

**Counties Manukau
District Health Board**

**Rheumatology
Health Services Plan**

February 2008

1.0 Current Services

The Rheumatology Service currently provides assessment, advice and management for patients who present to Middlemore Hospital. We also provide ambulatory care for the Counties Manukau population in partnership with primary care.

Services currently provided include:

- GP advice
- Assessment of patients referred from Emergency Care (EC)
- Inpatient care based on a multidisciplinary team approach on wards 2 and 23
- Assessment of patients (medical and non-medical) in the acute care setting
- A nurse helpline for patients
- Active research and audit
- The use of clinical research and evidence based practice to drive care
- Active consumer involvement in the team and service development

Outpatient services

- SMO/registrar clinics
- Weekly urgent clinics to facilitate GP access to our services and avoid unnecessary hospital admissions
- Nurse Specialist clinics and case management
- Multidisciplinary Outpatient Rheumatology and Rehabilitation
- Access to Health Psychology clinics
- Specialist Lupus and Gout clinics (medical and nursing) both at Manukau SuperClinic and in the community
- Other specialist clinics e.g. for patients requiring biological agents as part of their therapy (in development)
- Health Care Professional education in both primary and secondary care
- Clinics in primary care working with primary carers to up skill and effectively manage patient care

Describe model of service delivery

The rheumatology service uses a multidisciplinary model of care to provide services to the local community. This includes working in partnership with GP's, practice nurses and local NGO's (i.e. Arthritis NZ), as well as other medical specialties, and orthopaedic services. Patients are encouraged to take responsibility for their health across the continuum of care.

We also provide regular services to Northland DHB in the form of:

- Outpatient clinics at Whangarei Hospital - 3 times monthly plus regularly quarterly "blitz" clinics, to reduce waiting times to 3 months or less
- Phone consults for GP's
- In-patient admissions and care— approximately 3 patients per annum

Care Provided Across the Continuum

- Early detection/supported self care-primary care, and non-government agencies e.g. Arthritis NZ; Green Prescription gym facilities; Evening classes for patient groups (multidisciplinary).
- Disease specific primary care management with specialist medical and health professional (including nursing) being used to up skill primary care (including shared clinics).
- Day stay e.g. multidisciplinary assessment or infusions of medicines-ambulatory setting, including primary health centres, with support from rheumatology specialist staff.
- Inpatient care, predominantly for those with severe vasculitis or connective disorders, and Rheumatoid Arthritis with extra-articular features i.e. systemically unwell-provided by rheumatology specialist staff in conjunction with colleagues from other specialist services.

	Actual's	Projected outpatient visits								approx only		
		2006/07	2007	2008	2009	2010	2011	2016	2021	2026	Increase 2006-26	% Increase 2006-26
NP Consults	893	919	946	973	1,000	1,026	1,200	1,300	1,400	555	62	2.4
FU Consults	3,474	3,578	3,689	3,799	3,907	4,015	4,600	5,200	5,700	2,253	65	2.5

Volume information

Current Workforce

Resource*	FTE
SMO	2.45
RMO	2.00
HO	0.50
Nurse Specialist	1.00
Lupus RN	0.10
Physiotherapist	0.80

* NB this is only the resource in the Rheumatology budget and does not include ward or allied health other than what is stated above.

The main service linkages for the CMDHB Rheumatology Service are:

- Division of Medicine
- Arthritis NZ
- ARHOP
- Orthopaedics
- Regional Rheumatology

SWOT Analysis - Rheumatology

Strengths:	Weaknesses:
<p>The team</p> <ul style="list-style-type: none"> • MDT model and approach to patient care • Emphasis on a creative approach to problem solving. • Skill mix of staff. • Patient centric model of care. • Links with and active involvement in the community. • The ongoing development of effective local solutions for our local client base. • The education and professional development programme. • Audit activities. • Strong research base and active ongoing involvement in this area. • Links with the services for health of the older person. • Community/GP integration. • Development of educational material. 	<ul style="list-style-type: none"> • The inability to fill the 0.8 FTE physiotherapist role to support community rehabilitation, and provide specialist rheumatology physiotherapy input in wards and community. • Insufficient expert nurse resource to support our CNS-unable to do community liaison visits. • Inconsistent cover for the CNS position. • Insufficient OT resource to meet the patient need. • The limitations of our cross cultural networks, apart from Maaori, and to a lesser extent Pacific (e.g. Asian). • Patient co-ordination/navigation through the service/s. • Cooperation with orthopaedic services-need to develop a coordinated service.

