related to arthritis:

1. During the past 12 months, have you had pain, aching, stiffness or swelling in or around a joint?
2. Were these symptoms present on most days for at least one month (of those who had joint pain)?
3. Are you now limited in any way in any activities because of joint symptoms?
4. Have you ever seen a doctor, nurse, or other health professional for these joint symptoms?
5. Have you ever been told by a doctor that you have arthritis?
6. Are you currently being treated by a doctor for arthritis?

Two different definitions of arthritis are derived from the questions above. One is if arthritis has been diagnosed by a doctor, and the other is if the participant has joint symptoms. For the statistics that follow, arthritis is defined as either chronic joint symptoms and/or doctor-diagnosed arthritis.

According to 2001 BRFSS data:<sup>4</sup>

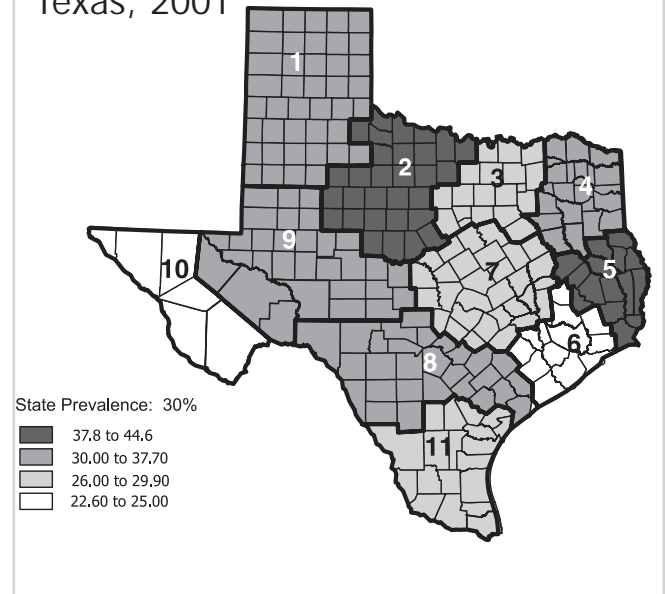
- An estimated 4.6 million (30%) Texans aged 18 and older self-reported doctor diagnosed arthritis and/or chronic joint symptoms during 2001.
- Forty-three percent of all respondents with chronic joint symptoms reported limitations in activities because of their joint symptoms.
- Prevalence of arthritis increased with increasing age of respondents. Among respondents aged 65 and older, 58 percent had arthritis.
- The proportion of adults reporting arthritis was higher for women than for men. An estimated 34 percent of women surveyed reported arthritis compared to 25 percent of men.
- Risk for arthritis by race was highest among non-Hispanic whites. The prevalence rates for arthritis or chronic joint symptoms were significantly higher for non-Hispanic whites (34%) and for African-Americans (31%) than for Hispanics (21%).

Hospital Discharge Data

The Texas Health Care Information Council collects hospital discharge data representing about 95 percent of all hospitalizations in Texas. In 2001, arthritis was listed as a principal diagnosis for 52,801 discharges. While not the principal diagnosis, arthritis was a factor in 164,017 hospital discharges.<sup>5</sup>

Hospital discharges listing arthritis as a principal diagnosis accounted for about \$1.2 billion in total

Prevalence of Arthritis by Public Health Region Texas, 2001



charges with an average charge per day of \$4,175.81. Discharges where arthritis was a factor accounted for total charges of about \$3.1 billion in total charges and an average charge per day of \$2,723.53.<sup>5</sup>

It is important to note that arthritis is largely treated on an outpatient basis, so the impact on ambulatory medical care is much greater.

Data Needs

The data presented above is an initial attempt to provide a picture of the impact of arthritis in Texas. Data remain to be collected on the many conditions which the term “chronic joint symptoms” does not adequately describe.

Hospital discharge data represent only one of the costs of arthritis. Others include ambulatory medical care costs, indirect costs such as days of work missed due to arthritis, rehabilitation costs, and disability costs.

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## II. Addressing Arthritis: A Texas Action Plan

# Addressing Arthritis: A Texas Action Plan

## CDC Grant to Reduce the Burden of Arthritis in Texas

The need to address arthritis in Texas was identified by a steering committee formed in 1999 consisting of representatives from the Arthritis Foundation chapters in Texas; representation from a pharmaceutical company; a parent of a child with arthritis; a person with arthritis; community based organizations involved with serving the older population; and the Texas Department of Health (TDH). The committee reviewed potential resources and, in 2002, supported development of a successful application for a Centers for Disease Control and Prevention (CDC) grant to develop a state level program to control arthritis and other rheumatic conditions.

The three-year grant provided funds to:

- establish arthritis program staff,
- establish an advisory group,
- define, monitor and report the prevalence and impact of arthritis in Texas,
- develop a state plan, and
- implement one or more of the plan strategies that includes promotion of self-management programs for diverse populations and a health communications campaign.

## Advisory Group - Texas Task Force on Arthritis

The Texas Task Force on Arthritis was developed in September 2002. One hundred and fifty stakeholders were contacted to submit nominations for applicants who had expertise in key areas: (1) expertise in arthritis, (2) agencies with activities relevant to arthritis, re-

sources for arthritis activities and access to target populations, (3) persons with arthritis or family members of persons with arthritis and (4) other governmental agencies that are directly or indirectly involved in some aspect of arthritis control and prevention.

Applicants chosen to serve included professionals and lay persons with diverse backgrounds in regard to gender, expertise, race, and geographic location. The task force consists of representatives from:

- the three Arthritis Foundation chapters in Texas (the North Texas Chapter headquartered in Dallas, the Northwest Texas Chapter headquartered in Fort Worth, the South Texas Chapter headquartered in Houston);
- the Texas Department on Aging;
- persons with/or affected by arthritis;
- organizations that serve the older adult population; and
- research and medical professionals with expertise in arthritis.

From December 2002 to June 2003, the task force met three times, reviewing available state arthritis data sources and program resources to determine the extent to which arthritis could be prevented or treated in Texas. From this information, the framework for a statewide arthritis action plan was formed. Vision and mission statements were developed, as well as key strategies and action steps, thereby creating the first Texas Arthritis Action Plan.

## Texas Arthritis Action Plan

In November, 1998, the first national plan to address arthritis using a public health approach, the *National Arthritis Action Plan: A Public Health Strategy*, was released. This landmark plan, developed under the leadership of the Centers for Disease Control and Prevention (CDC), the Arthritis Foundation, and the Association of State and Territorial Health Officials, with input from more than 90 organizations, recommends action in three major areas for individuals and groups interested in reducing the impact of arthritis:

- surveillance, epidemiology, and prevention research;
- communication and education; and
- programs, policies, and systems

Healthy People 2010 (HP2010), the prevention agenda for the nation, focuses on 28 areas representing the most significant preventable threats to health in the United States. The HP2010 Objectives mark the first time that objectives for arthritis have been included in this planning document (See Appendices, pg. 35).

