New Mexico

Arthritis Report

The Burden of Arthritis
Strategies for Action

2003

New Mexico

Arthritis Report 2003

The Chronic Disease Prevention & Control Bureau
Arthritis and Osteoporosis Prevention and Control Programs
&
The New Mexico Arthritis Advisory Council

Presented by the

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The Public Health Impact of Arthritis

There are over 120 different types of arthritis and rheumatic diseases that affect joints, surrounding tissues and other connective tissues. Some forms of arthritis can result in kidney disease, blindness, and premature death. Osteoarthritis, rheumatoid arthritis and fibromyalgia are the most common types.

Arthritis causes disability in millions of Americans and negatively impacts the quality of life and mental health of millions more. People with arthritis experience more physical and occupational limitations, have more financial difficulties, are less satisfied with their current circumstances, and are less optimistic about the future.[1]

The Impact of Arthritis Can Be Measured in the Following Ways

Disability: Arthritis is the leading cause of disability among adults in the United States. The Centers for Disease Control and Prevention (CDC) estimates 33% of U.S. adults have arthritis, chronic joint symptoms, or both.[2]

Cost: The Arthritis Foundation recently announced, "arthritis and rheumatic diseases cost the United States $124.8 billion annually." These figures include $42.6 billion in direct medical costs, and $82.2 billion in indirect costs, such as lost productivity.[2]

Age: Almost half the population with arthritis is under age 65; this includes an estimated 200,000 children.[1] The elderly population is the fastest growing segment of the U.S. population, and currently almost 60% of all persons over age 65 have arthritis.[1]

Women: More than 1/3 of all women in the U.S. have arthritis and almost 2/3 of persons with arthritis are women.[1,3]

Income and Education: Persons with lower incomes and less education have higher rates of arthritis. Nearly 1/3 of those with arthritis have less than a high school education.[1]

Daily Living and Quality of Life: Those who are physically inactive have higher rates of arthritis.[3] However, arthritis can cause symptoms that make physical activity difficult, including pain, limited range of motion, and fatigue.

Health and Happiness: Only 1/3 of those with arthritis say they are in excellent or very good health compared to 70% of those who do not have arthritis.[1] People with arthritis say they are less satisfied with their health and their financial circumstances than those without arthritis. Dealing with the pain and disability of arthritis increases the likelihood for feelings of helplessness, depression, anger and anxiety.[4]

Risk Factors for Arthritis

Certain risk factors can increase a person's chances for developing arthritis. There are a number of characteristics or behaviors over which people have control (modifiable risk factors) and a number over which they have no control (non-modifiable risk factors).

Non-modifiable Risk Factors

- Female gender
- Older age
- Genetic predisposition

Modifiable Risk Factors

- Obesity
- Joint injuries
- Infections (such as Lyme disease)
- Certain occupations (farming, jobs with repetitive knee bending, heavy industry)

In 1991, I was diagnosed with rheumatoid arthritis. My life was drastically changed forever. I was in a pit of despair and pain. On many days I could not even pick up a bar of soap. Today, I pick up weights with each hand.

In June 2002, my husband's niece was participating in the California AIDS Ride, a 575-mile bicycle ride from San Francisco to Los Angeles. As she talked about the ride, I wished that I could do something so daring, so I joined a local gym and started bicycle spin classes 3 times a week and weight lifting 2 times a week. By September, I was feeling stronger, pain-free and believed I could do the ride. I joined a bicycle club and rode 675 miles over a 4-month period. By the end of May I had ridden 1645 miles on my bike, and I was ready. On June 3, I rode out of San Francisco with 3000 riders and 575 miles later arrived at Los Angeles on June 9. It was an awesome experience.

Since I have started exercising, I feel like a new person. My mind feels clearer and my attitude and outlook on life are positive. I feel and am physically stronger right down to my fingers. I have energy to spare. My life has never been better, and I am having a ball living with arthritis.

—Doris Salinas

Prevention and Treatment Strategies

The high cost of arthritis can be controlled with early diagnosis and appropriate treatment protocols that include self-management strategies and physical activity.

Prevention Strategies

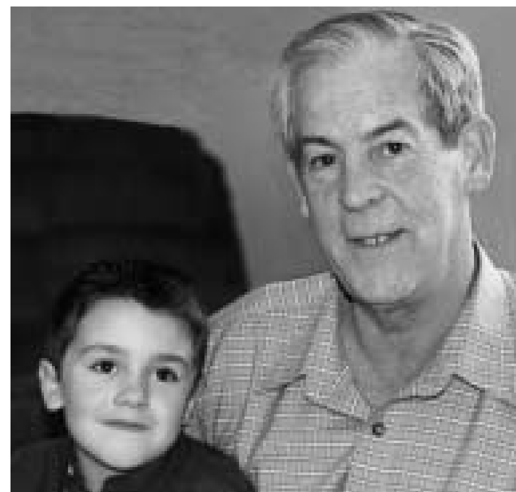
Primary prevention strategies for arthritis include weight control, sports or occupational injury prevention, and infectious disease control.

