Understanding Function in RA: The Nurse's Role in Patient Evaluation

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The current “treat to target” approach to rheumatoid arthritis incorporates an intensive, individualized management algorithm that includes an expanded role for the rheumatology nurse.

ABSTRACT: The intensive, individualized management algorithm incorporated into the “treat to target” approach to rheumatoid arthritis includes an expanded role for the rheumatology nurse. Recently added job responsibilities for nurses include in-depth patient evaluation, care coordination assistance, referral facilitation, and patient self-management education and support. However, there is a critical shortage of trained rheumatology nurses. Recently published recommendations for nurses in managing chronic inflammatory arthritis provide a clear framework for future role development, but determining the specifics for implementing them is challenging. Nurse-rheumatologist teams can have a positive influence on patients' knowledge, satisfaction, and pain and provide clinical outcomes as successful as those provided with usual rheumatologic care. Rheumatology nurses are well positioned to participate actively in the increasingly complex care management activities that are required.

The current “treat to target” approach to rheumatoid arthritis (RA) incorporates an intensive, individualized management algorithm that includes an expanded role for the rheumatology nurse. In 2010, an international task force provided recommendations for achieving optimal treatment outcomes in RA based on the following 4 principles: (1) promoting shared decision making between the patient and the rheumatologist; (2) maximizing patients' quality of life through symptoms control, joint damage prevention, function normalization, and engagement in social activities; (3) halting inflammation; and (4) using disease activity measures to adjust treatment. Included in the disease activity measures are assessments of patients' joint swelling and pain and their degree of functional impairment.

A major challenge is determining how these outcome data will be collected and by whom. This article, the fifth in a 5-part series designed to provide a practical approach to better understanding of function in RA as an essential component of treat to target management strategies, discusses the rheumatology nurse's potential role.

The first article in this series (“Understanding Function in RA: An Update on ‘Treat to Target,’” The Journal of Musculoskeletal Medicine, February 2012, page 10) provided an overview. In the second article (“Understanding Function in RA: Importance and Measurement,” The Journal of Musculoskeletal Medicine, March 2012, page 41), we first presented a standardized vocabulary for describing function, based on the World Health Organization's (WHO's) International Classification of Functioning, Disability and Health (ICF), and then applied it to an assessment tool frequently used in rheumatology, the Health Assessment Questionnaire (HAQ).

The third article (“Understanding Function in RA: The Role of Impairments,” The Journal of Musculoskeletal Medicine, April 2012, page 78), described how impairments in body systems caused by RA can affect function and how patients can adapt their activities to cope with these impairments.

In the fourth article (“Understanding Function in RA: Practical Evaluation in the Outpatient Setting,” The Journal of Musculoskeletal Medicine, May 2012, page 102), we discussed how functional assessment may be incorporated into clinical practice. This fifth article provides an overview of the nurse's role in the care of rheumatology patients, with a focus on RA.
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**Evolution of the Nurse's Role**

Rheumatology nurse activities have undergone a significant evolution since the 1980s. In the past, they consisted of limited data collection (e.g., vital signs, symptoms), drug therapy monitoring, patient and staff education, and patient counseling. More recently, job responsibilities have been added, including in-depth patient evaluation (e.g., detailed history and physical findings, review of laboratory studies), care coordination assistance, referral facilitation, patient self-management education and support, disease and treatment risk management, compliance/adherence counseling regarding the treatment regimen, and medical record (paper and electronic) documentation (Figure). However, specific nurse activities vary tremendously because of several factors, including education level, training, care experience, practice setting, geographic location, practice regulations, and the cultural context and attitudes of affiliated health care professionals.

In addition, there is a critical shortage of trained rheumatology nurses. Although the Bureau of Labor Statistics reports 2.7 million registered nurse jobs, the Association of Rheumatology Health Professionals (ARHP)—the division of the American College of Rheumatology (ACR) that represents nonphysician health care professionals specializing in rheumatology—has only about 500 nurse members. The Rheumatology Nurses Society, a professional organization for the development and education of nurses, has about 300 members (K. Lyons, personal communication, May 9, 2012). A position paper that details 10 recommendations for the nurse's role in the management of chronic inflammatory arthritis was published by the European League Against Rheumatism in 2011 to help determine practice, education, and research activities. These recommendations were developed from research evidence and expert consensus by a multidisciplinary task force of 15 nurses; a rheumatologist, an occupational therapist, a physical therapist, and a psychologist; 2 patient representatives; a research fellow; 2 conveners; and a rheumatologist/clinical epidemiologist. An extensive systematic literature review that used “nurse” and “inflammatory arthritis” as the key search terms identified only 54 studies.

Of the 10 task force recommendations, 4 had an “A” category strength of recommendation, indicating that evidence was obtained from a meta-analysis of randomized controlled trials or from at least 1 such trial in combination with expert knowledge. These recommendations called for provision of patient access to a nurse for education about the disease and its management; provision of patient access for nurse consultations to improve communication, continuity, and satisfaction with care; nurse participation in comprehensive disease management and outcome activities; and nurse assessment and intervention for psychosocial issues to reduce the risk of patients experiencing anxiety and depression.

The remaining 6 recommendations received only a “C” category strength grade. The activities for rheumatology nursing included performing telephone counseling, providing patient self-management, using care protocols and guidelines, participating in continuing education, promoting an expanded practice role for nurses, and assisting in treatment activities to control costs. Note that the “C” strength grade for these recommendations indicates mostly that the evidence was derived from descriptive studies or extrapolated from randomized controlled trials or quasi-experimental studies (a research design lacking randomization) rather than a difference of opinion among the experts.