### Texas Task Force on Arthritis Vision:

**The general public, healthcare providers, and state policy makers recognize arthritis as a major public health problem and sufficient resources are available and accessible to reduce the significant physical, social, and financial impact of arthritis in Texas.**

In 2002, the Texas Task Force on Arthritis reviewed both the national plan and HP2010 Objectives in developing an arthritis action plan for Texas. Available epidemiological data and information on the status of arthritis in Texas was presented by the Texas Department of Health and Texas Arthritis Foundation chapters. Based on this information, the task force formulated actions steps for primary and secondary prevention of arthritis within the framework of the following four strategies:

- Surveillance, Data, and Outcome Management
- Health Education, Communication and Outreach
- Community Policy and Environmental Change
- Clinical Prevention and Treatment

The action steps that follow are a work in progress. The task force will continue to review and update the plan, while gathering feedback from Texans with arthritis, health care providers, and other organizations that impact arthritis prevention and treatment in Texas.

Action steps have been identified and arranged according to responses from task force members as to whether the action step is an immediate, short term or long term step. Groups identified to take a lead or be involved in each action step are listed.

### Mission:

**To improve the lives of Texans at risk for or with arthritis and other related conditions through education, advocacy, increased access to care, and promotion of research.**

# STRATEGY 1: Surveillance, Data and Outcome Management

STRATEGY 1: Action Steps	TIMELINE TO ACHIEVE ACTION STEPS			Recommended Organizations/ Groups Needed to Accomplish Action Step
	Immediate (now)	Short Term (1-2 years)	Long Term (3-5 years)	
<p><b>Risk Factor</b></p> <ul style="list-style-type: none"> <li>Support continued administration of the Behavioral Risk Factor Surveillance System and seek validation of information as it relates to arthritis and related risk behaviors.</li> <li>Support the administration of the Youth Risk Behavior Survey and review information pertinent to the prevention of arthritis.</li> </ul>				<ul style="list-style-type: none"> <li>Texas Department of Health (TDH), other state health departments, Centers for Disease Control and Prevention (CDC), Behavioral Risk Factor Surveillance System (BRFSS)</li> <li>TDH, CDC</li> </ul>
<p><b>Data on Arthritis</b></p> <ul style="list-style-type: none"> <li>Provide input on types of conditions related to arthritis that are monitored, review data on arthritis and related conditions, and define which forms of arthritis to address.</li> </ul>				<ul style="list-style-type: none"> <li>Arthritis Foundation (AF), American College of Rheumatology (ACR), community and academic rheumatologists, CDC, National Institutes of Health (NIH), National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS), other state arthritis plans, task force, focus groups</li> </ul>
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>Define "access to care," review existing data related to access to care and provide input on ways to improve access to care.</li> </ul>				<ul style="list-style-type: none"> <li>TDH, Texas Medical Foundation (TMF), United Way, Texas Medical Association (TMA), local health departments, Managed Care Organizations (MCO), physician professional organizations, insurance companies, 3<sup>rd</sup> party payers, task force, focus groups, other state arthritis plans, patient-oriented groups, AFs, Texas Hospital Association (THA), Texas Organization of Rural and Community Hospitals (TORCH)</li> </ul>

STRATEGY 1: Action Steps	TIMELINE TO ACHIEVE ACTION STEPS			Recommended Organizations/ Groups Needed to Accomplish Action Step
	Immediate (now)	Short Term (1-2 years)	LongTerm (3-5 years)	
<p><b>Financial Impact</b></p> <ul style="list-style-type: none"> <li>Determine the financial impact (both direct and indirect costs) of arthritis in Texas.</li> </ul>				<ul style="list-style-type: none"> <li>Texas Workers' Compensation Commission, business groups, health plans, Texas Health Care Information Council (THCIC), Social Security Administration (SSA), Employees Retirement System of Texas (ERS)</li> </ul>
<p><b>Gaps in Data</b></p> <ul style="list-style-type: none"> <li>Identify the gaps in information and promote studies in Texas to gather prevalence, disease and disability due to arthritis.</li> </ul>				<ul style="list-style-type: none"> <li>TDH, hospital organizations, MCOs, AF, local health departments, physicians, support groups (i.e., fibromyalgia)</li> </ul>

# STRATEGY 2: Health Education, Communication and Outreach

STRATEGY 2: Action Steps	TIMELINE TO ACHIEVE ACTION STEPS			Recommended Organizations/ Groups Needed to Accomplish Action Step
	Immediate (now)	Short Term (1-2 years)	LongTerm (3-5 years)	
<p><b>General Public</b></p> <ul style="list-style-type: none"> <li>Inform the general public (i.e. citizens, employers, governmental officials, insurance companies) about healthy lifestyles that can prevent and mitigate arthritis.</li> <li>Promote awareness of signs and symptoms of arthritis and visiting a physician for early detection and treatment.</li> <li>Promote resources available to address healthy lifestyles.</li> </ul>				<ul style="list-style-type: none"> <li>NIH, CDC, media outlets, Texas Department on Aging (TDOA) and Aging Network, Area Agencies on Aging, AFs</li> <li>AFs, large employers, insurance groups, Texas State Human Resources Association (TSHRA)</li> <li>AFs, large employers, insurance groups, state HR groups, TSHRA</li> </ul>
<p><b>Professional</b></p> <ul style="list-style-type: none"> <li>Educate primary care physicians about arthritis.</li> <li>Educate nurses and allied health professionals about arthritis.</li> <li>Educate other professions about arthritis.</li> </ul>				<ul style="list-style-type: none"> <li>AF, internal medicine &amp; pediatricians, TMF, TMA, academic medical centers, geriatric education centers</li> <li>school of nursing, Texas Nurses Association (TNA)</li> <li>non-medical professions (i.e. lawyers, social security, TSHRA, school principals), Texas Employment Commission (TEC), support groups</li> </ul>
<p><b>Patient</b></p> <ul style="list-style-type: none"> <li>Promote, make available and increase participation in recognized management, education and physical activity interventions.</li> <li>Implement the CDC's health communications campaign: Physical Activity. The Arthritis Pain Reliever.</li> </ul>				<ul style="list-style-type: none"> <li>AF, Lupus Foundation of America, patient support groups, CDC, NIH, NIAMS, media, TDH, physicians, physical therapists, occupational therapists</li> <li>CDC, TDH, AF, local health departments</li> </ul>

# STRATEGY 3: Community Policy and Environmental Change

STRATEGY 3: Action Steps	TIMELINE TO ACHIEVE ACTION STEPS			Recommended Organizations/ Groups Needed to Accomplish Action Step
	Immediate (now)	Short Term (1-2 years)	LongTerm (3-5 years)	
<p><b>Community Access</b></p> <ul style="list-style-type: none"> <li>■ Increase the number of locations for delivery of evidence-based arthritis programs.</li> </ul>				<ul style="list-style-type: none"> <li>■ AF, Young Men’s Christian Association (YMCA), Young Women’s Christian Association (YWCA), county parks and recreation departments, local arthritis agencies, community centers</li> </ul>
<p><b>Advocacy</b></p> <ul style="list-style-type: none"> <li>■ Generate advocacy on arthritis as a major public health problem and create changes in policies, legislation, and adequate funding.</li> </ul>				<ul style="list-style-type: none"> <li>■ TDH, TMA, AF, government agencies, community centers, churches, libraries, schools, media, rheumatologists, pharmacists, primary care physicians, orthopedic specialists, physical therapists, sponsors (i.e., pharmaceutical company), general advocacy organizations</li> </ul>
<p><b>Collaboration</b></p> <ul style="list-style-type: none"> <li>■ Increase collaboration around arthritis with appropriate partners whose constituents will also benefit from maintaining a healthy weight and adopt an appropriate physical activity agenda.</li> </ul>				<ul style="list-style-type: none"> <li>■ TMA, Texas Department on Aging (TDOA), task force, AF partners, American Heart Association, American Diabetes Association</li> </ul>

