

Arthritis in Oklahoma

OKLAHOMA STATE DEPARTMENT OF HEALTH



the Painful Truth

2004 Data Report

ARTHRITIS PREVENTION AND EDUCATION PROGRAM

Oklahoma's Vision

The Oklahoma State Department of Health, the Oklahoma Arthritis Network and the Oklahoma State Turning Point Council are inspired by our shared vision.

BUILDING HEALTHY COMMUNITIES BY...

- Increasing public awareness of arthritis as a public health problem and the leading cause of disability.
- Preventing arthritis whenever possible.
- Promoting early diagnosis and appropriate health care management for people with arthritis to ensure the maximum number of healthy life years.
- Minimizing preventable pain and disability due to arthritis.
- Supporting people affected by arthritis in developing and accessing the resources they need to cope with their disease.
- Ensuring that people affected by arthritis receive the family, peer, and community support they need.

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Subscribe to the Oklahoma Arthritis Network listserv by

Sending e-mail to OKArthritisNetwork-subscribe@yahoogroups.com

The cover art depicts our joining of all the strategies of treatment and prevention of arthritis for a healthier Oklahoma.

CONTENTS

OKLAHOMA'S VISION AND MISSION		PROSPECTIVE DATA SOURCE PHOCIS Population Based Data System	19
EXECUTIVE SUMMARY	2-3	PREVENTION AND TREATMENT	20
WHAT IS ARTHRITIS?	4	OPPORTUNITIES FOR ACTION	21
INTRODUCTION	5	PARTNERSHIP NETWORK	22
Essential Services of Public Health Logic Model	6-7	APPENDIX	23
SNAPSHOT OF OKLAHOMA Projections	8 10	A. Healthy People 2010 Objectives Arthritis, Osteoporosis, and Chronic Back Conditions (Chapter 2)	
OKLAHOMA STATE DEPARTMENT OF HEALTH Behavioral Risk Factor Surveillance Survey (BRFSS)	12	Nutrition and Overweight (Chapter 9)	
Hospital Discharge Data	15	Physical Activity and Fitness (Chapter 22)	
INDIAN HEALTH SERVICE Outpatient Clinic Data	15	B. Arthritis Foundation Arthritis Self Help Course	24
DEPARTMENT OF HUMAN SERVICES Aging Services Division	17	People with Arthritis Can Exercise (P.A.C.E.)	
		Aquatics Program	
		REFERENCES	
		Acknowledgements	



OKLAHOMA ARTHRITIS NETWORK MISSION STATEMENT

Our mission is to increase public awareness about arthritis and related conditions and to maximize the quality of life for Oklahomans affected by these conditions through the development of resources, promotion of access to appropriate health care management, and the provision of education.





EXECUTIVE SUMMARY

To increase public awareness about arthritis and related conditions and to maximize the quality of life for Oklahomans affected by these conditions through the development of resources, promotion of access to appropriate health care management, and the provision of education.

– Oklahoma Arthritis Network Mission Statement

THE PEOPLE

The Oklahoma State Department of Health, along with its many partners within the Oklahoma Arthritis Network, is working tenaciously to address the goals and objectives in the Oklahoma Arthritis Action Plan. The OAN, a statewide coalition, meets regularly to communicate work progress, learn the latest medical and public health advances, and to meet new partners to facilitate working relationships to expedite processes and maximize limited resources. Together, we are increasing arthritis surveillance and research, increasing communication and education and improving the integration of arthritis health information into programs, policies, and systems – a multilevel and multidisciplinary approach.

PREVALENCE

Arthritis affects all ages, genders, ethnicities and socioeconomic classes. With the aging of the Baby Boomers, the numbers of people affected will escalate, as will the associated disabilities.¹ In Oklahoma, 28% (726,000) of the adult population report having doctor-diagnosed arthritis, and another 17.4% (444,000) have possible arthritis.² For many of these Oklahomans, performing normal routine activities, such as work, recreation and self-care, becomes extremely difficult, in many cases due to a combination of physical symptoms and feelings of helplessness, lack of self-control and changes in self-esteem.³

COSTS

The new national estimate of arthritis costs is \$86 billion (\$51 billion in direct costs and \$35 billion in indirect costs). In Oklahoma, \$1.2 billion (\$726 million in direct costs and \$499 million in indirect costs) is expended to address the costs associated with arthritis.⁴ With more than 100 different types of arthritis, rheumatoid arthritis accounts for annual health care costs of \$17,822 for disabled employees, almost three times more than non-disabled employees with rheumatoid arthritis (\$6,131).⁵ It is these cost estimates, along with those costs that remain unreported, that impede our productivity potential and quality of life.

PREVENTION

While there is no known treatment to prevent or remedy the disease, research has produced viable methods for controlling arthritis through self-management. By way of example, this research indicates that participation in Arthritis Foundation evidence-based courses can increase self-efficacy (the feeling of self control/self confidence) by 17%, reduce pain by 19%, increase exercise by 39%, and decrease physician visits by 43%.⁶ This is an estimated savings of \$320 per person over four years.⁷ Unfortunately, this invaluable information has largely gone untapped. Oklahoma must now seize upon the opportunity to tap this underutilized resource.

SOLUTIONS

Working together to train individuals to implement and administer these community-based programs will reap immediate benefits. While education is an essential step in seeking and securing a solution, many more steps remain. The Oklahoma Arthritis Action Plan describes these strategic, solution-producing steps. In reviewing this report, you will see that the old adage, “no pain, no gain,” holds no truth in Oklahoma. Oklahoma will gain by taking action in helping fellow Oklahomans reduce their pain resulting from arthritis.

*S. Marisa New, OTR, MPH
Arthritis Prevention and Education Program
Oklahoma State Department of Health*



WHAT IS ARTHRITIS?

Arthritis is the leading cause of disability.

Literally, the word “arthritis” means inflammation of the joint. For the purpose of this document, arthritis includes more than 100 different types of rheumatic conditions that are characterized by pain, stiffness and sometimes swelling in or around the joints (not all conditions cause inflammation). Some forms of arthritis can even lead to kidney disease, blindness and premature death. Arthritis can be categorized into non-inflammatory joint diseases (e.g., osteoarthritis), inflammatory joint diseases (e.g., rheumatoid arthritis), soft tissue disorders (e.g., fibromyalgia) and connective tissues disorders (e.g., lupus) or better known as autoimmune diseases.

*“truth
Arthritis trails
only heart
disease as a
cause of work
disability.”⁸*

Arthritis affects all ages, genders, races, ethnicities and socioeconomic classes. Many of our older populations have a higher prevalence of arthritis, but it doesn’t diminish the fact that over 300,000 children are diagnosed with forms of arthritis, such as juvenile rheumatoid arthritis.

Arthritis untreated can cause pain and premature disability. Consequently, it is found to be the leading cause of disability and the second leading cause of work disability in the United States.⁸ People with arthritis experience more physical and occupational limitations, have more financial difficulties, are less satisfied with their current circumstances, and less optimistic about their future.⁹

In 2001, an estimated 49 million Americans over the age of 18 had doctor-diagnosed arthritis, and 21 million more adults may possibly have the disease.¹⁰ With upwards of one-third of our adult population having to live with this incurable disease, the consequences of ignoring this truth may prove to be the ultimate source of pain.

INTRODUCTION

10 Essential Services of Public Health

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and actions to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure a competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health services.

This report provides data depicting the prevalence of arthritis in Oklahoma. Partners within the Oklahoma Arthritis Network have submitted data reflecting how many Oklahomans are living with arthritis. These numbers reinforce the need to follow the Oklahoma Arthritis Action Plan to minimize disability and maximize the abilities of our strongest asset – the people of Oklahoma.