<p>Opportunities:</p> <ul style="list-style-type: none"> • Development of the expert lupus nurse role. • Involvement in the ongoing development of allied community health services. • Further development of group education initiatives. • Increased emphasis on community based care. • Increased emphasis on health disparities and in particular that of Maaori and Pacific patients. • Ongoing development and resource for the Maaori & Pacific educator position within Arthritis NZ. • Development of a Pacific educator role within Arthritis NZ. • The development of cross cultural networks both internally and externally. 	<p>Threats:</p> <ul style="list-style-type: none"> • Insufficient funding for biological drugs as they are developed and released on the market. • Potential changes in government and funding models. • Any changes in government policies. • Ageing population with changing patient demographics' which will require increased funding to support.
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2.0 Key Issues

Development of a Lupus nurse role based within the Rheumatology Service and designed to build links with the renal service to provide the following services:

- Completing assessment and education of lupus patients on the ward.
- Working with the Lupus support and Arthritis New Zealand Educators to ensure continuity of care where the patient agrees to a referral to these services.
- Develop a weekly lupus clinic.
- Provide a resource and support for lupus patients.
- Co-ordinate patient appointments to link with other speciality clinics i.e. renal, cardiac, respiratory, rheumatology.
- Undertake home visit lupus patients if needed to assist with management in the community.
- Work closely with the Renal team to provide optimum care for patients with lupus, including initiatives to improve adherence to medication and avoidance of renal failure and dialysis.
- Assist with audits, to improve suboptimal quality of care.

Involvement in the ongoing development of Allied community health services

- Work with team for the health of older people to develop community resources and access.
- Further development of home based services and support.

Further development of group education initiatives

- Continue to evaluate group initiatives.
- Modify the programmes based on customer feedback and needs.
- Work with Arthritis NZ to provide community based and easily accessible programmes.

Increased emphasis on community based care

- Continued evolution of community based clinics with GP's.
- Continued evolution of partnership model with practice nurses to up-skill and educate them in patient management.
- Active nurse specialist case management for patients with complex needs.

Increased emphasis on health disparities and in particular that of Maaori and Pacific patients.

- Increase in community based clinic's in areas of high need i.e. following the model of the current Tuakau gout clinic.
- Ongoing development and resource for the Maaori educator position within Arthritis NZ.
- Development of a Pacific educator role within Arthritis NZ.
- Work with Arthritis NZ to develop and support Maaori and Pacific educators who are actively involved in the community in Counties.
- Work with Maaori and Pacific Health Divisions to develop campaigns to address rheumatological conditions with high prevalence in these populations e.g. lupus, gout, or those where management regimens are increasingly complex e.g. vasculitis, rheumatoid arthritis.

Ongoing development of links with NGO's including Arthritis NZ.

- Continue current support and education of educators.
- Work in a shared care model with GP's and Arthritis NZ to ensure seamless care for patients in the community.

Work force development.

- Development of a nurse practitioner role which would allow prescribing within defined limits of anti rheumatic medications, as part of a comprehensive management programme, including specialist advice for patients discharged to their general practitioners.
- Working with allied health to promote team based role promoting specialisation.
- Promoting appropriate development of different workforce personnel e.g. specialist physiotherapists, GPs with special interests, rehabilitation assistants.
- Ongoing support, development and training for the fellow and registrar posts.
- Working with local institutions who train nursing, allied health and support staff from our local community.

Involvement in DHB health prevention initiatives.

- Health promotion especially Nutrition and Exercise (Healthy Eating, Healthy Action), Quit smoking-strong links with morbidity in rheumatological conditions, as well as causative in Rheumatoid Arthritis RA.
- Lets Beat Diabetes (strong links between diabetes and gout).
- Secondary prevention of cardiovascular disease (strong links with gout, RA, Lupus).
- Maaori responsiveness - Tikanga Best Practice.