Secondary prevention for arthritis emphasizes early diagnosis and treatment to reduce the impact of the condition. This type of prevention is critical for many types of arthritis, especially those with severe health consequences. Yet many people, particularly men and young people, never see a doctor for arthritis symptoms, even when symptoms begin to cause activity limitation.[4]

Tertiary prevention strategies lessen the impact of an established disease or condition. The goal is to eliminate or delay disability and complications. Strategies include education, self-management skills, physical activity, weight control, physical and occupational therapy, and medical or surgical interventions.

In the *National Arthritis Action Plan*, the CDC recommends that arthritis prevention strategies be designed for whole population groups and should emphasize secondary and tertiary prevention strategies. The most common of these include:

- Social marketing messages designed to change attitudes about arthritis and teach behaviors which can alleviate the impact of the condition.
- Promotion of early diagnosis and treatment.
- Education, including courses such as the Arthritis Self-Help Course.
- Promoting and increasing options for physical activity for people with arthritis.
- Ensuring access to appropriate medical and rehabilitation services.



After putting together my own program of exercise for the 10-week Take Charge Challenge, I have range of movement I haven't had in years. My doctor didn't think I should exercise, but after the Challenge he is amazed at the difference. He said he would have to rethink prescribing exercise for my type of arthritis. Now I have more fun with my grandkids and can get right down on the floor with them! They wear out before I do!

—John Palmer

Treatment Strategies

Medical Intervention

Medical treatment modes include drug therapies, specialty care visits, in and outpatient procedures and surgeries, home health care and nursing home care.

At least eight categories of drugs are used to treat arthritis and musculoskeletal diseases. Drug therapy for many types of arthritis can delay disease progression before irreparable joint damage occurs. It is crucial to follow the treatment plan for prescriptions and other physician recommendations to ensure effective results.

Rehabilitation therapies are often time limited, but it is imperative that patients understand the benefit of continuing prescribed therapy on their own.

Surgery, although an effective treatment option, is usually a last resort and often can be delayed or prevented by following a treatment plan that includes using self-management skills and appropriate prescribed physical activity.

Physical Activity and Weight Management

The American College of Rheumatology recommends physical activity as a first line treatment for osteoarthritis and rheumatoid arthritis, along with patient education.[5,6] The *U.S. Surgeon General's 1996 Report on Physical Activity and Health* states that arthritis symptoms can be relieved and function improved with regular moderate aerobic activity or resistance training.[7] The *2001 Surgeon General's Call to Action to Prevent Overweight and Obesity Report* concludes that every two-pound increase in excess body weight increases the risk of arthritis by at least nine percent.[8]

The Arthritis Foundation PACE Program (People with Arthritis Can Exercise) and the Aquatics Program are non-clinical recreational exercise programs designed to improve functional ability and decrease pain in a socially supportive environment. Evidence suggests participation in these programs also decreases depression and increases self-efficacy. Participants report increased energy, function and quality of life. State and national efforts to quantify the effectiveness of these programs are underway.

Education and Self-Management

Researchers at the Stanford University Arthritis Center designed and tested the 6-week Arthritis Foundation "Arthritis Self-Help Course." The research demonstrates that participants have a 20% reduction in pain, 40% fewer physician visits and a 9% decrease in physical disability for as long as four years after participation in the course.[9] A recent cost-benefit analysis by independent researchers showed that use of the course, along with medical treatment, can reduce medical costs when compared with conventional medical therapy alone.[10]

Education, self-management strategies, physical activity, weight control and medical treatment used in a concerted and well-managed way can increase a person's sense of control over their disease, reduce pain and disability, and improve quality of life.

Arthritis in New Mexico

Arthritis and chronic joint symptoms affect approximately 415,000 adult New Mexicans - nearly 1/3 of the adult population.

The New Mexico Department of Health, Office of Epidemiology conducts an annual statewide Behavioral Risk Factor Surveillance System (BRFSS) survey. This CDC sponsored survey collects information about risk factors and behaviors related to the major causes of death and disease, such as arthritis, diabetes, asthma and cancer.

The BRFSS survey is conducted in all 50 states and is an on-going, state-based, random-digit dialed telephone survey of civilian, non-institutionalized individuals aged 18 and older. New Mexico BRFSS survey data provide population estimates for arthritis prevalence, related behaviors and health consequences (see: www.cdc.gov/nccdphp/states/new_mexico.htm).

There are several limitations with the BRFSS instrument. Data are self-reported and not confirmed by medical record review. The sample excludes those in institutions, the military and individuals without phones. Certain populations, such as rural American Indians, may be under-represented in the sample.

Defining Arthritis/CJS

Three BRFSS questions were used to determine the population of people with arthritis or chronic joint symptoms or both (defined herein as arthritis/CJS). A person was considered to have arthritis/CJS if they answered "yes" to both the first and second questions listed below, or if they answered "yes" to the third question:

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?
3) Have you ever been told by a doctor that you have arthritis?

The six-question 'Arthritis Module' in the 2001 BRFSS provided information on self-reported activity limitation and treatment. Disability status was determined based on five questions from the Disability Module and Disability-Related Supplemental Items from the New Mexico BRFSS survey instrument. In addition to these arthritis and disability-related questions, standard demographic information was collected, and questions were asked to assess the impact of arthritis on general health and quality of life.