The Oklahoma State Department of Health (OSDH) focuses on providing services that protect the health of the public at large – 10 Essential Services of Public Health. Overcoming the numerous challenges faced by people with arthritis cannot be addressed by a single organization. It takes many organizations to embrace the challenges. Within the Oklahoma Arthritis Network, the OSDH Arthritis Prevention and Education Program partners with others to develop and implement strategies to accomplish the goals, objectives and strategies within the Oklahoma Arthritis Action Plan. Our coordinated public health approach is reflected in the following logic model.



Logic Model

Action Plan Components

Process

Increase Communication
and Education

Increase coordination of activities related to arthritis and related conditions throughout Oklahoma

Raise community awareness about arthritis and related conditions

Increase the integration of arthritis-related conditions within medical and allied health education programs and professional associations

Increase number of CME/CEU course offered in Oklahoma

Increase number of arthritis prevention programs available in the community

Provide surveillance and cost benefit analyses related to arthritis prevention activities

Establish state funded APEP within OSDH

Identify operational, reimbursement and medical service opportunities within the Oklahoma public health system

Develop cultural/language specific strategies for the Native American population and one other ethnic group where arthritis and related conditions are highly prevalent

Expand Surveillance and
Research

Develop a reference guide of standardized arthritis related terminology used in different settings

Develop and utilize a coordinated arthritis database

Expand BRFSS to include more arthritis-related questions

Integrate arthritis and related conditions into community wellness assessments

Increase surveys of health professional knowledge about arthritis and related conditions

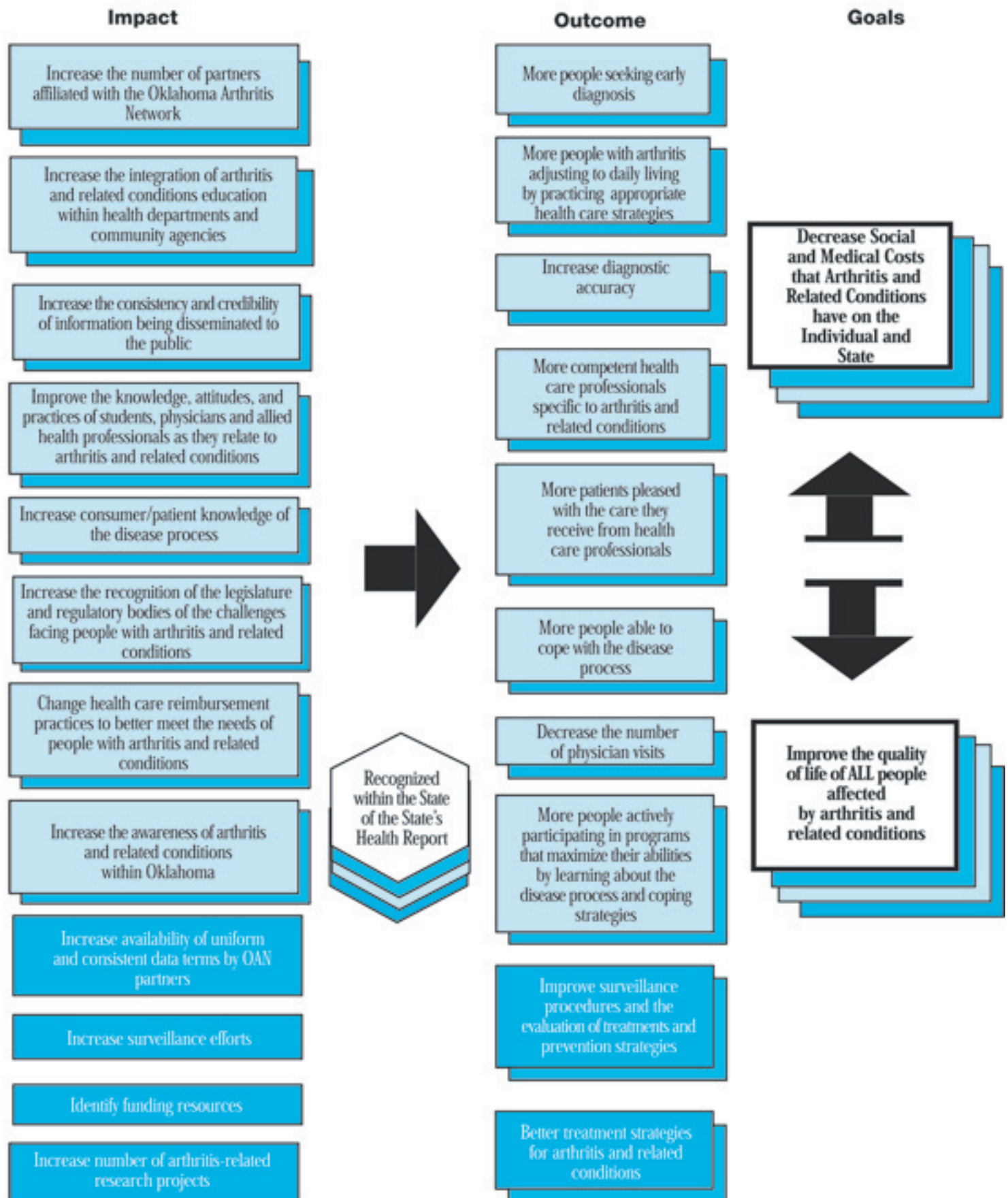
Increase analyses of hospital discharge records, workers compensation, and other health care data

Introduce information into the State of the State's Health Report

Conduct Evaluation/
Re-evaluation
Activities



Logic Model



SNAPSHOT OF OKLAHOMA

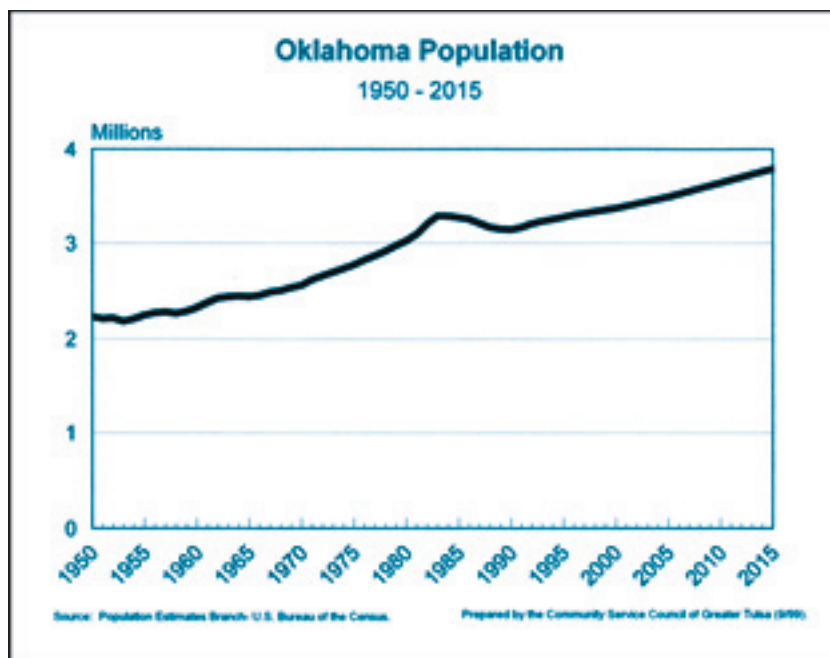
Oklahoma with its 77 counties covers 69,919 square miles and ranks 18 in the nation in size.¹¹

- According to 2000 US Census, Oklahoma's population is 3,450,654 with [from a single race] 76.2 % White, 7.6% African American or Black, 7.9% American Indian and Alaska Native, 1.4% Asian, 1% Native Hawaiian and other Pacific Islander and 5.2% Hispanic or Latino [of any race]. Seventy four percent are 18 years of age or older.