# STRATEGY 4: Clinical Prevention and Treatment

STRATEGY 4: Action Steps	TIMELINE TO ACHIEVE ACTION STEPS			Recommended Organizations/ Groups Needed to Accomplish Action Step
	Immediate (now)	Short Term (1-2 years)	LongTerm (3-5 years)	
<p><b>Professional Practice</b></p> <ul style="list-style-type: none"> <li>■ Evaluate clinical practice guidelines for managing arthritis, develop specific guidelines (as needed) and evaluate secondary prevention strategies.</li> <li>■ Promote use of the clinical practice guidelines and systematic changes for diagnosis, counseling, referral and treatment of arthritis.</li> </ul>				<ul style="list-style-type: none"> <li>■ ACR, primary care physicians, medical agencies, groups, and schools, universities, AF</li> <li>■ TMA, TMF, professional organizations for each profession, TNA, support groups</li> </ul>
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>■ Promote the increase of the number of rheumatologists and pediatric rheumatologists practicing in Texas.</li> <li>■ Improve access to arthritis treatment.</li> </ul>				<ul style="list-style-type: none"> <li>■ medical societies and schools, county hospital districts, TMA, AF, government (study on utilization)</li> <li>■ AF, TDH, big pharmaceutical companies, industrial and governmental agencies, TDH, arthritis advocates, physicians</li> </ul>



“Lots of people have minor aches and pains, and that fact probably hurts us getting others to understand what “serious” arthritis is like. Lupus kills people. Most rheumatoid arthritis patients will die before their natural life expectancy. But for most of us, it is just intensely painful and debilitating. And not just physically.”

*-Dallas business owner  
and civic leader with arthritis*

## III. Arthritis and Public Health

Many diseases cause pain in the joints and surrounding tissues as shown in the list below. Some are common, easily diagnosed and treated by primary care providers. Others are rare and involve care by specialist physicians such as rheumatologists and orthopedic surgeons.

Achilles tendinitis, Achondroplasia, Acromegalic arthropathy, Adhesive capsulitis, Adult onset Still's disease, Ankylosing spondylitis, Anserine bursitis, Avascular necrosis, Behcet's syndrome, Bicipital tendinitis, Blount's disease, Brucellar spondylitis, Bursitis, Calcaneal bursitis, Calcium pyrophosphate dihydrate (CPPD), crystal deposition disease, Caplan's syndrome, Carpal tunnel syndrome, Chondrocalcinosis, Chondromalacia patellae, Chronic synovitis, Chronic recurrent multifocal osteomyelitis, Churg-Strauss syndrome, Cogan's syndrome, Corticosteroid-induced osteoporosis, Costosternal syndrome, CREST syndrome, Cryoglobulinemia, Degenerative joint disease, Dermatomyositis, Diabetic finger sclerosis, Diffuse idiopathic skeletal hyperostosis (DISH), Discitis, **Discoid lupus erythematosus**, Drug-induced lupus, Duchenne's muscular dystrophy, Dupuytren's contracture, Ehlers-Danlos syndrome, Enteropathic arthritis, Epicondylitis, Erosive inflammatory osteoarthritis, Exercise-induced compartment syndrome, Fabry's disease, Familial Mediterranean fever, Farber's lipogranulomatosis, Felty's syndrome, **Fibromyalgia**, Fifth's disease, Flat feet, Foreign body synovitis, Freiberg's disease, Fungal arthritis, Gaucher's disease, Giant cell arteritis, Gonococcal arthritis, Goodpasture's syndrome, **Gout**, Granulomatous arteritis, Hemarthrosis, hemochromatosis, Henoch-Schonlein purpura, Hepatitis B surface antigen disease, Hip dysplasia, Hurler syndrome, Hypermobility syndrome, Hypersensitivity vasculitis, Hypertrophic osteoarthropathy, Immune complex disease, Impingement syndrome, Jaccoud's arthropathy, Juvenile ankylosing spondylitis, Juvenile dermatomyositis, **Juvenile rheumatoid arthritis**, Kawasaki disease, Kienbock's disease, Legg-Calve-Perthes disease, Lesch-Nyhan syndrome, Linear scleroderma, Lipoid dermatoarthritis, Lofgren's syndrome, **Lyme disease**, Malignant synovioma, Marfan's syndrome, Medial plica syndrome, Metastatic carcinomatous arthritis, Mixed connective tissue disease (MCTD), Mixed cryoglobulinemia, Mucopolysaccharidosis, Multicentric reticulohistiocytosis, Multiple epiphyseal dysplasia, Mycoplasmal arthritis, Myofascial pain syndrome, Neonatal lupus, Neuropathic arthropathy, Nodular panniculitis, Ochronosis, Olecranon bursitis, Osgood-Schlatter's disease, **Osteoarthritis**, Osteochondromatosis, Osteogenesis imperfecta, Osteomalacia, Osteomyelitis, Osteonecrosis, **Osteoporosis**, Overlap syndrome, Pachydermoperiostosis, Paget's disease of bone, Palindromic rheumatism, Patellofemoral pain syndrome, Pellegrini-Stieda syndrome, Pigmented villonodular synovitis, Piriformis syndrome, Plantar fasciitis, Polyarteritis nodosa, Polymyalgia rheumatica, Polymyositis, Popliteal cysts, Posterior tibial tendinitis, Pott's disease, Prepatellar bursitis, Prosthetic joint infection, Pseudoxanthoma elasticum, Psoriatic arthritis, Raynaud's phenomenon, Reactive arthritis/Reiter's syndrome, Reflex sympathetic dystrophy syndrome, Relapsing polychondritis, Retrocalcaneal bursitis, Rheumatic fever, **Rheumatoid arthritis**, Rheumatoid vasculitis, Rotator cuff tendinitis, Sacroiliitis, Salmonella osteomyelitis, Sarcoidosis, Saturnine gout, Scheuermann's osteochondritis, Scleroderma, Septic arthritis, Seronegative arthritis, Shigella arthritis, Shoulder-hand syndrome, Sick cell arthropathy, Sjogren's syndrome, Slipped capital femoral epiphysis, Spinal stenosis, Spondylolysis, Staphylococcus arthritis, Stickler syndrome, Subacute cutaneous lupus, Sweet's syndrome, Sydenham's chorea, Syphilitic arthritis, **Systemic lupus erythematosus (SLE)**, Takayasu's arteritis, Tarsal tunnel syndrome, Tennis elbow, Tietze's syndrome, Transient osteoporosis, Traumatic arthritis, Trochanteric bursitis, Tuberculosis arthritis, **Arthritis of ulcerative colitis**, Undifferentiated connective tissue syndrome (UCTS), Urticarial vasculitis, Viral arthritis, Wegener's granulomatosis, Whipple's disease, Wilson's disease, Yersinia arthritis.

# Arthritis and Public Health

## Forms of Arthritis



Arthritis comprises over 100 different diseases and conditions that affect joints and surrounding tissue. The most common are **osteoarthritis**, **rheumatoid arthritis**, and **fibromyalgia**. Common symptoms include pain, aching, stiffness, and swelling in or around the joints.