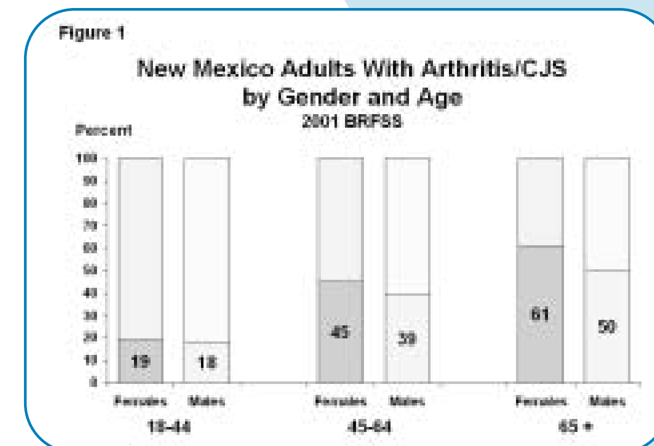
Prevalence of Arthritis/CJS, 2001 New Mexico BRFSS

32% of adult New Mexicans have arthritis/CJS.

Among the 415,000 adults with arthritis/CJS, 118,000 are over the age of 65. With the increasing aging population, this number is expected to double by 2025. Public health interventions should be applied now to improve function, decrease pain and delay disability among persons with arthritis, especially those at high risk for disability or functional impairment.[11]

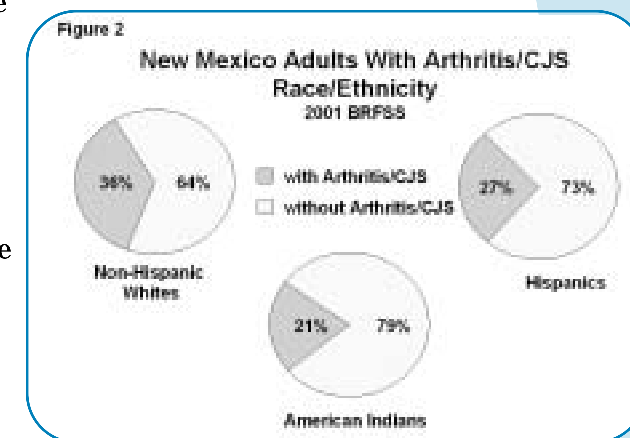
34% of women have arthritis/CJS compared to 29% of men.

Women are significantly more likely than men to be affected by arthritis/CJS. However, when gender and age are examined together, age is a more reliable predictor for developing arthritis/CJS than gender. The proportion of both men and women with arthritis/CJS in each age group increases with advancing age (see Figure 1). More than half of New Mexico adults aged 65 and older have arthritis/CJS; 42% of adults aged 45-64 have these conditions.



36% of non-Hispanic Whites have arthritis/CJS compared to 27% of Hispanics and 21% of American Indians (see Figure 2).

Among those with doctor-diagnosed arthritis, there are marked differences in prevalence between all three race/ethnic groups (non-Hispanic Whites: 26%; Hispanics: 18%; American Indians: 13%). Among those with CJS only, both Hispanics and American Indians have rates of 17% compared to a rate of 27% for non-Hispanic Whites. These figures indicate the need for awareness, early detection and diagnosis in specific sub-populations.



Arthritis in New Mexico, cont'd

20% of New Mexicans with arthritis/CJS have not been seen by a doctor.

Characteristics of the 61,000 New Mexicans with CJS who have not seen a doctor for their chronic joint symptoms may include people who are: younger, male, Hispanic, are without health insurance or a personal doctor, have less than a high school education, no activity limitations, and are in excellent, high or good health.[12]

39% of New Mexicans who do not engage in leisure time physical activity have arthritis/CJS.

More than one-quarter of New Mexico adults with CJS and more than one-third of those with arthritis/CJS do not engage in any type of physical activity or exercise. National recommendations advise that all adults participate in regular, moderate-intensity leisure time activity. Moderate physical activities such as walking, gardening, bicycling and swimming have been shown to reduce pain and disability, and to improve physical performance and self-efficacy in persons with arthritis.[13]

23% of all New Mexico adults have CJS and 10% have both CJS and limitations in their activities.

Activity limitation is defined as the inability to perform a person's major activities. This may include basic tasks such as preparing meals, shopping, making phone calls, taking medications and managing finances or more serious mobility measures, such as dressing, bathing and walking.[2]

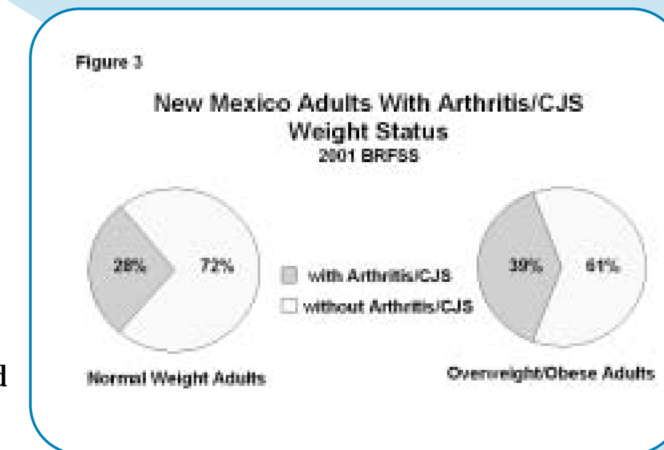
33% of Hispanics with CJS have activity limitations compared to 29% of Non-Hispanic Whites.*

However, among those with doctor diagnosed arthritis, Hispanics are just as likely as non-Hispanic Whites to have activity limitations (46% and 45% respectively). According to research, older Hispanics with arthritis or CJS are at greatest risk of functional deterioration and most likely to benefit from interventions such as exercise.[14]

* The sample size for American Indians was too small for a reliable estimate in this category.