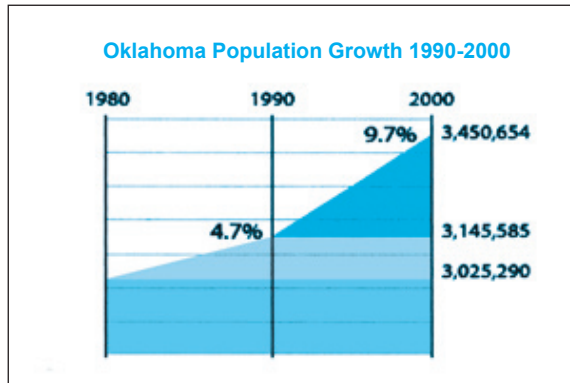
truth

The Public Health Challenge is identifying and implementing strategies for improving the health of an entire population.³

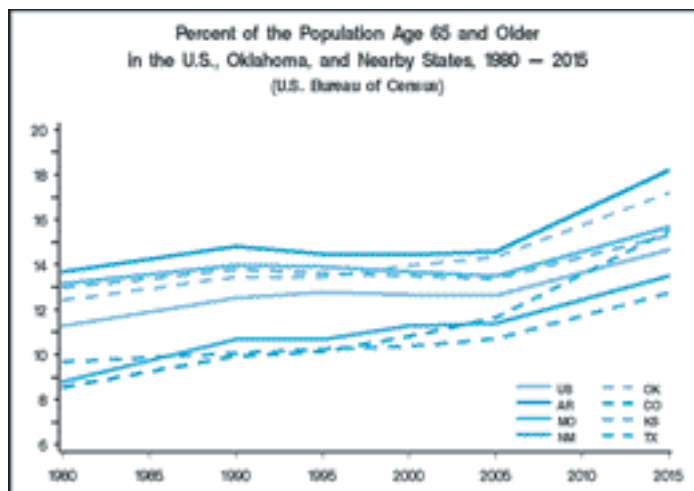
-National Arthritis Action Plan



- Oklahoma grew 9.7 percent since 1990, more than double its growth over the previous 10 years. (US Bureau of the Census, 2000)



- Oklahoma ranks 27th in the nation in population Oklahoma has more American Indians than any other state. (Oklahoma Department of Tourism and Recreation)
 - * Thirty-nine of the American Indian tribes currently living in Oklahoma are headquartered in the state.
 - * Oklahoma has the largest American Indian population of any state. Many of the 252,420 American Indians living in Oklahoma today are descendents from the original 67 tribes inhabiting Indian Territory.
- People of Latin origin more than doubled from 1990 to 2000, from 86,160 to 179,304. (US Bureau of the Census, 2000)
- Oklahoma's overall health ranking declined from 31st in 1990 to 45th in 2003. (United Health Foundation)



SNAPSHOT OF OKLAHOMA

PROJECTIONS

The racial and ethnic minorities in Oklahoma are expected to reach 50% of the Oklahoma population by 2010-2015.
- Health Care Rx: Access For All, The President's Initiative on Race 1998.

* The number of Americans age 65 and older who have arthritis or chronic joint symptoms is projected to nearly double from 21.4 million in 2001 to 41.4 million in 2030 as the population ages. -CDC, 2001 BRFSS

* In 2025, the projected number and percentage of Oklahomans age 65 years and older with arthritis or chronic joint symptoms will be 193,000 or 55.6% of this population. -CDC, 2001 BRFSS

* In Oklahoma, there are 42 Health Professional Shortage Areas (HPSAs). *Self-management programs* are necessary due to the number of HPSAs and lack of primary care services available for arthritis and other chronic conditions.

Self-management interventions

The Arthritis Self-Help Course (ASHC) developed by Stanford University and sponsored by the Arthritis Foundation. ASHC has proven to reduce arthritis-related pain by 20% while also reducing physician visits by 40%¹⁴ making it a highly cost-effective public health intervention.

In 2003, there were eight Arthritis Self Help Courses conducted in Oklahoma. More women than men participated. Of those who identified race, the majority were white with about 11 percent identified as Native Americans.

The participants' ages ranged from 31 to 81 years, with a median age of 70.5 years. Two-thirds of the participants were married, 23 percent were widowed, 8 percent were divorced or separated, and 2 percent were single and had never married.

Participants reported health problems that included arthritis (100 participants; 90 percent of participants), hypertension (55; 50 percent), heart disease (12; 11 percent), diabetes (11; 11 percent), lung disease (6; 5 percent), and anemia (5; 5 percent). [Other health problems were mentioned by individuals; these were the only problems that more than one participant reported.]

“truth

Older adults 65 years of age or older have the highest risk of arthritis, 58.8%, but two-thirds of all people with arthritis are younger than age 65.

-CDC, 2004



“truth

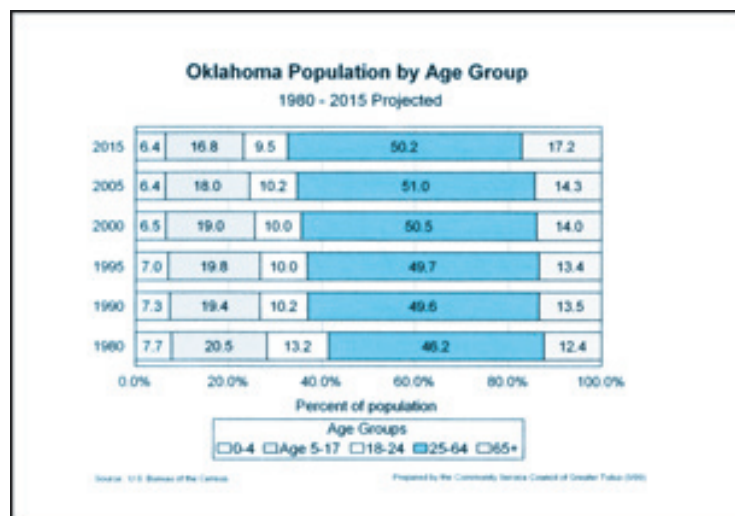
Participants' median level of education was 12 years. Eight participants reported having less than a high school education, and a few reported at least some college. Most participants reported annual household income of \$30,000 or less.

Most (58 percent) participants were retired. Nineteen percent were homemakers, 13 percent were employed for wages, and 9 percent were disabled or unable to work.

These courses were held in Adair, Caddo, Canadian, Logan, Oklahoma, Stephens, Tulsa and Woodward counties.

More leaders need to be trained. More ASHCs need to be offered in communities statewide. What is available is literally few and far between in number when looking at how many people live with this chronic disease. Partnerships will increase collaborative efforts necessary to implement and sustain these programs.

The rate of arthritis and its associated disabilities is higher among persons with low education and low income.^{15, 16, 17}



As Oklahoma's makeup changes and the minority populations increase in size, we will find more Oklahomans at risk. Higher percentages of minority populations have no health insurance, according to the *Health Care Rx: Access for all the President's Initiative on Race, 1998*. They make half as many physician visits for preventive health. Research on health responses to specific diseases and interventions by race are underfunded. It is these unique issues affecting the uninsured, the underinsured, the poor, the disabled, the poorly educated, the unskilled workforce, minority populations and other vulnerable groups that must be understood and addressed.³



OKLAHOMA STATE DEPARTMENT OF HEALTH

BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY (BRFSS)

PURPOSES AND METHODS

The Behavioral Risk Factor Surveillance System (BRFSS) is a telephone survey that is conducted annually to track health status, health behavior, and risk factors in the United States. The survey randomly selects about 2,000 telephone numbers per month, and attempts to reach each number up to 15 times. The calls are made Monday through Friday from 11:00 AM until 4:00 PM, and from 5:00 until 9:00 PM, and on Saturday between 9:00 AM and 1:00 PM. In 2002, 6773 Oklahomans completed surveys. To arrive at accurate estimates for the state of Oklahoma, responses from the survey's participants are weighted according to the probability that a specific telephone number is selected, and by the number of adults and number of telephones in the household. The weighting also adjusts for the survey's inability to include households without telephones.