While the onset of osteoarthritis symptoms result from the breakdown of cartilage in the joint, other forms of arthritis such as rheumatoid arthritis and **lupus** are autoimmune disorders that can affect multiple organs and cause widespread symptoms. When one looks at a list of some of the conditions known as arthritis, it becomes clear that the general definition of “joint disease” falls short in painting a clear picture of arthritis. Although the exact causes of most forms of arthritis are unknown, researchers continue to focus on the genetic, environmental and lifestyle factors that may affect how arthritis begins and the symptoms that arise.

### Definitions of common forms of arthritis

**Osteoarthritis**, also known as “degenerative joint disease,” is the nation’s number one crippling disease, affecting an estimated 20.7 million Americans. Osteoarthritis most often affects the hip, knee, foot, and hand - but can affect other joints as well. Degeneration of joint cartilage and changes in underlying bone and supporting tissues lead to pain, stiffness, movement problems, and activity limitations.<sup>6,7</sup>

**Rheumatoid Arthritis** afflicts approximately 2.1 million Americans and is characterized by chronic inflammation of the joint lining. Symptoms include pain, stiffness, and swelling of multiple joints. The inflammation may extend to other joint tissues and cause bone and cartilage erosion, joint deformities, movement problems, and activity limitations. Rheumatoid arthritis (RA) can also affect connective tissue and blood vessels throughout the body, triggering inflammation in a variety of organs, including the lungs and heart. In severe cases, RA can lead to death from respiratory and infectious diseases.<sup>6,7</sup>

**Fibromyalgia** literally means “pain in the muscles, ligaments and tendons.” Fibromyalgia pain syndrome involves muscle and muscle attachment areas. Common symptoms include widespread pain throughout the muscles of the body, sleep disorders, fatigue, headaches, and irritable bowel syndrome. This disease affects about 2 percent of Americans.<sup>6,7</sup>

**Juvenile Arthritis** affects about 285,000 children in the United States. About 10 percent of these children have systemic onset type which begins with very high fevers, skin rash, and inflammation in many internal organ systems as well as the joints. Pauciarticular onset disease affects fewer than five joints and affects about half of all children with arthritis. Some who develop this type from infancy to age 5 risk developing inflammatory eye problems. Older children may develop one of the adult forms of arthritis. Polyarticular disease affects more than five joints and can begin at any age. Some of these children have adult type rheumatoid arthritis that begins at an earlier age than usual.<sup>8</sup>

# Arthritis and Public Health

*Systemic lupus erythematosus (Lupus, SLE):* Lupus and other related autoimmune disorders are rare conditions affecting less than 0.1% of the population overall. However, they can have life-threatening consequences if undiagnosed and untreated. Lupus affects women 10 times more commonly than men, and African American and Hispanic women most of all. Joint pain is only one feature of lupus, but can cause confusion with rheumatoid arthritis or fibromyalgia. These conditions are frequently difficult to diagnose and are usually treated by specialists.

Definitions for many arthritis conditions can be found on the Arthritis Foundation web site:

[www.arthritis.org](http://www.arthritis.org)

“Your range of motion is limited and you hurt all the time, but you try to not let anyone know.”

-attorney with arthritis

## Risk Factors Contributing to Arthritis



**Four risk factors for arthritis are nonmodifiable: age, sex, genetic predisposition and ethnicity.<sup>6,9</sup>**

### Age

Half of the elderly population is affected by arthritis and risk increases with age.

### Gender

Women are at higher risk of many forms of arthritis than men:

- Osteoarthritis affects 21 million Americans, including 16 million women.
- Rheumatoid arthritis, lupus and fibromyalgia are conditions that occur much more often in women than in men, although men have a higher risk of osteoarthritis after age 55 than women.
- Researchers believe that female hormones may play some role in arthritis because women are affected so much more frequently than men. Hormones also appear to affect arthritis symptoms in certain cases. For instance, women frequently experience remission of RA symptoms during pregnancy, and lupus sometimes flares during pregnancy.

## Genetic predisposition

Scientists have uncovered clear evidence that genetic factors are associated with an increased risk of developing many types of arthritis, including rheumatoid arthritis, osteoarthritis, juvenile arthritis, systemic lupus erythematosus and ankylosing spondylitis. More research is needed to learn more about the specific genes associated with arthritis.

## Ethnicity

- Lupus occurs three to four times more often in African Americans than in Caucasians.
- One genetic marker for rheumatoid arthritis is found in 25 percent of Caucasians but in only 10 percent of African Americans. This may suggest that there is actually more than one disease with similar features.
- Native American groups are at higher risk for other conditions: A study found that Choctaws in Oklahoma had an incidence of scleroderma that was 20 times higher than that of the general population.
- Eskimos and Native Americans have been found to carry the genetic marker for ankylosing spondylitis twice as often as Caucasians, and their incidence of the disease is higher as well.

**There are also several clearly *modifiable* risk factors associated with increased risk of arthritis: weight, injury, infections and certain occupations<sup>6,9</sup>**

## Weight

People who are more than 10 pounds overweight have a higher risk of osteoarthritis, especially in weight-bearing joints like the knees.

## Injury

A past severe injury which damages cartilage and creates conditions favorable to its breakdown, adds to osteoarthritis risk.

## Infections

Certain gastrointestinal or genitourinary infections can lead to arthritis. Such arthritis can persist for months or even years after the initial infection is cured. Lyme disease, a bacterial infection transmitted by certain ticks, can also result in arthritis.

## Certain occupations

Jobs requiring heavy physical labor, particularly those with repetitive stooping, crawling, or carrying heavy loads can increase the risk of osteoarthritis.

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“The days I couldn’t lift my baby out of the crib because my wrists were too weak and hurt too much always made me cry.”

---

-young mother with arthritis

# Arthritis and Public Health

## Multiple Approaches to Varying Levels of Pain and Disability



*Adapted from the National Institute of Arthritis and Musculoskeletal and Skin Diseases.<sup>10</sup>*

The treatment of musculoskeletal pain is a complex problem, made critical by the large numbers of individuals seeking pain relief from a variety of medical and non-medical practitioners. It can be as simple as the modification of activities and the use of adaptive devices, or it can involve complex pain management protocols with physical therapy, behavioral therapy, and psychological counseling. Medications must be viewed as part of the management of chronic pain, not the mainstay, and the therapy should be tailored to the type of arthritis or musculoskeletal pain being treated. “One-size-fits-all” approaches should be avoided.

The pain of arthritis may come from different sources. These may include inflammation of the synovial membrane (tissue that lines the joints), the tendons, or the ligaments; muscle strain; and fatigue. A combination of these factors contributes to the intensity of the pain. Persons with autoimmune forms of arthritis such as lupus often suffer from pain and conditions associated with other body systems and organs (e.g., gastrointestinal, skin, kidneys, cardiovascular) that play a factor in pain management.

The pain of arthritis varies greatly from person to person, for reasons that doctors do not yet understand completely. Factors that contribute to the pain include swelling within the joint, the amount of heat or redness

present, or damage that has occurred within the joint. In addition, activities affect pain differently so that some patients note pain in their joints after first getting out of bed in the morning, whereas others develop pain after prolonged use of the joint. Each individual has a different threshold and tolerance for pain, often affected by both physical and emotional factors. These can include depression, anxiety, and even hypersensitivity at the affected sites due to inflammation and tissue injury. This increased sensitivity appears to affect the amount of pain perceived by the individual. Social support networks can make an important contribution to pain management.