3.0 Trends and Future Directions

- The use of biological agents, particularly in Rheumatoid Arthritis, where there is up to 50% remission with these agents, but also in seronegative spondylarthritis e.g. Ankylosing Spondylitis, Psoriatic Arthritis, with PHARMAC subsidies expected next year, and in lupus, with rituximab.
- Other high cost drugs for complications of vasculitis and connective tissue diseases e.g. bosentan for pulmonary hypertension.
- The Nurse Practitioner role-analgesic, anti-inflammatory drugs and disease modifying antirheumatic drugs lend themselves to prescribing via protocol, as well as uric acid lowering drugs in gout, proton pump inhibitors, and osteoporosis therapy. These roles would complement those currently done by the rheumatology nurse specialist.
- GP specialists, specialist physiotherapists, expansion of healthcare assistant role.
- The use of investigative tools – expanded use of MRI ,CT.
- Rehab facilities/involvement with service delivery, particularly for those under 65.
- Point of care investigation e.g. Ultrasound.

- Increasing involvement of patients in research and audit projects, including sponsored pharmaceutical research.

3.1 Future State

Rheumatology includes all forms of arthritis, including inflammatory and non-inflammatory conditions, together with life threatening conditions such as vasculitis and connective tissue disorders, such as lupus. Non inflammatory conditions, including back pain, osteoarthritis, and conditions of tendons and other soft tissues are treated at secondary care level by a variety of specialists, including orthopaedic surgeons, and physiotherapists. Inflammatory conditions, including rheumatoid arthritis, vasculitis, and connective tissue disorders (CTDs) require specialist supervision by rheumatologists, though the multisystem nature of these disorders means that other specialties are also involved. Occasionally, inpatient treatment is required for potentially life threatening episodes of care or for multidisciplinary rehabilitation where ambulatory services are insufficient. The majority are managed as outpatients or day patients, with the primary care team taking an important role of shared care between visits to specialist services. The treatments of these conditions are now sufficiently advanced that remission can be anticipated in 50% of patients with RA, and good outcomes for patients with vasculitis.

To achieve this requires complex medication regimens, including immunosuppressive drugs with the risk of infections as side effects, with the more recent and highly effective biological agents being expensive, and in some instances facilities which can provide infusions of the medication. This requires specialised medical and nursing staff to administer safely. This will also require expansion of specialty clinics, which currently include lupus and gout clinics, to include early arthritis clinics, in view of the importance of introducing Disease Modifying Antirheumatic Drugs (DMARDs) at the earliest opportunity before permanent damage to the joints occurs.

Engagement of the patient in their treatment regimen is also important, which requires education with a view to self management as much as possible, and awareness of the need to attend specialist clinics for monitoring of treatment, and escalation where required, since non-adherence has significant potential for increased morbidity and mortality, including renal failure with the need for dialysis. This is a particular issue for Maaori and Pacific patients, and a multidisciplinary team, working closely with non-governmental agencies such as Arthritis NZ, and including cultural health teams is important.

4.0 Key Directions

- ✓ *Up skilling of primary care teams, associated with credentialing, so that patient visits to specialist can be spaced more widely, though with a safety net of registers to ensure that suboptimal care is avoided, this will include telemedicine education and observational learning clinics in primary care.*
- ✓ *Telemedicine, so that virtual clinics can be performed, and direct links between patients and clinical staff, can be established.*
- ✓ *Biologicals clinics, including infusion facilities, in the community, depending on economies of scale, attached to Health Centres.*
- ✓ *Combined clinics, where appropriate, with other specialist groups e.g. renal, orthopaedic, adolescent health.*
- ✓ *A more efficient triage system, where patients with musculoskeletal and connective tissue disorders will be reviewed by a nurse and rheumatologist, and devolved to orthopaedic surgeons, pain specialists, nurse practitioners, specialist physiotherapists, rheumatologists, GPs with special interest in musculoskeletal conditions, with much of the subsequent management being in multidisciplinary teams in the community.*
- ✓ *Incorporation of clinical research and audit into everyday practice.*

All these programmes are in place in centres throughout the world, and will be developed as human and financial resources allow. The rheumatology team will have a consultative role. Access to

investigations, including point of care ultrasound, will be required in the ambulatory setting, and an increase in bed numbers is not anticipated.

We are currently operating at Level 6 according to the NSW Role Delineation Model.

3.2 Regional Considerations

- There are no particular regional considerations, in the past the use of radioactive yttrium for radiation synovectomy has meant that ADHB is required to provide the service.
- Outpatient specialist referral service is provided or Northland patients in conjunction with educational sessions for GP's.