Government agencies and other health officials use the survey's information to improve the health of the American people. When BRFSS began in 1984, fifteen states collected data. Oklahoma joined the program in 1989 and, by 1996, residents of all 50 states, the District of Columbia, Puerto Rico, Guam, and the US Virgin Islands participated in the annual BRFSS surveys. Models are now being developed internationally for Scotland, China and Australia.

The section of this data report that concerns the BRFSS focuses on responses to the six questions that comprise its Arthritis Module. The module was introduced in four states (Arizona, Georgia, New Jersey, and Ohio) in 1998. In 1999, Oklahoma and six other states (Georgia, Louisiana, Mississippi, Missouri, Nebraska, and West Virginia) and Puerto Rico began collecting the Arthritis Module data. In 2000, 37 additional states began

BRFSS ARTHRITIS MODULE

Oklahomans were classified as having "physician-diagnosed arthritis" if they answered "yes" to the following:

Question 4: Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?

Oklahomans were classified as having "possible arthritis" if they answered "no" to the previous question, but "yes" to both of the next two questions. [The two questions refer to the joints, excluding the back or neck.]

Question 1: DURING THE PAST 30 DAYS, have you had any symptoms of pain, aching, or stiffness in or around the joint?

Question 2. Did your joint symptoms FIRST begin more than 3 months ago?

The Arthritis module also included:

Question 3. Have you EVER seen a doctor or other health professional for these joint symptoms?

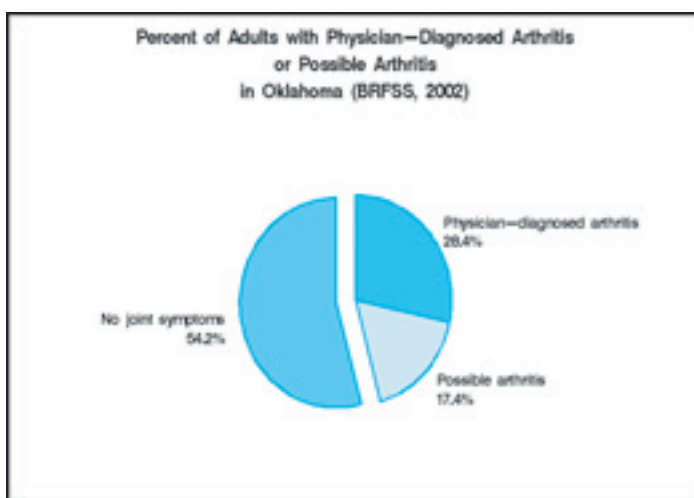
Question 5. Are you now limited in any way in any of your usual activities because of arthritis and joint symptoms?

Adults of working age (18-64) were also asked the following about work for pay:

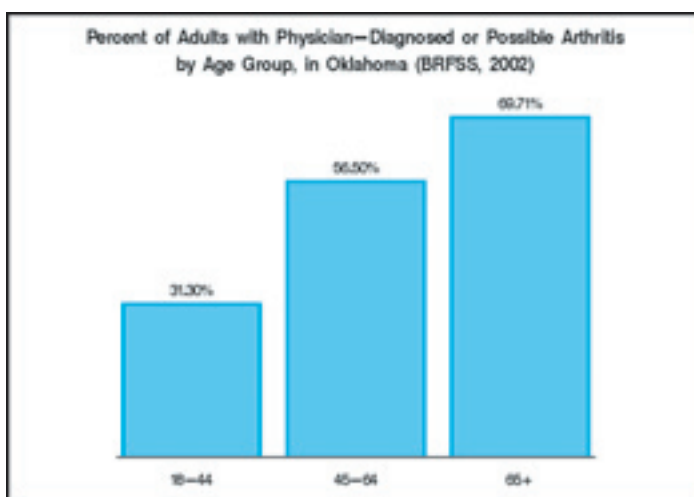
Question 6. Do arthritis or joint symptoms now affect whether you work, the type of work you do, or the amount of work you do?

BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY (BRFSS)

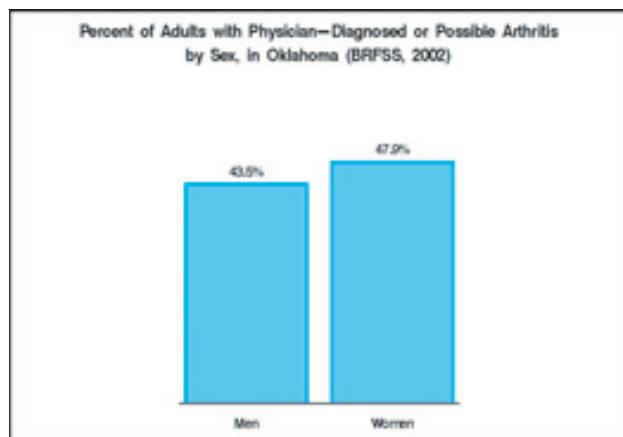
28.4% OF ADULT OKLAHOMANS HAVE BEEN
DIAGNOSED WITH ARTHRITIS



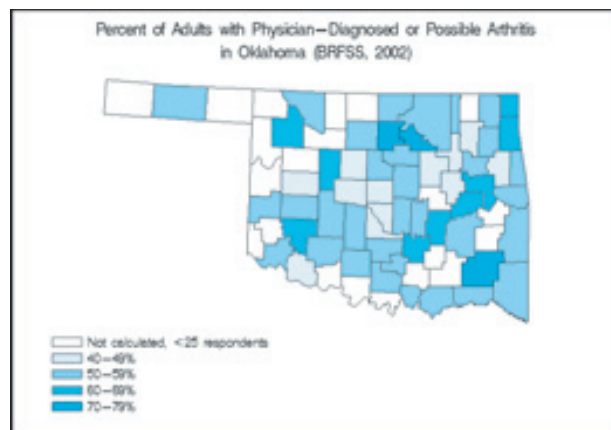
RISK INCREASES WITH AGE



MORE WOMEN THAN MEN ARE AFFECTED



ARTHRITIS PREVALENCE BY COUNTY*

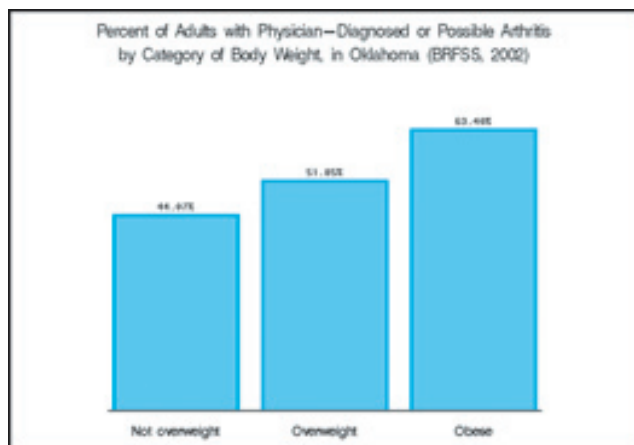


* Derived from raw, unweighted responses to the BRFSS survey.