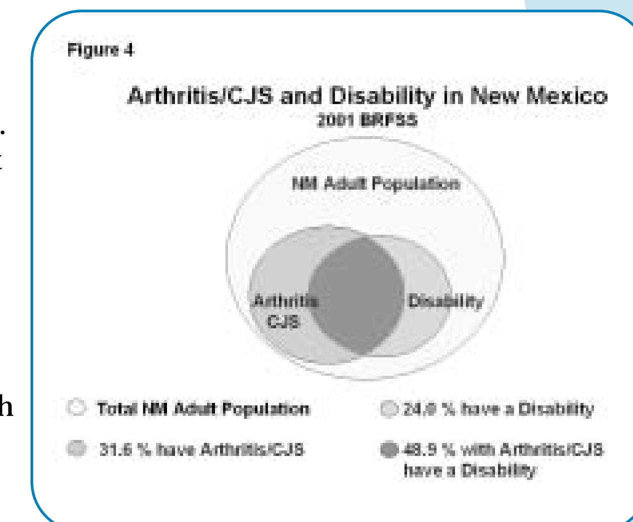
The prevalence of arthritis increases as body mass index (BMI) increases and physical activity decreases.

Obese/overweight adults are 27% more likely than normal weight adults to have arthritis/CJS (see Figure 3). In addition, obese/overweight adults are one-third more likely to have activity limitations due to CJS. As BMI increases, the percentage of adults with doctor diagnosed arthritis increases. One-quarter of normal weight adults with CJS have limitations due to their symptoms while more than a third of overweight and obese adults have these problems. Being overweight or obese increases the risk of developing gout or osteoarthritis of the knees, and is associated with increased pain in weight-bearing joints.



Arthritis/CJS impacts disability status.

Twenty-five percent of adult New Mexicans have a disability. Almost one-half of adults with arthritis/CJS have a disability (see Figure 4). Among disabled adults not requiring assistance, 57% have arthritis/CJS, however among disabled adults requiring assistance, 77% have arthritis/CJS. Only 22% of adult New Mexicans with no disabilities have arthritis/CJS. The BRFSS data do not indicate whether arthritis is a primary or a secondary disabling condition. However, data do indicate that arthritis is at least twice as prevalent as hypertension, cardiovascular disease, diabetes and osteoporosis in this population. Effective health promotion efforts that address the needs of those with disabilities would reduce the impact and cost of these conditions.



Arthritis in New Mexico, cont'd

27% of New Mexicans with CJS and activity limitations say they are very satisfied with their lives compared to 49% without these conditions who say they are very satisfied with their lives.

Individuals with arthritis are three times more likely than the general population to report poor health status and are at increased risk for stress and depression. Adults with arthritis/CJS, especially those with activity limitations, are all more likely to say they rarely or never receive the support they need than those who do not have these conditions.

Target Groups

New Mexico BRFSS data are used to identify target populations, and they reflect the need to increase awareness, early detection, treatment and lifestyle change in those who are:

- Over the age of 45
- Obese or overweight
- Physically inactive
- In lower income brackets
- In high risk race/ethnic populations

Additionally, data analysis indicates areas for further research. The interaction between BMI, activity limitation and arthritis is unclear at this point. The link between race/ethnicity and higher rates of activity limitation may be affected by many factors. Research indicates older Hispanics have been identified as an at risk population for more serious consequences of arthritis. As stated previously, BRFSS data on American Indians are not very reliable, yet research on American Indians reveals the need to regard arthritis as a substantial health problem. Interventions must be developed and tested in culturally divergent populations. Over time, national and state surveillance efforts and the implementation and evaluation of interventions in various populations will address the unknown associations and yield more descriptive data for use in reducing the impact of arthritis as a growing public health problem.

Arthritis has not inhibited my life; it is something I have adjusted to over the years. I've learned how to adapt. It doesn't stop me from doing what I want to do. Granted there are times when I wish I didn't have it, but it is a reminder to me that life has its ups and downs...and you find a way to get through, no matter how painful it is. It has made me who I am: strong, independent, and stubborn.

—Jolene Aguilar

Cost of Arthritis

While there are data on the number of individuals with arthritis, and on the physical and mental health impact of the condition, information on the cost of treating those with arthritis and other rheumatic conditions in New Mexico has not been readily available.

In 2002, the New Mexico Department of Health funded a study to determine healthcare costs for arthritis patients who were health plan members in one of New Mexico's large managed care organizations (MCO) during an 18-month period from January 2000 through June 2001.

Only members who were continuously enrolled health plan members during the study period were included. A member was classified as having arthritis by the following criteria: 1) the individual had one or more arthritis diagnosis codes as an inpatient; or 2) the individual had two or more diagnosis codes on separate days as an outpatient. This method was used to eliminate individuals who received tests that ultimately ruled out an arthritis diagnosis.