## How Is Arthritis Treated?

There is no single treatment that applies to everyone with arthritis, but rather the doctor will develop a long-term management plan designed to minimize specific pain and improve the function of the joints. Many times, pain can get suddenly worse (“flare”) requiring short-term treatments such as:

**Heat and cold:** The decision to use either heat or cold treatment for arthritis pain depends on the type of arthritis and should be discussed with a doctor or physical therapist. Moist heat, such as a warm bath or shower, or dry heat, such as a heating pad, placed on the painful area of the joint for about 15 minutes may relieve the pain. An ice pack (or a bag of frozen vegetables) wrapped in a towel and placed on the sore area for about 15 minutes may help to reduce swelling and stop the pain. Persons with poor circulation should not use cold packs.

**Joint protection:** Using a splint or a brace to allow joints to rest and protect them from injury can be helpful. A physician or physical therapist can make recommendations.

**Transcutaneous electrical nerve stimulation (TENS):** A small TENS device that directs mild electric pulses to nerve endings that lie beneath the skin in the painful area may relieve some arthritis pain. TENS seems to work by blocking pain messages to the brain and by modifying pain perception.

**Massage:** In this pain-relief approach, a massage therapist will lightly stroke and/or knead the painful muscle. This may increase blood flow and bring warmth to a stressed area. However, arthritis-stressed joints are very sensitive, so the therapist must be familiar with the problems of the disease.

The individualized approach to the treatment of patients with chronic arthritis should include both non-pharmacologic and pharmacologic therapies. Long-term goals should be set by the patient and a multi-disciplinary team of physicians, physical therapists, and occupational therapists.

“What hurts most of all is that the family quits calling to ask you do things because they know you won’t be able to do the walking involved.”

*-grandparent with arthritis*

## Non-Pharmacologic Therapies

**Weight reduction:** Excess pounds put extra stress on weight-bearing joints such as the knees or hips. Studies have shown that overweight women who lost an average of 11 pounds substantially reduced the development of osteoarthritis in their knees by 50%. In addition, if osteoarthritis has already affected one knee, weight reduction will reduce the chance of it occurring in the other knee.

**Physical activity:** Swimming, walking, low-impact aquatic exercise, and range-of-motion exercises may reduce joint pain and stiffness. In addition, stretching exercises are helpful. A physical therapist can help plan an exercise program that will provide the most benefit.

**Assistive devices:** Canes or walkers can provide balance and safety, as well as take stress off painful joints. Splints can be worn on the fingers or the hands to protect inflamed tissues. Other items used on a daily basis, such as key rings, pens and door knobs, have been modified to provide greater ease of use for persons with arthritis.

**Surgery:** In select patients with arthritis, surgery may be necessary. The surgeon may perform an operation to remove the synovium (synovectomy), realign the joint (osteotomy), or in advanced cases replace the damaged joint with an artificial one (arthroplasty). Total joint replacement has provided not only dramatic relief from pain but also improvement in motion for many people with arthritis.

# Arthritis and Public Health

## Pharmacologic Therapies

The types of drugs used to treat arthritis depend on the specific condition. Some drugs are familiar because they are commonly used to treat other kinds of pain. Many of them are available over the counter at reduced dosages. However, long-term use of any drug should be discussed with a physician to avoid side effects. This list is not all-inclusive and is meant for information only. Any chronic use of medication, prescription or over the counter, should be discussed with a health care provider.

**Acetaminophen:** This non-aspirin pain reliever is safe for most people who limit their alcohol use, including the elderly. It is often the first drug tried for patients with osteoarthritis but must be taken three or four times a day. It may not work for everyone and the maximum dose should not be exceeded due to the possibility of liver toxicity.

**Nonsteroidal anti-inflammatory drugs (NSAIDs):** These are a class of drugs including ibuprofen, naproxyn, indomethacin, and many others. Some of them are available as generic drugs at lower cost. These drugs relieve pain and inflammation in some people. One major concern with these drugs is the risk of ulcers when taking them. Newer drugs (rofecoxib, celecoxib and others) have been developed to lessen the risk of gastrointestinal side effects. Other problems include a risk of kidney disease and worsening hypertension. It should be remembered that aspirin is an NSAID and should not be combined with similar drugs without consulting a physician. Unlike patients with osteoarthritis, patients

with rheumatoid arthritis are generally treated with other drugs to reduce or prevent joint destruction (see DMARDs below).

**Corticosteroids:** These are hormones that are very effective in treating inflammation but can cause many side effects. Corticosteroids can be taken by mouth or given by injection. Prednisone is the corticosteroid most often given by mouth to reduce the inflammation of rheumatoid arthritis or systemic lupus erythematosus.

For rheumatoid arthritis, the doctor may inject a corticosteroid into the affected joint to stop pain. Oral corticosteroids are not used to treat osteoarthritis. Because frequent injections may cause damage to the cartilage, they should be done only once or twice a year.



Photo Credit: Hank Vehige

**Disease-modifying antirheumatic drugs (DMARDs):** These

are the major class of drugs used to treat people with rheumatoid arthritis. The most commonly used DMARD is methotrexate. Others include hydroxychloroquine, sulfasalazine, and leflunomide. These drugs are thought to influence the abnormalities of the immune system responsible for a disease like rheumatoid arthritis. Treatment with these medications requires careful monitoring by the physician to avoid side effects.

**Biological response modifiers:** These are the newest drugs for the treatment of rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis. They reduce inflammation in the joints by blocking the action of molecules directly involved in inflammation. These

drugs include etanercept, infliximab, anakinra, and adalimumab. They have been shown to be extremely powerful; however, they may make patients more susceptible to infection. From a financial perspective, the high costs of these drugs may prohibit many from using them.

**Hyaluronic acid:** Hyaluronic acid products mimic a naturally occurring body substance that lubricates joints and permits flexible joint movement without pain. It can be injected into large joints (mainly the knee) and has been shown to be effective in some patients with osteoarthritis.

**Glucosamine:** This chemical is a normal constituent of normal cartilage. In the United States it is considered a dietary supplement, not a drug. It is often taken along with chondroitin, another cartilage component, to relieve the discomfort of osteoarthritis. While there is no convincing evidence yet that these compounds cause repair of damaged joints, there is some scientific evidence that they offer pain relief comparable to NSAIDs or acetaminophen.

**Fibromyalgia medications:** Currently, no drugs have been developed or approved specifically for fibromyalgia; however, a variety of medications are used to treat specific symptoms. There is increasing evidence that abnormalities of the nervous system involving heightened pain perception play a role in its development. Chemicals that convey pain messages from nerve cells to the spinal cord and brain have been shown to be altered in persons with fibromyalgia. Two such chemicals are substance P, which initiates pain signals after injury, and serotonin, which tones down the intensity of pain signals. Studies have shown elevated levels of substance P and low levels of serotonin in people with fibromyalgia.<sup>11</sup> Accordingly, antidepressants known as

selective serotonin reuptake inhibitors (SSRIs) may be prescribed to help correct this imbalance. Tricyclic antidepressants can help combat sleep disturbances and chronic pain. Muscle pain and spasms may be relieved with muscle relaxants and a seizure medication called gabapentin.