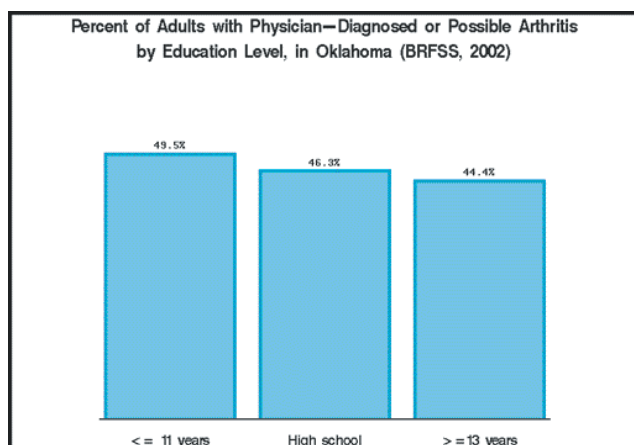


BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY (BRFSS)

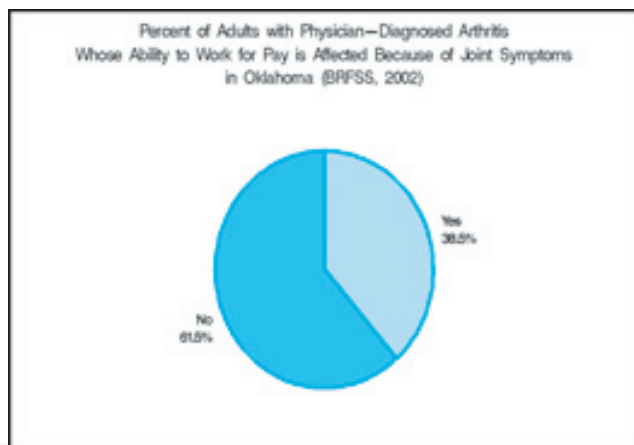
RISK INCREASES WITH WEIGHT GAIN*



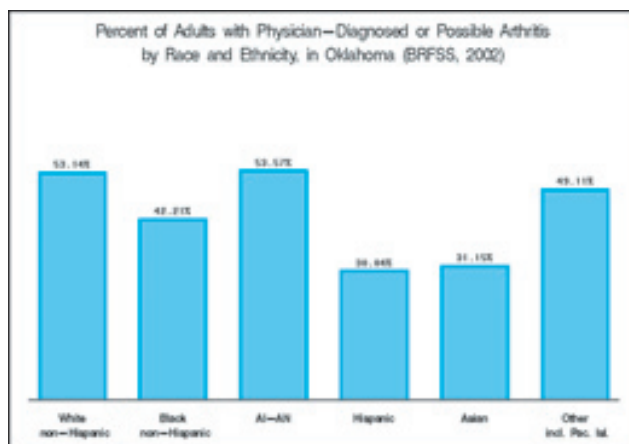
EDUCATION



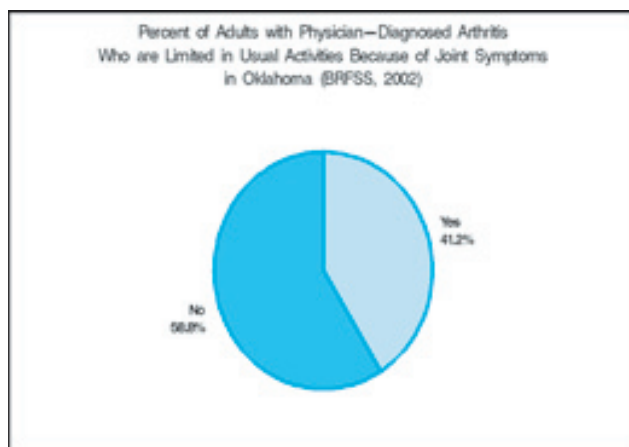
WORK FOR PAY - DO ARTHRITIS OR JOINT SYMPTOMS NOW AFFECT WHETHER YOU WORK, THE TYPE OF WORK YOU DO, OR THE AMOUNT OF WORK YOU DO?



RACE AND ETHNICITY*



ARE YOU NOW LIMITED IN ANY WAY OF YOUR USUAL ACTIVITIES BECAUSE OF ARTHRITIS OR JOINT SYMPTOMS?



* Derived from raw, unweighted responses to the BRFSS survey.

HOSPITAL DISCHARGE DATA

PURPOSES AND METHODS

The Oklahoma Health Care Information System Act (OS 63, Section 1-115 et seq) created an information system for the State of Oklahoma. The Act called for the collecting, processing, and disseminating of health care data so that policy-makers can better understand patterns and trends in the:

1. health status of Oklahomans;
2. utilization and costs of health care services; and
3. capacity of Oklahoma's health care industry to provide needed services.

The Oklahoma Health Care Information System Act mandates the collection of discharge data from inpatient facilities licensed by the state. To comply with this mandate, the Oklahoma State Department of Health created the Oklahoma Hospital Inpatient Discharge Data System (HIDDS) and began collecting data in 1998. Because the legislation applies only to licensed facilities, data from Indian Health Service and military and veterans' facilities are not part of the record. To facilitate hospital participation, the HIDDS uses existing fields in the Uniform Billing Form (UB-92). These fields include diagnoses (using codes from the ICD-9), total charges, and length of stay.

FINDINGS RELATED TO ARTHRITIS

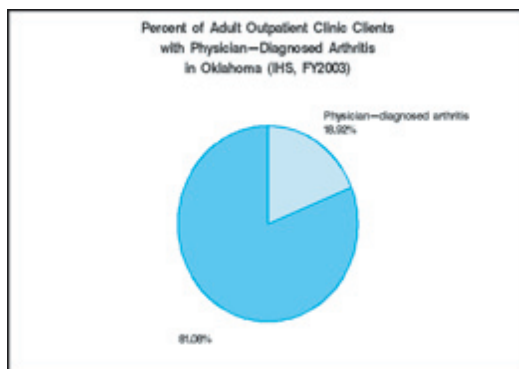
- The Oklahoma HIDDS for 2000 recorded over 265,000 hospital admissions. The median length of stay was three days and the median hospital charges, among those admissions for which the data are available, was \$6150.
- Hospital Admissions where arthritis was the patient's primary or secondary diagnosis numbered 2249. The admissions resulted in a median length of stay of three days, and median charges of \$7120.

INDIAN HEALTH SERVICE (IHS)

OUTPATIENT CLINIC DATA

PURPOSES AND METHODS

The Indian Health Service or tribes within Oklahoma operate seven hospitals and 36 ambulatory clinics. These facilities abstract all hospital admissions and ambulatory patient visits into a statewide statistical record. The Indian Health Service shares statistical summaries on specific disease entities with the Oklahoma State Department of Health. The database includes information on patient diagnoses using codes from the ICD-9. These codes were used to determine the percentage of Indian Health Service clients whose physicians specifically diagnosed them with a form of arthritis, and to calculate the percentage of clients for whom arthritis is a primary or secondary diagnosis.