Results presented below reflect this MCO's member population only and are not to be generalized to the state population. Study results revealed a lower percentage of arthritis among MCO members (20%) than among the general population statewide (32%), possibly because these health plan members are all more likely to be employed and less likely to be disabled. These differences could lead to a lower cost experience for MCO members than what might be expected in the general population.

MCO Members Diagnosed with Arthritis

- 123,679 MCO members continuously enrolled for the study period.
- 20% (24,692) of these individuals were diagnosed with arthritis as a primary or secondary diagnosis during the study period.

Description of Membership and of Those Diagnosed with Arthritis

	Gender		Race/Ethnicity			Age				Plan Type		
	Female	Male	Non-Hisp	Hisp	Amer-Indian	<18	18-44	45-64	65 & >	HMO	Medi care	PPO
All MCO Members	53%	47%	62%	37%	1%	24%	32%	31%	13%	51%	11%	38%
Those with Arthritis	58%	42%	64%	35%	1%	10%	24%	40%	26%	50%	23%	27%

Cost of Arthritis, cont'd

Estimates on Children

Although the preceding chart shows a diagnosed rate of 10% in those aged <18, estimates of 5%, 7% or 10% were produced depending on the classification method. Chart reviews indicated a significant number of diagnoses were from a code that included pain in the joints from sports injuries, sprains and fractures (ICD-9 719.4). This may lead to overestimation of utilization and cost for arthritis, particularly in children. The most conservative estimate (5%) excluded children with any 719.4 code and only estimates children with an arthritis specific diagnosis code. The moderate prevalence estimate of 7%, included those with 719.4 coding in conjunction with an arthritis specific diagnosis code. Defining children with arthritis in this study requires further refinement.

Type of Diagnosis in Children < 18	Number
Arthritis specific only (e.g. no 719.4 codes)	1,231
General diagnosis only (e.g. only 719.4 codes)	567
Both	419
Total	2,217

Primary Reasons for Treatment

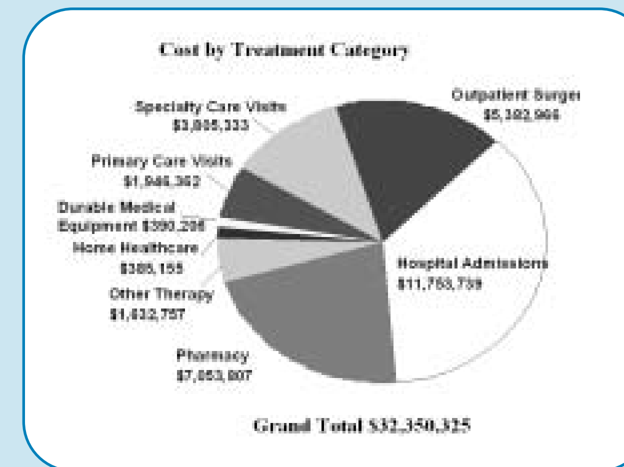
- Joint Pain
- Soft Tissue Disease
- Osteoarthritis

Females were twice as likely as males to be treated for myalgia and almost three times as likely as males to be treated for rheumatoid arthritis. Males were nearly five times as likely to have gout as females.

Types of Services and Average Cost

Cost data were calculated for all 22,890 patients who had a primary diagnosis of arthritis (i.e., their primary reason for seeking medical care) at some point during the study period.

Types of Services	Members with Arthritis Who Received Services	Average Cost Per Person
Primary Care Visits	14,772	$132
Specialty Care Visits	12,375	$308
Hospital Admissions	548	$21,448
Outpatient Surgery	1,072	$5,021
Other Therapies	3,447	$474
Overall Average Cost Per Person		$1,413



Primary Care Visits - Primary care visits are the first point of contact in the healthcare system.

- A patient must see their primary care physician (PCP), generally in the fields of family practice, internal medicine, OB-GYN or pediatrics, for a referral before seeking any other type of care.

Specialty Care Visits - A person with arthritis is referred to a specialist when the PCP determines the need.

- The predominant types of specialty care visits during the study period were for orthopedics, rheumatology and podiatry.
- Other types of specialty visits included the hand clinic, the pain clinic, neurology, dermatology, and less frequently, other specialties such as thoracic surgery, nephrology, or ophthalmology.

Hospital Admissions - A hospital admission is generally ordered by a specialist.

- 90% of all hospital admissions for persons with arthritis were for surgery.
- Osteoarthritis and soft tissue disease accounted for 83% of all arthritis related hospital admissions.
- Single hip or single knee replacement were the most common procedures.

I've had psoriatic arthritis for 14 years. Thanks to the right medication and my rheumatologist's guidance, I've taken control of my arthritis and my life. I'm active and happy. My motto is: Every day is a good day, and some days are great days!!

—Sue Levan

Cost of Arthritis, cont'd

Outpatient Surgery - Outpatient surgery is used for less elaborate surgical procedures, such as laproscopic surgery of the knee or shoulder, that do not require a hospital stay.

- The most common outpatient surgical procedures were for the elbow, wrist or hand, and for the ankle or foot.

Other Therapies - Other therapies include acupuncture, chiropractic, occupational therapy and physical therapy.