For more information on these and other drugs used for arthritis treatment, visit the Arthritis Foundation web site and view the 2003 Drug Guide:

[www.arthritis.org](http://www.arthritis.org)

## What Alternative Therapies Might Relieve Arthritis Pain?

Many people seek other ways of treating their disease, such as special diets or supplements. Some alternative or complementary approaches may help persons with arthritis cope with or reduce some of the stress of living with a chronic illness. It is important to inform your doctor if you are using alternative therapies. If the doctor feels the approach has value and not harmful, it can be incorporated into the treatment plan. However, it is important not to neglect regular health care or treatment of serious symptoms.

Alternative and complementary approaches include, but are not limited to, the following:

- Chiropractic
- Massage
- Meditation
- Biofeedback
- Acupuncture
- Therapeutic Touch
- Herbal Therapies

# Arthritis and Public Health

## Individual Recognition of Modifiable Risk Factors and Symptoms



The most clearly modifiable risk factor for arthritis is being overweight. The number of overweight and obese Texans has risen steadily over the past decade. In 1990, an estimated 30.6 percent of Texans were overweight. That number rose to 36.7 percent in 2001. Even more alarming, the percentage of obese Texans has doubled over the last 11 years from 12.3 percent of Texans obese in 1990 to 24.6 percent obese in 2001.<sup>12</sup>

In 2001, 43 percent of Texans reported meeting recommendations for physical activity, 40 percent did some physical activity but did not meet recommendations, and 16 percent reported being physically inactive.<sup>4</sup> With the combination of no regular physical activity and an increase in being overweight, more persons may develop arthritis or persons with arthritis may find it more difficult to manage the disease.

When early warning signs of arthritis are detected and action is taken, joint damage and disability can be limited for some forms of arthritis. However, many still view arthritis as an inevitable consequence of aging and fail to take the necessary steps to avoid future disability, i.e., weight loss, appropriate physical activity, visiting the doctor, or medications. The Centers for Disease Control and Prevention estimates that in 2001, about one-fifth of adults with chronic joint symptoms, or 10.3 million people, had not seen a health professional for these symptoms. About two million of these people had joint symptoms that limit activity.<sup>13</sup>

## Selected Characteristics of Respondents with Arthritis

2001 Texas Behavioral Risk Factor Surveillance System

Have health care coverage	81%
Did not participate in any physical activities or exercise in the past 30 days	36%
Symptoms of arthritis present on most days for at least one month	82%
Limited in any way in any activities because of these symptoms	39%
Ever seen a health professional for these symptoms	66%
Overweight/Obese (BMI > 25)	66%
Currently being treated by a doctor for arthritis	42%

“Most people who get severe cases of arthritis don’t talk about it until they have experienced a loss of function. When they find themselves crawling to the bathroom; when their knees or ankles hurt too badly to step on the brakes in their cars; when it hurts their bodies to lie under the sheets on their beds, that’s when they throw in the towel, seek help, and learn they have a condition they have to deal with the rest of their lives.”

*-Dallas business owner/civic leader with arthritis*

- Targeted, culturally appropriate initiatives to increase awareness of modifiable risk factors for arthritis are needed.
- Early detection of arthritis, followed by appropriate treatment at the onset, is key to preventing or limiting disability.

## Access to Health Care



Recent advances in medications promise decreased pain and suffering and fewer physical activity limitations for some with arthritis. New arthritis therapies include new forms of non-steroidal anti-inflammatory drugs known as COX-2 inhibitors as well as new biologic and immunosuppressive drugs.

These new medications come at a cost. Over the past decade, the cost of providing medications has risen 15-18 percent per year. Costs for improved medications currently in development promise to be even higher with some biologic agents costing \$10,000 per year or more.<sup>14</sup> Lack of insurance or expensive co-pays place these drugs out of reach for many.

Approximately 35 percent of Medicare beneficiaries do not have prescription drug coverage, and many others have limited coverage that can prove inadequate for individuals often living on fixed incomes while facing a chronic disease.<sup>15</sup> As the second leading cause of work-related disability,<sup>16</sup> the impact on the working-age population with arthritis is also severe, leaving many to suffer outside the loop of employer health plans and struggling to qualify for government assistance programs.

Some studies have shown that average annual medical costs for persons with arthritis are two to three times higher than those of people without arthritis. In addition to higher prescription drug charges, there is evidence that persons with arthritis acquire more charges for respiratory, heart, gastrointestinal and psychiatric issues and encounter more charges for procedures, hospital care, imaging studies, physician services, and laboratory tests.<sup>17</sup>

- Recognizing this trend, it is critical that the right medications be used when they are most effective to provide maximum benefit for the patient with arthritis. Through proper medical treatment along with lifestyle modifications, medication costs can then be offset by benefits such as decreased suffering, disability and unemployment resulting from arthritis.



Photo Credit: Arthritis Foundation

## Availability of Specialists



Optimal care for persons with arthritis is provided by rheumatologists. Rheumatologists specialize in the treatment of diseases of the musculoskeletal system and can improve the accuracy of diagnoses resulting in more appropriate and cost-effective management. Rheumatologists also utilize a team approach, including the services of orthopedists, nurses, physical and occupational therapists, social workers, podiatrists, vocational counselors and clinical psychologists.<sup>18</sup>

While need for rheumatologists would seem to increase with a growing population affected by arthritis, the opposite actually occurs. As managed care enrollment increases, financial and organizational pressure to reduce speciality physician services can decrease the

# Arthritis and Public Health

actual demand for these services.<sup>19</sup> As a result, diagnosis and treatment often becomes the responsibility of primary care physicians. Unfortunately, medical schools often provide little curriculum time to arthritis for primary care residents.<sup>18</sup>

According to the American College of Rheumatology Research and Education Foundation, the number of physicians entering rheumatology training programs has dropped over 40 percent since 1992. Government funding for rheumatology trainees in academic medical programs is also in jeopardy.<sup>20</sup>

The trend of increasing need coupled with decreasing demand for specialty services, and a shortage of those best qualified to treat arthritis, may severely impair outcomes of medical treatment for persons with arthritis.



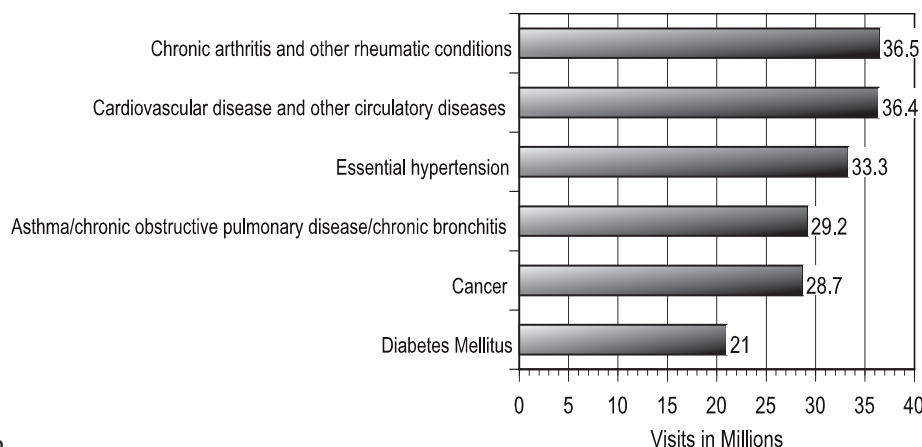
The 1997 National Ambulatory Medical Care and National Hospital Ambulatory Medical Care Surveys indicated that chronic arthritis and other rheumatic conditions accounted for 36.5 million ambulatory medical care visits, the largest diagnostic category among common selected chronic conditions.<sup>16</sup>