INDIAN HEALTH SERVICE

OUTPATIENT CLINIC DATA

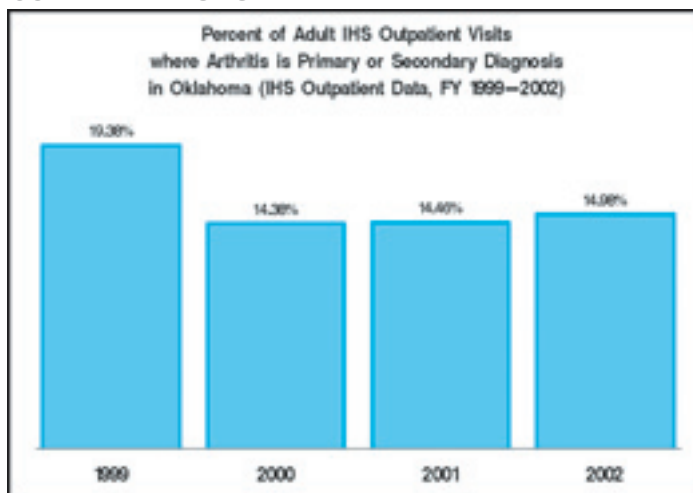
MORE WOMEN THAN MEN ARE AFFECTED



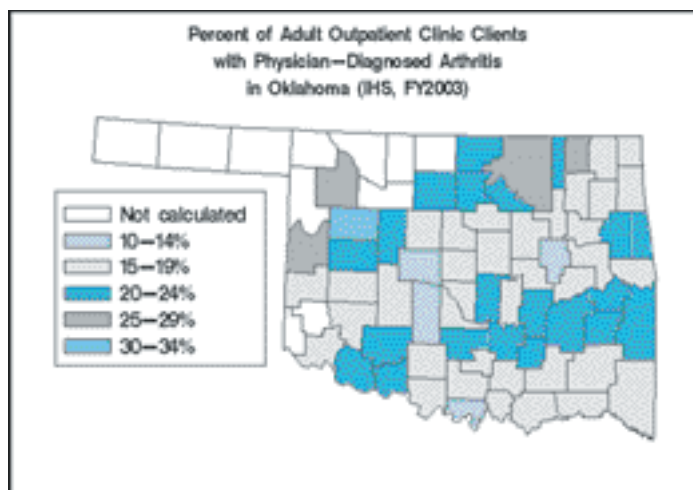
RISK INCREASES WITH AGE



OUTPATIENT VISITS



PHYSICIAN - DIAGNOSED ARTHRITIS



DEPARTMENT OF HUMAN SERVICES (DHS), AGING SERVICES DIVISION

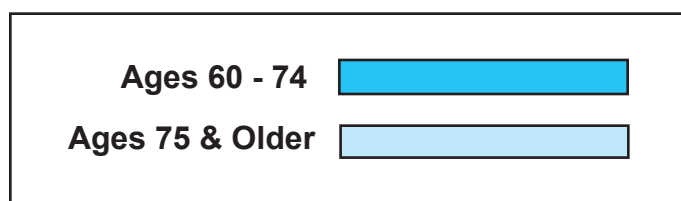
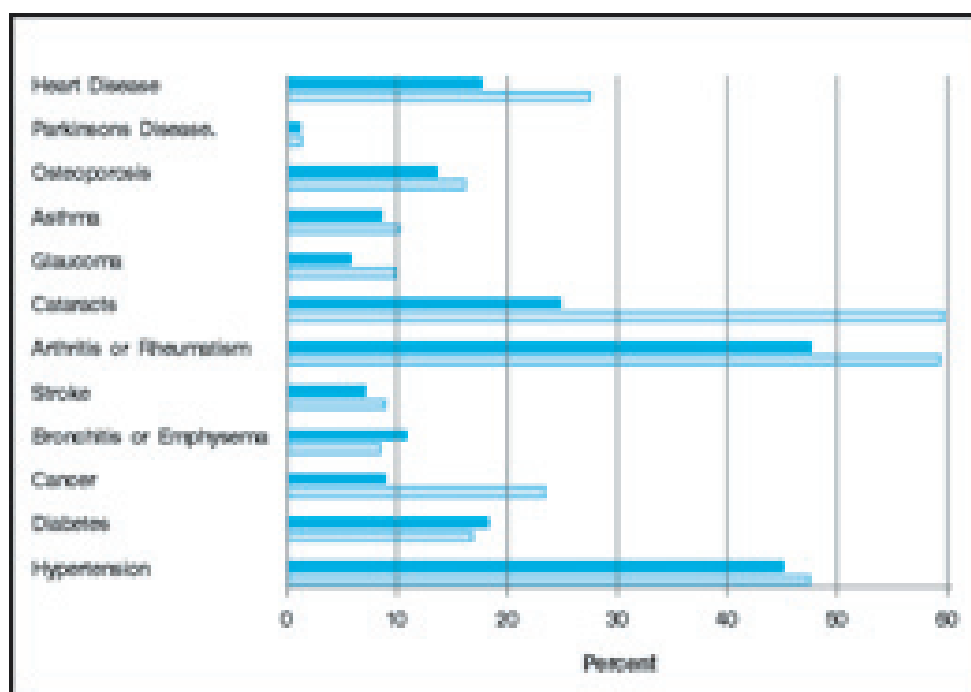
STATEWIDE SURVEY OF OLDER OKLAHOMANS

PURPOSES AND METHODS

A telephone survey of Oklahomans 60 years of age and older was completed during the period from November 12, 2001, through January 15, 2002, by trained, supervised interviewers at the University of North Carolina (UNC) Urban Institute Community and Research Services Division. The UNC Charlotte contractor designed the survey questions in conjunction with Oklahoma DHS Aging Services Division staff. Cases were selected so that there were approximately 150 individuals per planning and service area (PSA), with the sex distribution in each PSA reflecting the actual sex distribution of the PSA's older residents. A weighting procedure was employed to more accurately reflect Oklahoman's older population. The survey revealed:

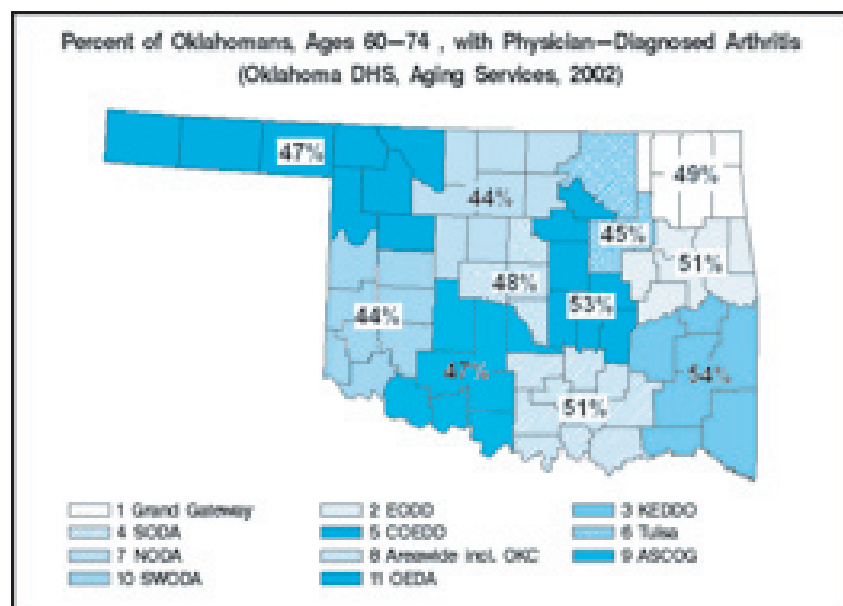
ARTHRITIS/RHEUMATISM LEADS IN PREVALENCE WITH SENIORS AGE 60+

(DHS, 2002)



DHS AGING SERVICES DIVISION

AGES 60 - 74



AREA AGENCIES ON AGING

GRAND GATEWAY

Area No. 1 serving Craig, Delaware, Mayes, Nowata, Ottawa, Rogers and Washington counties.

EODD AREA

Area No. 2 serving Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah and Wagoner counties.

KEDDO AREA

Area No. 3 serving Choctaw, Haswell, Latimer, LeFlore, McCurtain, Pittsburg, and Pushmataha counties.

SODA AREA

Area No. 4 serving Atoka, Bryan, Carter, Coal, Garvin, Johnston, Love, Marshall, Murray and Pontotoc counties.

COEDD AREA

Area No. 5 serving Hughes, Lincoln, Okfuskee, Pawnee, Payne, Pottawatomie and Seminole counties.

TULSA AREA

Area No. 6 serving Creek, Osage and Tulsa counties.

NODA AREA

Area No. 7 serving Alfalfa, Blaine, Garfield, Grant, Kay, Kingfisher, Major and Noble counties.