- Acupuncture and chiropractic, both forms of "complementary and alternative medicine," are primarily used to control pain.
- Occupational and physical therapy are most often used as rehabilitation following surgery. They are used to help reduce pain, restore mobility, increase functioning, improve strength and flexibility, and prevent any unnecessary disability due to arthritis.

Durable Medical Equipment - Expensive items such as wheelchairs, lifts/transfer devices, and hospital beds.

Home Healthcare – Unskilled and skilled home care, including physical therapy and occupational therapy.

Pharmacy Charges - Types of drugs prescribed included pain relievers, anti-inflammatory drugs, anti-depressants (for fibromyalgia), and muscle relaxants.

Strategies for Action

Arthritis imposes a tremendous individual and societal burden – effective interventions are available – a coordinated public health effort is essential.

Power in Partnership

Through a cooperative agreement, the CDC provides funding to the New Mexico Department of Health (DOH) to create the infrastructure and capacity to effect positive changes on the impact of arthritis in New Mexico. In 1999, the DOH Arthritis Program was created with a mandate to develop alliances with public and private agencies and organizations to reduce the personal and financial costs of arthritis.

Thirty-three local, regional and state agencies and organizations formed the New Mexico Arthritis Advisory Council (NMAAC). The NMAAC was charged with assessing need and collaborating on a five-year *New Mexico Strategic Arthritis Plan* to determine the scope of arthritis, improve public and professional knowledge of arthritis, and to provide programs and solutions for individuals with arthritis. The NMAAC has provided visibility for arthritis issues and opportunities for new collaborations between NMAAC organizations and a key partner, the Arthritis Foundation, Greater Southwest Chapter.

The NMAAC followed the guidelines of the *National Arthritis Action Plan* in designing a state plan with action areas in Surveillance, Communication and Education, and Programs, Policies and Systems.

Surveillance

The Arthritis Surveillance Team, including the DOH Offices of Epidemiology and Disability and Health, and NMAAC organizations has assisted the DOH Arthritis Program in establishing a system to monitor population trends and provide descriptive information related to arthritis and chronic joint symptoms. The team created the surveillance objectives in the state plan, developed the content and outline for this report, and will assess other data sources for their utility in arthritis-related surveillance. Data are used to plan prevention and intervention programs, to measure impact, and to inform the public. The DOH Arthritis Program publishes annual reports on arthritis data for an audience including the NMAAC, policy makers, legislators, health care providers, and the public.

Communication and Education

Informing the public, providers, administrators, and community and state leaders on key arthritis issues is critical to increasing awareness, changing attitudes and beliefs, and promoting behavior change to improve quality of life and reduce the consequences of arthritis. Various partnerships have been developed through DOH and the NMAAC to accomplish plan objectives. Activities designed to meet these objectives include:

- Distribution of professional and consumer educational information through health care clinics.
- Initiation of an annual education and physical activity event, the Annual Stroll and Roll for Osteoporosis and Arthritis.

- Presentations for organizations that serve people with arthritis, including:

  State Division of Vocational Rehabilitation

  Agency on Aging and senior centers

  Corporations with staff with arthritis

- Inclusion of arthritis programs and tracks offered at established annual professional conferences such as:

  NM Geriatric Education Center's Arthritis Track, Summer 2002

  Geriatric Institute for Health Care Professionals

  Annual NM Disability and Health Conference and Research Symposium

Programs, Policies and Systems

Public health action includes the delivery and measurement of evidence-based programs for people with arthritis, the establishment of community and state policies to support program implementation, and a health infrastructure that bridges medical, public health, and volunteer organizations to provide an environment conducive to arthritis prevention and control. Actions to meet plan objectives include:

- Maintain partnerships between the Arthritis Foundation, DOH Arthritis Program and NMAAC organizations to provide programs for people with arthritis, including the Arthritis Self-Help Course, PACE, and the Arthritis Foundation Aquatics Program.
- Continue collaboration between the Geriatric Education Center, the Arthritis Foundation and the DOH Arthritis Program to provide programs for American Indian communities.
- Continue collaboration between the DOH Arthritis Program, the Office of Disability and Health, AARP, and senior centers to conduct the Take Charge Challenge, a 10-week physical activity intervention for seniors with arthritis and persons with disability.

I did the Take Charge Challenge and an arthritic knee is still functioning. I'm a mall walker- this has kept me from further medical treatment. This program made exercise most important.

—Ida K. Smelser

The mission of the Arthritis Foundation is to improve lives through leadership for the prevention, control and cure of arthritis and related diseases. New Mexico is part of the Greater Southwest Chapter of the Arthritis Foundation, which includes New Mexico, Arizona and El Paso, Texas. The chapter office is located in Phoenix, Arizona. A full time director for programs and services was hired in 2001 to implement Arthritis Foundation programs and services in New Mexico and El Paso.

The Greater Southwest Chapter, through partnerships with the DOH Arthritis Program and other Arthritis Advisory Council organizations, provides information, education, self-help courses and exercise programs to support efforts to limit the impact of arthritis in individuals.

Since release of the *New Mexico Strategic Arthritis Plan*, more than 200 new Arthritis Foundation volunteers and health professionals have been trained as leaders to teach the 6-Week Arthritis Self-Help Course (ASHC), 7-week Fibromyalgia Self-Help Course (FSHC), PACE (People with Arthritis Can Exercise) and Arthritis Foundation Aquatics Program (AFAP) exercise programs.