The majority of arthritis visits were made to primary care physicians' offices (52.9%), followed by orthopedic surgeons (19.6%) and rheumatologists (16.5%). This amounts to 13.7 visits per 100 people in the U.S. population for arthritis or other rheumatic conditions. In addition, more than 1.4 million arthritis visits in 1997 were emergency room visits, possibly the result of inadequate access to health care.<sup>16</sup>

Few of these patients received counseling or educational services. As a result, opportunities to utilize effective nonpharmaceutical interventions such as the Arthritis Foundation's Self-Management Program, and weight management and physical activity programs were missed. There is evidence that persons with arthritis who attend the Arthritis Self-Management Program report a 20% decrease in pain and a 40% decrease in physician visits.<sup>21</sup>

- Quality treatment can be achieved through increased recognition by managed care providers of the cost effectiveness and improved outcomes afforded by rheumatologists and other specialties.
- Increased training of rheumatologists and others who treat persons with arthritis is needed.

**Number of ambulatory medical care visits for selected chronic diseases as the primary diagnosis**  
National Ambulatory Medical Care Survey/National Hospital Ambulatory Medical Care Survey, 1997.



- Taking advantage of arthritis interventions could improve quality of life for many while reducing demands on the health care system.

## Evidence-based Programs



The Arthritis Self-Management Program is one of several programs offered by the Arthritis Foundation that are evidence based. That is, research has shown that they work. The challenge remains to make such programs more accessible to persons with arthritis and further tailor them to meet the needs of a population with a wide range of pain, disability, emotional and economic issues.

These programs take into consideration and are evaluated upon desired changes in the following areas:

- Function/mobility
- Pain
- Perceived quality of life/ well-being
- Knowledge and practice of self-management behaviors
- Physical activity
- Communication with physicians
- Use of health care system/cost savings



Photo Credit: Arthritis Foundation

A listing of Arthritis Foundation programs can be found in the Appendices (pg. 31).

- Communities and workplaces are key to providing the facilities, transportation and time that will allow these programs to expand and be fully utilized.

## Disability



Despite advances in the prevention and treatment of arthritis, the fact remains that substantial disability is associated with arthritis. Among people with arthritis, 40-70 percent reported work disability according to the Social Security Survey of Disability and Work and other studies.<sup>22</sup>

Persons with arthritis should be advised of Social Security disability benefits when they have not been able to work due to arthritis for 12 consecutive months, or as soon as it appears that disability will last longer than 12 consecutive months. At this point, application

for Social Security Disability Insurance is often denied, starting a series of appeals and hearings that can take months or years. In the meantime, the applicant may have no livelihood and no resources for treatment, all the while experiencing significant pain and mobility issues. Physicians can be of assistance in this application process by having a

clear understanding of the type of patient records needed to justify a disability claim for their patients. Diseases such as fibromyalgia require very precise documentation if a claim is to be successful due to the fact that much of the information about the disease is new and unrecognized. Legal assistance may also be required.<sup>23</sup>

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## IV. Appendices

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# Texas Arthritis Program Resources



The mission of the Arthritis Foundation is to improve lives through leadership in the prevention, control and cure of arthritis and related diseases.

## 1. Arthritis Foundation (AF)

### Health Promotion Department Quality of Life Programs

The Health Promotion Department is responsible for working with all components of the Arthritis Foundation to ensure the adoption of public health approaches including: broad, population-based activities to help prevent arthritis (primary prevention); to stimulate early detection and treatment (secondary prevention); and to encourage movement along a continuum of educational activities that can ultimately result in reduced arthritis-related complications and disability (tertiary prevention).

The department has several core functions: establishing collaborative relationships with managed health care systems, public health agencies and agencies that serve minority groups and other organizations; program development based on consumer research; program review and evaluation; staff and volunteer training and certification; and product review and commendation.

The department also collaborates with the Communication & Public Relations and the Public Policy & Advocacy departments to help create health policies and supportive environments, such as putting arthritis on agendas of managed care organizations so people with arthritis have a greater opportunity to get comprehensive care including self-management education.

The following tables represent the specific program offerings that are provided through the department. Each chapter reserves the right to determine the specific program offerings for their community.

# Texas Arthritis Program Resources

Arthritis Foundation Programs				
Program Name	Target Audience	Key Features		Evaluation Results/Status
		Format	Content	
<b>Arthritis Self-Help Course (ASHC) - One Hour Workshop</b>  ("Break the Pain Cycle")	All individuals with arthritis	1.5 hours	Problem solving; exercise; pain and stress management; using medications wisely; communicating with healthcare team	<ul style="list-style-type: none"> <li>• Increased knowledge</li> <li>• Increased self-efficacy</li> <li>• Increased contact with the Arthritis Foundation</li> </ul>
<b>Arthritis Foundation YMCA Aquatic Program (AFYAP)</b>	People with impaired joint motion and strength	1 hr/ 2-3 times wk; 6-10 wks; or ongoing	Muscle strengthening, range of motion, and endurance building exercises	<ul style="list-style-type: none"> <li>• Improved daily function</li> <li>• Decreased pain</li> </ul>
<b>Arthritis Self-Help Course (ASHC)</b>	All individuals with arthritis	2 hrs/week; 6 weeks	Problem solving; exercise; cognitive pain and stress management; managing fatigue; coping with depression; using medications wisely; evaluating unproven remedies; communicating with healthcare team	<ul style="list-style-type: none"> <li>• Increased knowledge</li> <li>• Increased frequency of exercise and relaxation</li> <li>• Increased self-efficacy</li> <li>• Decreased depression</li> <li>• Decreased pain (15-20%)</li> <li>• Decreased physician visits (43% decrease in 4 years)</li> </ul>
<b>People with Arthritis Can Exercise (PACE)</b>	Most people with arthritis	1 hr/2-3 times wk; 9 wks; or ongoing (community based)	Exercises for endurance building and joint mobility	<ul style="list-style-type: none"> <li>• Increased functional ability</li> <li>• Increased self-care behaviors</li> <li>• Decreased pain</li> <li>• Decreased depression</li> </ul>
<b>Walk with Ease</b>	Most people with arthritis	Varies - participants develop a walking plan that meets their individual needs. A group format is also available.	This program is designed to motivate people with arthritis to get physically active	<p>These materials are based on programs which have been successfully implemented in research settings and have resulted in positive outcomes such as:</p> <ul style="list-style-type: none"> <li>• Increased physical activity</li> <li>• Increase in walking distance and speed</li> <li>• Decrease in pain</li> <li>• Decrease in depression</li> </ul>
<b>Tai Chi from the Arthritis Foundation</b>	Most people with arthritis	1 hr/2-3 times wk; 8 wks; or ongoing; (community based)	Exercises for flexibility and balance	Not available

# Texas Arthritis Program Resources



## Funding Research to Find a Cure

The Arthritis Foundation is the largest voluntary health organization funding medical research in the area of arthritis. Only the National Institutes of Health funds more research. Throughout the years it has funded more than 2000 scientists. Currently, it is awarding \$24 million annually to approximately 150-200 studies deemed the most promising to find a cure by a panel of expert peers.