AREAWIDE AGING AGENCY, INC

Area No. 8 serving Canadian, Cleveland, Logan, and Oklahoma counties.

ASCOG AREA

Area No. 9 serving Caddo, Comanche, Cotton, Grady, Jefferson, McClain, Stephens and Tillman counties.

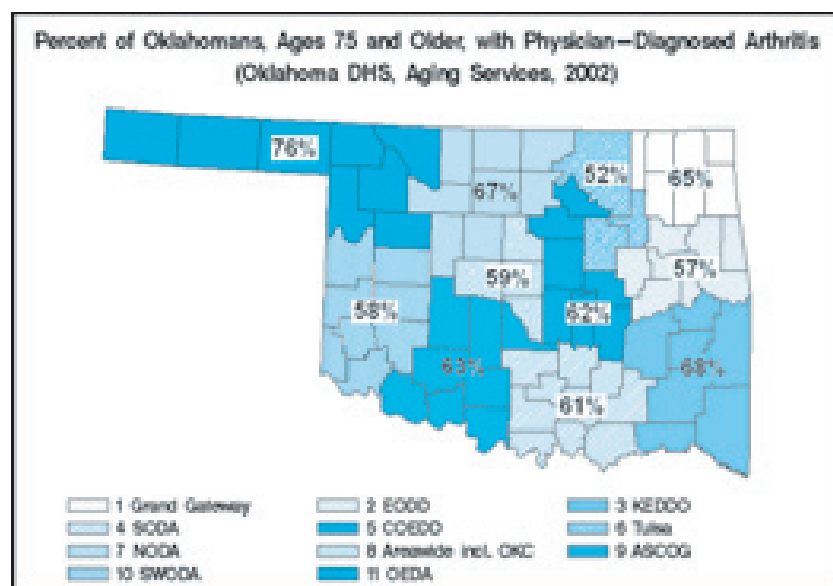
SWODA AREA

Area No. 10 serving Beckham, Custer, Greer, Harmon, Kiowa, Jackson, Roger Mills and Washita counties.

OEDA AREA

Area No. 11 serving Beaver, Cimarron, Dewey, Ellis, Harper, Texas, Woods and Woodward counties.

AGES 75 AND OLDER



PROSPECTIVE DATA SOURCE

PHOCIS POPULATION BASED DATA SYSTEM

The Oklahoma State Department of Health (OSDH) is developing a public health Oklahoma client information system (data collection) called PHOCIS that compiles population-based services delivered by OSDH employees. Information is gathered through creation of electronic encounter and outcome records completed by OSDH employees. The encounter and outcome records are attached to a demographic record for identified customers. The customers in this system will include schools, day care centers, hospitals, other government organizations, civic and business groups as well as task forces and other outside committees to which our staff provide a service. A number of pre-determined reports will be available for agency managers and others.

An employee creates an Outcome Record whenever significant effort has been expended in a population based activity. Outcome Records may also be created to emphasize activities or to track the results of a special project. The Outcome Record is associated with specific Encounter Records, which are linked by a common topic.

The Outcome Record consists of two main parts: Goals and Results. A Goal may be entered and saved prior to the inclusion of the Results or the entire Outcome Record may be created in one session. In some instances, the Goal may be recorded as 'No Goal Identified'.

Both the Goal and the Results consist of a narrative outlining the primary points of interest as seen from the employee's perspective. These may include such topics as lessons learned and obstacles overcome. The Outcome Record is intended to provide insight and guidance for other staff, programs or the agency in general. It is also intended to be a source of information for creation of grants. Program areas are encouraged to provide guidance to their staff as to the format used in the narrative.

“truth

Effective arthritis strategies exist, yet few have been implemented fully.³

”



PREVENTION AND TREATMENT³

Primarily prevention is designed to prevent a disease or condition from occurring in the first place. Only a few primary prevention strategies are considered effective for arthritis. Primary prevention strategies include:

- Weight control
- Occupational injury prevention such as from repetitive joint use
- Sports injury prevention
- Infectious disease control

“truth

Medication, self-management education, physical activity, and surgery are four effective treatment strategies that can make a difference.³

Secondary prevention efforts attempt to identify a disease at its earliest stages so that prompt and appropriate management can take place. The focus is on reducing the impact of the disease. Secondary prevention strategies include: early diagnosis - many people never see a doctor for their arthritis.

Medical treatment - for example, early use of disease modifying anti-rheumatic drugs (DMARDS) for rheumatoid arthritis can improve long-term health outcomes.

Tertiary prevention focuses on reducing or minimizing the consequences of a disease once it has started. The goal is to eliminate or delay the onset of complications and disability. Tertiary prevention strategies include: self-management including weight control and physical activity; education such as the Arthritis Self Help Course, PACE and Aquatics programs; rehabilitation services such as occupational therapy or physical therapy; and medical and surgical treatments such as DMARDS and joint replacement therapy.

In order to meet the needs of those living or affected by arthritis with the resources available, the focus of our public health efforts is on secondary and tertiary prevention.

With the resources available, we are taking a secondary and tertiary public health prevention approach in order to meet the needs of those living with, and affected by arthritis.

OPPORTUNITIES FOR ACTION

THE ARTHRITIS PREVENTION AND EDUCATION PROGRAM works with the Arthritis Foundation to address arthritis issues in Oklahoma. This Oklahoma State Department of Health (OSDH) program was established in 1999 with funding from the Centers for Disease Control and Prevention. Soon after, a statewide coalition was formed bringing together the Arthritis Foundation, the state health department, universities, non-profit agencies, businesses, consumers and many others who have continued to meet monthly to complete the development of the Oklahoma Arthritis Action Plan and initiate its implementation in 2001.

“truth

A variety of demographic trends indicate that the impact of arthritis will only increase.¹⁸

”

ARTHRITIS FOUNDATION¹³ The mission of the Arthritis Foundation is to improve the lives through leadership in the prevention, control and cure of arthritis and related diseases. The Oklahoma and Eastern Oklahoma Chapter consists of two volunteer offices in the state. Each regional office has an executive director and a program director. The regional offices provide public and professional education, awareness opportunities, and patient programs. In addition, fundraising efforts of the Arthritis Foundation help support research on arthritis and related conditions.

The Arthritis Foundation and the OSDH Arthritis Prevention and Education Program have collaborated to promote arthritis awareness; to build the infrastructure of self management leaders needed for the evidence-based PACE, Aquatics and Arthritis Self-Help Courses; and to promote the availability of arthritis community education and exercise.

Self-management includes everything people with arthritis do to help control their pain and improve their quality of life, from pain medications to exercise, stretching, nutrition, and relaxation. By engaging in a variety of self-management activities, people with arthritis can significantly reduce pain and disability.