The 10 recommendations provide a clear framework for future role development in rheumatology nursing. However, determining the specifics for implementing them is challenging because of the many factors that affect nurses' activities noted above.

**Benefits of Care Delivered by Rheumatology Nurses**

Although research on care provided by rheumatology nurses is limited, it has been shown that patients with RA definitely can benefit. Two studies of nursing interventions for patients with RA
demonstrated the effectiveness of nurse-delivered patient education and counseling, drug 
monitoring, referrals, and assistance with adaptations for activities of daily living.\textsuperscript{10,11}
Specifically, nurse-rheumatologist teams can have a positive influence on patients' knowledge, 
satisfaction, and pain and provide clinical outcomes (eg, improvements in quality of life and function 
and decreases in disease activity) as successful as those provided with usual rheumatologic care. In 
addition, patients who are coached to use self-management strategies are more likely to attend 
exercise and pain management programs, receive appropriately prescribed pharmacological 
therapy, and keep clinic appointments.\textsuperscript{3}

**Anatomy of the Office Visit**

With the tremendous advances seen in medicine in recent years, the anatomy of an office visit has 
become increasingly complex and time-consuming. The elements in a typical visit now include the 
following: the patient registers and checks in; the nurse or other health care professional rooms the 
patient and obtains his or her chief complaint, interval history, medication review, and vital signs; 
the physician collects additional history, conducts a physical examination, reviews outside 
information, engages in discussion and joint decision making with the patient, provides 
documentation in the electronic or paper medical record, and creates referral communication; and 
the patient checks out, schedules follow-up, and pays the bill. Completing all these activities in a 15- 
to 30-minute session is challenging.

Although all the elements are important for achieving positive clinical outcomes and patient 
satisfaction, the nuances of performing them and the precise responsibility assignment for 
completing them successfully often is not fully defined. In the RA treat to target strategy, for 
example, a patient's disease activity is evaluated with clinical, laboratory, and other studies every 1 
to 3 months and treatment modifications are made on the basis of these parameters. All this 
information must be collected, assessed, and then used for decision making after the data are 
discussed with the patient.

Perspectives about RA inflammatory activity may be provided by laboratory tests, including acute 
phase reactant and anatomical imaging studies, but the tests must be used in concert with clinical 
assessment of joint swelling and tenderness and the patient's functional impairment. Precisely which 
measure of RA disease activity to use for clinical practice was addressed recently by the ACR, which 
recommended the following 6 possible tools: (1) Clinical Disease Activity Index, (2) 28-joint Disease 
Activity Score, (3) Patient Activity Scale (PAS), (4) PAS II, (5) Routine Assessment of Patient Index 
Data 3 (RAPID3), and (6) Simplified Disease Activity Index.\textsuperscript{12} In a study conducted by Yazici and 
associates,\textsuperscript{13} the median time needed to complete a 28-joint count was 90 seconds, compared with 
9.6 seconds for a multidimensional HAQ RAPID3.

Joint count challenges include both the time and expertise required to perform and record a 
standardized examination; with self-report measures, the obstacles are administration logistics and 
patient reporting variations. The nurse can be an active participant in obtaining important clinical 
data to assist in treat to target clinical decision making.\textsuperscript{14}

**Evaluation of Function**

Rheumatology nurses' assessments and interventions address patients' impairments in body 
functions and structures, limitations in activities, and restrictions in participation. The WHO's ICF 
classification,\textsuperscript{15} discussed in the second article in this series, has relevance to rheumatology nurses: 
By understanding and using this classification as a common language, they can communicate 
effectively with interdisciplinary team members about patients' functional problems and treatment 
plans.

A recent study of 57 rheumatology nurses in 15 countries, including the United States, examined the 
ICF Core Set for RA from the viewpoint of nurses.\textsuperscript{16} Nearly 60% of the nurses' activities could be 
connected to ICF categories.

For example, the nurses reported that they manage pain in patients' upper and lower extremities, 
which are categories within the body functions component of the ICF. Other frequently endorsed 
nursing activities involved the ankles, feet, and hands, all of which are categories within the body 
structures component. Similarly, the nurses acknowledged that they focus on specific self-care and 
 mobility issues in their patients, which are represented by dressing, walking, and other ICF 
categories.

To maximize the role that nurses in their practice can play, rheumatologists may consider 
encouraging them to participate in online programs offered by the ARHP, such as the Advanced 
Rheumatology Course (http://www.rheumatology.org/education/ProfMeetingCourses/nppa.asp) or the 
soon to be launched Fundamentals of Rheumatology Course 
(http://www.rheumatology.org/education/ProfMeetingCourses/fronlinecourse.asp). Also, educational
and networking opportunities are provided at the ACR/ARHP Annual Scientific Meeting. For ARHP membership information, contact the membership department at arhp@rheumatology.org or (404) 633-3777 or go to http://www.rheumatology.org/membership/join/alliedhealth_info.asp.

Conclusion
From both the patient's and the rheumatologist's perspectives, achieving successful outcomes with RA treat to target strategies requires intensive, individualized therapy based on specific clinical, laboratory, and other data. With their educational background and clinical skills set, rheumatology nurses are well positioned to participate in the increasingly complex care management activities that are required.

References:
REFERENCES


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