The Self-Help Course and ten new Arthritis Foundation exercise programs, including PACE and AFAP, have been implemented in Albuquerque, Santa Fe, Los Lunas, Farmington, Los Alamos, Jal, Hobbs, Zuni and Las Cruces.

Over the last three years, approximately 20,000 persons throughout New Mexico have taken part in Arthritis Foundation and DOH sponsored Educational Seminars, Turnkey Programs, Arthritis and Fibromyalgia Self-Help Courses, Health Fairs, Wellness Conferences and Support Groups. Educational Seminar topics include: *Arthritis Basics for Change; Speaking of Pain; Osteoporosis and You; Arthritis in the Workplace; Take Action Against your Arthritis; Arthritis Prevention and Care; It's a Joint Activity-Exercise and your Arthritis; and Rheumatoid Arthritis vs. Osteoarthritis.*

Arthritis Foundation and DOH Prevention Efforts	2000	2001	2002
Individuals reached through health fairs	800	4600	5910
Participants trained or re-certified as an Arthritis Foundation Leader for ASHC, FSHC, AFAP, PACE	26	117	85
Participants in Arthritis Foundation Classes for ASHC, FSHC, AFAP, PACE	150	258	595
Number of participants in Educational Seminars, Turnkey Programs	223	491	1217

Arthritis Foundation Action, cont'd

The partnership between the New Mexico Geriatric Education Center, the Arthritis Foundation and the DOH Arthritis Program provides Leader Training Workshops for the Self-Help Course, Aquatics Program and PACE for American Indians. Program participants represent10 of the 19 pueblos in the state. Pojoaque and Zuni Pueblos have especially active arthritis programs. There is consistent demand for recurrent training and arthritis interventions in Indian communities.

The Arthritis Foundation offers educational and group programs for children with arthritis and their families providing opportunities to meet, play and share experiences. The Southwest Chapter sponsors children and their families for out-of-state events. Since 2000, fifteen New Mexico children have attended Camp Cruz in Arizona. This summer camp for children with arthritis gives them the opportunity to ride horses, fish, swim, take nature walks, drive go-carts and work with arts and crafts. Over the past three years the Southwest Chapter has sponsored a family's attendance at the Regional Juvenile Arthritis Organization Conference. In June 2003, the Southwest Chapter hosted one of the two Regional American Juvenile Arthritis Organization Conferences in Phoenix, Arizona.

The Southwest Chapter supports, advocates for and funds research at the national level to prevent and cure arthritis. The Chapter has recruited over 250 New Mexican advocates to work on arthritis legislation or policy changes. Each year, selected advocates are sent to the Arthritis Advocacy Summit in Washington, DC to meet with congressional representatives and to promote the need for funding programs and services for New Mexicans with arthritis.

In 1990, osteoarthritis and osteoporosis initially manifested themselves. Then, 4 years later I was diagnosed with Type II Adult Onset Diabetes and my osteoarthritis had settled into my back, knee, and hip. I steadfastly refused spinal surgery and my doctor told me I had only two options left: do nothing and be wheelchair-bound within a year (I was hobbling around with a cane in 1995)....or participate in the Arthritis Foundation's aquatic exercise classes. Within a few weeks, I could perceive a noticeable benefit to my health, reduction in pain, and increased mobility/flexibility. I have no doubt that I would currently be in a wheelchair without doing those aquatic exercises as regularly as I do (I now teach the Aquatics class!) and I've postponed spinal disc surgery for over seven years due to this aquatic exercise regimen.

—Michael Lambright

Future Directions

This *New Mexico Arthritis Report* sets the stage to examine the accomplishments from the Strategic Arthritis Plan with stakeholder organizations and to ensure that appropriate measures are in place to assess effectiveness of applied interventions. Future directions include a need to review policies that affect people with arthritis and provide broader system and community support for interventions. By using available data, cost saving measures can be implemented and analyzed to determine the best strategies for reducing the impact, cost and burden of arthritis in health care systems and for people with arthritis in New Mexico. Future efforts will be focused in these areas:

- Continue to monitor the burden of arthritis in New Mexico.
- Collaborate with MCOs and other providers to assess arthritis prevalence and costs in New Mexico's health care systems.
- Measure the impact of arthritis in American Indian communities and meet the demand for arthritis education, training, and programs in this population.
- Disseminate the results of data analysis to persuade organizations to address policies and systems regarding arthritis care and treatment.
- Systematically increase, measure and sustain the Arthritis Self-Help Course, PACE and the Arthritis Foundation Aquatics Program through a statewide network of partners.
- Measure changes in health impact, quality of life and functioning for those in self-management programs.
- Test, implement and evaluate a social marketing campaign to promote the benefits of physical activity for arthritis pain relief and management.
- Continue to support and evaluate community events such as the Annual Stroll and Roll.
- Provide assistance to communities interested in conducting arthritis action strategies.

Call to Action

This document underscores the fact that arthritis is, and will continue to be, a major public heath problem for New Mexicans. Arthritis seldom causes death, but has a profound impact on health and quality of life for individuals, communities and health care systems. Although arthritis and rheumatic diseases are complicated, new treatments are available and the improved outcomes are known to occur with appropriate self-management that includes physical activity. It is imperative that public health and other health agencies, non-profit organizations, medical societies, academic institutions, educators, health professionals, patients and volunteers engage in the collaborative effort to continue to educate and improve the health and quality of life for New Mexicans with these conditions.