## [www.arthritis.org](http://www.arthritis.org)

AF provides an authoritative web site for current updates on treatments, research, and activities to support those with arthritis and their caregivers. In addition to national news, Texans can enter their zip code on the home page to go to their local chapter web site for specific offerings in their area.

## Arthritis Today

An award winning bimonthly magazine published by the AF, Arthritis Today has a readership of almost 700,000 people seeking arthritis education, treatment information and research updates.

## Additional Education/Counseling Services

AF provides telephone counseling to arthritis patients and their caregivers, stages forums for patients and the general public, and provides continuing education for physicians and allied health professionals. Local chapters provide literature on a range of arthritis topics and referral lists for rheumatologists and facilities offering AF land and water exercises upon request.

## Texas Arthritis Foundation Chapters

### North Texas Chapter

4300 MacArthur  
Dallas, Texas 75209  
(214) 826-4361  
(800) 442-6653  
email: [info.ntx@arthritis.org](mailto:info.ntx@arthritis.org)

### Heart of Texas Branch – North Texas Chapter

7003 Woodway, Suite 304  
Waco, Texas 76712  
(254) 772-9303  
email: [info.ntx.htb@arthritis.org](mailto:info.ntx.htb@arthritis.org)

For residents in El Paso:

### Greater Southwest Chapter

1313 E. Osborn Road, Suite 200  
Phoenix Arizona 85014  
(602) 264-7679  
(800) 477-7679  
email: [info.caz@arthritis.org](mailto:info.caz@arthritis.org)

For information about Arthritis Foundation activities in your area, visit the AF web site at [www.arthritis.org](http://www.arthritis.org) and enter your zip code where indicated, or contact the national office at 1-800-283-7800, email: [help@arthritis.org](mailto:help@arthritis.org).

# Texas Arthritis Program Resources

## 2. Health Communication Campaign

The Centers for Disease Control and Prevention's "Physical Activity. The Arthritis Pain Reliever" campaign promotes physical activity as a method of arthritis self-management. The campaign is targeted at lower-income African American and Caucasian males and females, ages 45-64 with arthritis who have a high school education or less and an income under \$35,000. The campaign makes people aware that there are things they can do to help manage their arthritis. In addition, it teaches them about the importance and benefits of being physically active while building their confidence.



## 3. Texas Department of Health

[www.texasarthritisprogram.org](http://www.texasarthritisprogram.org)

The future web site of the Arthritis Program at the Texas Department of Health will contain information on current program activities, arthritis data for Texas, and arthritis health promotion activities and campaigns.

## Wellness Incentive Programs

These materials may be used for a worksite or community setting to engage employees or community members in a fun and supportive program for lifestyle changes promoting physical activity and nutrition.

- **Five A Day Five A Week Challenge**

This 4-week, non-competitive program combines healthy eating, physical activity, and stress relief. Specifically, this program focuses on eating five servings of fruits and vegetables each day, exercising at least five days a week, and doing at least five stress relief activities a week.

- **Texas State Agency Physical Activity Challenge**

This ten-week, team-based program provides participants the opportunity to engage in physical activities that will motivate them to adopt and maintain a healthy lifestyle. Participants are motivated to form teams, set realistic personal goals for physical activity, and are rewarded for achieving both individual and team goals.

## 4. Texas Department on Aging

Disease prevention and health promotion services administered through the Texas Department on Aging and provided by the 28 Area Agencies on Aging in Texas for persons 60 and older include, but are not limited to:

- 1) health risk assessments;
- 2) routine health screening (e.g., hypertension, glaucoma, cholesterol, cancer, vision, hearing,

# Texas Arthritis Program Resources

- diabetes, bone density, nutrition);
- 3) health promotion programs relating to prevention and reduction of effects of chronic disabling conditions (e.g., osteoporosis, cardiovascular disease), alcohol and substance abuse reduction, smoking cessation, weight loss and control, stress management;
  - 4) home and injury control services including screening of high-risk home environments and provision of educational programs on injury prevention (including fall and fracture prevention) in the home;
  - 5) educational programs on the availability, benefits, and appropriate use of preventive health services;
  - 6) medication management screening and education to prevent incorrect medication and adverse drug reactions;
  - 7) nutritional counseling and educational services for individuals and their caregivers; and
  - 8) counseling regarding social services and follow-up health services.

Individuals over 60 with a disability may utilize in-home services that may include, but are not limited to personal care services, services of homemakers and home health aides, visiting and telephone reassurance, chore maintenance, in-home respite (short-term/temporary relief) for families and caregivers, and minor modification of the home that is necessary to facilitate the ability of the older individual to remain in the home.

Availability of these services varies with communities throughout the state.

## Helpful Web Sites

### **Arthritis Foundation**

(enter zip code for local chapter offerings)  
[www.arthritis.org](http://www.arthritis.org)

### **Juvenile Arthritis**

[www.arthritis.org/communities/juvenile\\_arthritis/children\\_young\\_adults.asp](http://www.arthritis.org/communities/juvenile_arthritis/children_young_adults.asp)

### **Centers for Disease Control and Prevention Arthritis Program**

[www.cdc.gov/nccdphp/arthritis/index.htm](http://www.cdc.gov/nccdphp/arthritis/index.htm)

### **National Institute of Arthritis and Musculoskeletal and Skin Diseases**

[www.niams.nih.gov](http://www.niams.nih.gov)

### **American College of Rheumatology**

[www.rheumatology.org/ar/ar.html](http://www.rheumatology.org/ar/ar.html)

### **Texas Department on Aging**

[www.tdoa.state.tx.us](http://www.tdoa.state.tx.us)

### **Texas Department of Health/Bureau of Chronic Disease and Tobacco Prevention**

[www.tdh.state.tx.us/bdip](http://www.tdh.state.tx.us/bdip)

# Healthy People 2010 Objectives for Arthritis

Healthy People 2010, the prevention agenda for the nation, focuses on 28 areas representing the most significant preventable threats to health in the United States. The following Healthy People 2010 objectives relate directly to arthritis:

- Increase the mean number of days without severe pain among adults who have chronic joint symptoms (2-1).
- Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis (2-2).
- Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence (2-3).
- Increase the proportion of adults with arthritis who seek help in coping if they experience personal and emotional problems (2-4).
- Increase the employment rate among adults with arthritis in the working-age population (2-5).
- Eliminate racial disparities in the rate of total knee replacements (2-6).
- Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms (2-7).
- Increase the proportion of people with arthritis who have had effective, evidence based arthritis education as an integral part of the management of their condition (2-8).

The following objectives are indirectly related to arthritis:

- Increase the proportion of adults who are at a healthy weight (19-1).
- Reduce the proportion of adults who are obese (19-2).
- Reduce the proportion of adults who engage in no leisure-time physical activity (22-1).
- Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day (22-2).
- Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion (22-3).
- Increase the proportion of adults who perform physical activities that enhance and maintain muscular strength and endurance (22-4).
- Increase the proportion of adults who perform physical activities that enhance and maintain flexibility (22.5).

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