Numerous studies have been conducted to validate outcomes from evidence-based programs such as those sponsored by the Arthritis Foundation - Arthritis Self Help Course, Aquatics and the PACE programs. [see APPENDIX for descriptions]



PARTNERSHIP NETWORK



OKLAHOMA ARTHRITIS NETWORK STATE RESOURCES

ARTHRITIS FOUNDATION

Oklahoma Chapter

3232 W. Britton Road, Suite 200
Oklahoma City, OK 73120
(405) 936-3366, (800) 627-5486
www.arthritis.org

Eastern Oklahoma Chapter

4520 S. Harvard #100
Tulsa, OK 74135
(918) 743-4526
www.arthritis.org

OKLAHOMA LUPUS ASSOCIATION

3131 N. MacArthur, Suite 106B
Oklahoma City, OK 73122
(405) 495-8787
www.oklupus.com

OKLAHOMA STATE

DEPARTMENT OF HEALTH

Arthritis Prevention and Education Program
1000 NE 10th St.
Oklahoma City, OK 73117
(405) 271-6127, FAX (405) 271-1225
www.health.state.ok.us/program/apec

NATIONAL RESOURCES

CENTERS FOR DISEASE CONTROL AND PREVENTION

4770 Buford Highway
MS K-51
Atlanta, GA 30341-3724
(770) 488-5464
www.cdc.gov/nccdphp/arthritis/index.htm

ARTHRITIS FOUNDATION AND AMERICAN JUVENILE ARTHRITIS FOUNDATION

1330 West Peachtree St.
Atlanta, GA 30309
(404) 872-7100 or (800) 283-7800
www.arthritis.org

LUPUS FOUNDATION OF AMERICA

1300 Piccard Dr., Suite 200
Rockville, MD 20850-4303
(301) 670-9292 or (888) 385-8787
www.lupus.org

AMERICAN AUTOIMMUNE RELATED DISEASES ASSOCIATION

22100 Gratiot Ave.
E. Detroit, MI 48021
(586) 776-3900

NATIONAL INSTITUTE OF ARTHRITIS AND MUSCULOSKELETAL & SKIN DISEASES

Bldg. 31/Room 4C02
31 Center Drive, MSC 2350
Bethesda, MD 20892-2350
(301) 496-8190
www.nih.gov/niams

NATIONAL FIBROMYALGIA RESEARCH ASSOCIATION

PO BOX 500
Salem, OR 97308
(503) 588-1411 or (800) 574-3468
www.teleport.com-nfra

AMERICAN COLLEGE OF RHEUMATOLOGY

1800 Century Place, Suite 250
Atlanta, GA 30345
(405) 633-3777
www.rheumatology.org

APPENDIX A

HEALTHY PEOPLE 2010 OBJECTIVES¹²

ARTHRITIS, OSTEOPOROSIS, AND CHRONIC BACK CONDITIONS (CHAPTER 2)

1. (Developmental) Increase the mean number of days without severe pain among adults who have chronic joint symptoms.
2. Reduce the proportion of adults with chronic joint symptoms who experience a limitation in activity due to arthritis.
3. Reduce the proportion of all adults with chronic joint symptoms who have difficulty in performing two or more personal care activities, thereby preserving independence.
4. (Developmental) Increase the proportion of adults aged 18 years and older with arthritis who seek help in coping if they experience personal and emotional problems.
5. Increase the employment rate among adults with arthritis in the working-age population.
6. (Developmental) Eliminate racial disparities in the rate of total knee replacements.
7. (Developmental) Increase the proportion of adults who have seen a health care provider for their chronic joint symptoms.
8. (Developmental) Increase the proportion of person with arthritis who have had effective, evidence-based arthritis education as an integral part of the management of their condition.
9. Increase the proportion of persons with systemic rheumatic disease who receive an early specific diagnosis and appropriate management plan.
10. Increase the proportion of hospitals, managed care organizations, and large group practices that provide effective, evidence-based arthritis education for patients to use as an integral part of the managed of their condition.
11. Increase the proportion of person at risk for who have arthritis that receive counseling from their health care provider about weight control and physical activity to prevent arthritis-related disabilities.

**Related objectives from other focus areas
(persons with arthritis are a targeted subgroup).**

NUTRITION AND OVERWEIGHT (CHAPTER 9)

1. Increase the proportion of adults who are at a healthy weight.
2. Reduce the proportion of adults who are obese.

PHYSICAL ACTIVITY AND FITNESS (CHAPTER 22)

1. Reduce the proportion of adults who engage in no leisure-time physical activity.
2. Increase the proportion of adults who engage regularly, preferably daily, in moderate physical activity for at least 30 minutes per day.
3. Increase the proportion of adults who engage in vigorous physical activity that promotes the development and maintenance of cardiorespiratory fitness three or more days per week for 20 or more minutes per occasion.



APPENDIX B - ARTHRITIS FOUNDATION EVIDENCE-BASED PROGRAMS¹³

ARTHRITIS SELF-HELP COURSE (ASHC)

For people with arthritis or fibromyalgia, living the most active life with the least amount of pain, fatigue and disability involves becoming an active partner in your arthritis care. This means working with your health-care providers as well as learning how to manage your arthritis on a day-to-day basis. The Arthritis Self-Help Course is designed to help you learn and practice the different skills needed to build your own individualized self-management program, and gain the confidence to carry out this program.

The ASHC is a group education program designed to complement the professional services provided by your health-care team. Trained volunteers, many of whom have arthritis or fibromyalgia, lead the courses. The course allows you to share experiences with others, offering you the opportunity to both help and learn from people like yourself. The Arthritis Self-Help Course is designed to identify and teach you the latest pain management techniques, help you develop your own individualized exercise program, help you learn to manage fatigue and stress more effectively, discuss the purposes and effective use of medications, help you find solutions to problems caused by your arthritis, identify ways to deal with anger, fear, frustration and depression, discuss the role of nutrition in arthritis management, help you learn new ways to communicate with family and friends and teach you how to form a partnership with your health-care team. Past participants of the Arthritis Self-Help Course have experienced such benefits as increased knowledge about their arthritis, increased frequency of exercise and relaxation, increased self-confidence, decreased depression, decreased pain, and decreased physician visits. Studies have shown that ASHC participants have reported a 20% reduction in pain and arthritis-related doctor visits decreased by 40%.

PACE® (PEOPLE WITH ARTHRITIS CAN EXERCISE)

For many years it was thought that people with arthritis and related conditions shouldn't exercise because it would damage their joints. Today, however, doctors and therapists know that moderate physical activity can improve your health without hurting your joints. With this in mind, the Arthritis Foundation introduced PACE® (People with Arthritis Can Exercise).

PACE® is an exercise program designed specifically for people with arthritis that uses gentle activities to help increase joint flexibility and range of motion and to help maintain muscle strength. It also helps increase overall stamina. Because there are many different types of arthritis and related conditions, levels of fitness, and degrees of limitation, two levels of PACE® classes are available - basic and advanced.

Instructors who have undergone a special Arthritis Foundation instructor-training workshop conduct classes. The exercises you learn in the PACE® program, however, should not replace therapeutic exercises prescribed for you by a therapist.

Participants previously enrolled in the PACE® program have experienced such benefits as increased functional ability, increased self-care behaviors, decreased pain and decreased depression.

ARTHRITIS FOUNDATION AQUATIC PROGRAM (AFAP)

If you have a form of arthritis or a related condition, your physician may recommend that you begin an exercise program to help improve your flexibility and decrease pain. If you're searching for a program that will lessen joint stiffness, increase your stamina and still be fun, aquatic exercise may be the answer for you.

Water is a safe, ideal environment for relieving arthritis pain and stiffness. That's why the Arthritis Foundation offers its Aquatic Program, designed to safely keep your joints moving and improve your sense of well-being. The Arthritis Foundation Aquatic Program (AFAP) is a water exercise program designed for people with arthritis and related conditions. Water exercise is especially good for people with arthritis, because it allows you to exercise without putting excess strain on your joints and muscles.

The AFAP gives you the opportunity to do gentle activities in warm water, with guidance from a trained instructor. Although it is a nonclinical program (one that will not replace a prescribed regimen of therapeutic exercise), past participants have enjoyed some physical benefits such as decreased pain and stiffness. The AFAP also provides a friendly and supportive atmosphere in which you can make new friends and try new activities. This social interaction can help decrease feelings of depression and isolation. Progress in the aquatic activities can lead to independence and improved self-esteem.

Co-developed by the Arthritis Foundation and the Young Men's Christian Association (YMCA), the AFAP is offered in pools throughout the United States. When the program is offered in a YMCA pool facility, it is called the Arthritis Foundation YMCA Aquatic Program or AFYAP. The program is available in non-YMCA facilities as well.

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