If you or your organization would like to take part in arthritis action, receive a copy of the *New Mexico Strategic Arthritis Plan*, or this report, contact the DOH Arthritis Prevention and Control Program at 505-841-5888, via the web at www.arthritisnm.org, or write to the program coordinator, Lauri Wilson, New Mexico Department of Health, 625 Silver, SW, STE 325, Albuquerque, NM 87102.

As a three year old, I contracted Juvenile Rheumatoid Arthritis, which attacked every joint in my body. By the age of five, I had to use a wheelchair due to the damage to my joints. After growing up with JRA, I spent the summer of 1985 in Iceland for graduate studies and was awarded a fellowship to live in Ireland to study medieval literature. There I earned a diploma with distinction and a PhD in medieval literature in 1993 from the University of Washington. Currently, I am a professor in the University Honors Program at the University of New Mexico, where I teach a variety of interdisciplinary courses. I have published a book as well as several articles on medieval topics.

—Leslie Donovan

Resources

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Arthritis and Osteoporosis Prevention and Control Programs
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Centers for Disease Control & Prevention
Health Care and Aging Studies Branch
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(770) 488 5464
www.cdc.gov/nccdphp/arthritis/index.htm

National Institutes of Health
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(301) 496 8190
www.nih.gov/niams

References

1. National Academy on an Aging Society. Arthritis, a leading cause of disability in the United States; challenges for the 21st century; Chronic and Disabling Conditions, March 2000. No.5.
2. Dunlop D, Manheim L, Yelin E, Song J, and Rowland W. Chang. The costs of arthritis. Arthritis and Rheumatism (Arthritis Care Research), 2003. 49(1):101-113.
3. Centers for Disease Control and Prevention. Prevalence of arthritis - United States, 1997, MMWR, 2001. 50(17):334-6.
4. National Arthritis Action Plan: A Public Health Strategy 1999. Arthritis Foundation, ASTHO, Centers for Disease Control and Prevention. Atlanta, GA.
5. American College of Rheumatology Subcommittee on Osteoarthritis Guidelines. Recommendations for the medical management of osteoarthritis of the hip and knee, 2000 update. Arthritis and Rheumatism, 2000. 43(9):1905-15.
6. Kwoh CK, Simms RW, Anderson LG, et al. Guidelines for the management of rheumatoid arthritis; Arthritis and Rheumatism, 1996. 39:713-22.
7. The U.S. Surgeon General's 1996 Report on Physical Activity and Health. U.S. Department of Health and Human Services, Public Health Office of the Surgeon General, Rockville, MD.
8. The Surgeon General's Call to Action To Prevent Overweight and Obesity 2001. U.S. Department of Health and Human Services, Public Health Office of the Surgeon General, Rockville, MD.
9. Lorig KR, Mazonson PD, Homan HR. Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs; Arthritis and Rheumatism, 1993. 36(4):439-446.
10. Kruger JM, Helmick CG, Callahan LF, Haddix AC. Cost-effectiveness of the arthritis self-help course; Archives of Internal Medicine, 1998. 158:1245-1249.
11. Public health and aging: projected prevalence of self-reported arthritis or chronic joint symptoms among persons aged > 65 years; MMWR, May 30, 2003. 52(21):489-491.
12. Adults who have never seen a health-care provider for chronic joint symptoms—United States 2001; MMWR, May 9, 2003. 52(18):416-419.
13. Hootman, J.M., et al. Physical activity levels among the general US adult population and in adults with and without arthritis; Arthritis Care and Research, 2003. 49(1): 129-135.
14. Wang,G., et al. Inactivity –associated medical costs among US adults with arthritis; Arthritis Care and Research, 2001. 45:439-445.

Special Thanks to the Members of the NEW MEXICO ARTHRITIS ADVISORY COUNCIL

AARP
Arthritis Foundation - Greater Southwest Chapter
Carrie Tingley Hospital
Governor's Committee on Concerns of the Handicapped
Jewish Community Center
Lovelace Clinic Foundation
Lovelace Sandia Health Systems:
- Lovelace Division of Rheumatology
- Sandia Senior Care
- Sandia Women's Care

Medicare Plus
New Mexico Commission on the Status of Women
New Mexico Geriatric Education Center
New Mexico Aging and Long-term Care Department
New Mexico Medical Review Association
New Mexico Medical Society
New Mexico Department of Health:
- Chronic Disease Prevention & Control Bureau
- Office of Disability & Health Programs
- Injury Prevention/EMS Bureau
- Office of Epidemiology
- Office of School Health
- Primary Care/Rural Health
- Stanford Public Health Office

New Mexico State Division of Vocational Rehabilitation
New Mexico State University, Cooperative Extension
Osteoporosis Foundation of New Mexico
Presbyterian HealthPlex:
- Presbyterian Arthritis Center
- Presbyterian Salud

San Juan Center for Independence
University of New Mexico:
- Health Sciences Center
- Occupational Therapy Program
- Center for Development and Disability

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YWCA of the Middle Rio Grande

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