

# Arthritis in Minnesota:



## **A Working Plan For Action**

Center for Health Promotion,  
Minnesota Department of Health

Arthritis Foundation, Minnesota Chapter  
**1999**

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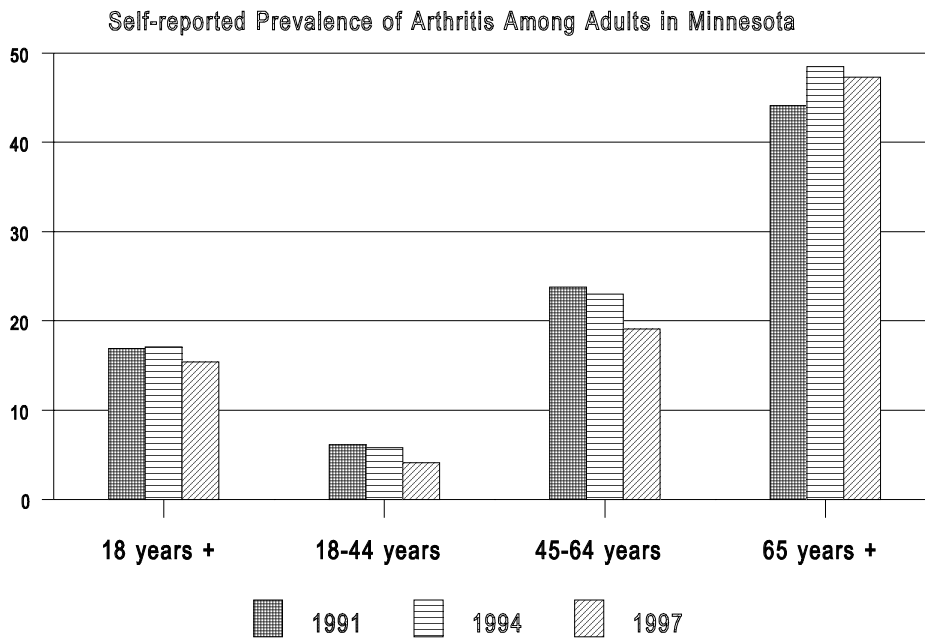
The Arthritis Foundation, Minnesota Chapter and the Center for Health Promotion of the Minnesota Department of Health share the common goals of preventing arthritis and other rheumatic conditions and improving the quality of life for those affected with these diseases. We have come together to outline this framework for action as a first step to moving forward to decrease the burden of arthritis in Minnesota. This plan is a work in progress. It was developed with the knowledge and experience we bring from our own efforts and those of our partners. It is a dynamic working document that will develop, shift and change as we move forward and more partners join our efforts and provide their input and experience.

Additional resources will be needed to develop the ideas presented in this plan. This framework will give us focus as we identify opportunities to direct resources toward this work. Additional partners will also be needed to effectively implement these strategies. The framework can give us a common page to start from as we form new and strengthen existing relationships.

Arthritis is one of the most common diseases in the United States and Minnesota and a primary cause of disability and decreased quality of life.

(1) More than 15% of Minnesota's adult population report they have arthritis. The number of people affected increases with age and in those 65 years and older almost half have arthritis as illustrated in the figure below.

(1)



Minnesota's older population is expected to grow dramatically. More than half of our adult population has one or more risk factors for arthritis. By 2025, more than half of Minnesota's population will be over 40 and by 2030, the number of Minnesotans over age 65 will have almost doubled. (1)

(1) With this aging of our population, the prevalence of arthritis can be expected to grow dramatically, as well. Nationally the number of people with arthritis is expected to increase by 50% by 2020. Given Minnesota's aging population we can expect similar or greater increases.

While osteoarthritis in adults is the most common form, arthritis does affect children, usually as juvenile rheumatoid arthritis. Other facts about arthritis we must consider:

- , Arthritis is the leading cause of disability among Americans over the age of 15.
- , Arthritis is second only to heart disease as a cause of work disability.
- , Arthritis affects women more often than men.
- , Arthritis limits everyday activities such as walking, dressing, and bathing for more than 7 million Americans.
- , Costs to the US economy total nearly \$65 billion annually - an impact equal to a moderate recession.
- , Arthritis affects people in all age groups, including as many as 285,000 children.
- , Baby boomers are now at prime risk. More than half of those affected are under age 65.
- , Half of those Americans with arthritis don't think that anything can be done to help them.
- , Arthritis refers to more than 100 different diseases that affect areas in and around the joints. The diseases also affect other parts of the body. Arthritis causes pain, loss of movement and sometimes swelling.

There is increasing recognition that there are identifiable risk factors for arthritis that can be modified. A public health approach that identifies and implements strategies to decrease risk and improve the health of an entire population is needed to significantly impact the burden of arthritis we will face in Minnesota as the baby boom population ages.

Those risk factors that are not modifiable: female gender, age and genetic predisposition, do not offer opportunities themselves for modifying risk, however they do add import to providing tools and information to those with these unmodifiable risk factors so that they might compensate by modifying those risk factors under their control.

Risk factors that may be modifiable and are associated with increased risk of arthritis include:

- C **Obesity:** weight management to maintain or decrease body weight can lower risk for certain types of arthritis - particularly osteoarthritis of the knee in women and gout in men. Regular physical activity is key to weight management.
- C **Joint injuries:** prevention of sports injuries, occupation-related injuries and repetitive use joint injuries can decrease risk of arthritis.
- C **Infections:** Lyme disease is endemic in Minnesota and rates of disease are significantly higher in Minnesota than the national average. Fourteen percent of Minnesota cases of Lyme disease have had continuing complications including arthritis. There is increasing recognition that foodborne pathogens may trigger reactive arthritis in some people.

## Goals

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We have identified four goals that define arenas for action. These are broad areas that offer many possibilities for collaborative action. We have

outlined some suggestions as a starting point for discussions and to provide insight into areas and activities so that partners might better identify their contributions to this effort.

**GOAL 1: Develop data and surveillance systems to better define and monitor the burden of arthritis in Minnesota and the quality and costs of care.**

**GOAL 2: Develop health communications strategies using a variety of techniques and channels to enhance health knowledge, attitudes, beliefs and behaviors of people with arthritis, their families and health care providers.**

**GOAL 3: Develop community-wide interventions to promote community-based prevention and control of arthritis.**

**GOAL 4: Promote systems change to improve quality of care in diagnosis and treatment for people with arthritis.**

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## **Data and Surveillance**

Statewide data about arthritis is limited to basic prevalence data on adults who self-identify with arthritis. Information is needed that can characterize the type of rheumatic disease occurring, extent of disability, use of care modalities, effect on quality of life, relationship to primary risk factors, co-morbidities and demographic factors. We need information about children affected with arthritis; we need information about the economic costs of arthritis; and we need information about health care systems and arthritis

care in Minnesota. Good public policy decisions are built on good information. Program development that meets the needs of those it is intended to serve depends on our knowledge of the issues and the target populations. We need to know more about the populations that need to be served. We need to know who is being served by current efforts and who is not. We also need the capacity to bring together data from all the stakeholders to look at the collective picture it provides, identify the gaps and maximize the resources currently available for monitoring and surveillance.

**Possible strategies include:**

- < Expand the Behavioral Risk Factor Surveillance Survey to include questions about diagnosis, treatment, disability, and quality of life.
- < Identify communities and organizations that are collecting arthritis-related information to facilitate coordination, use of standard questions. Compile data from local data collection to assist in clarifying issues across the state and in geographic, demographic and racial/ethnic populations.
- < Develop the use of claims data to describe arthritis diagnosis and treatment and their economic and quality implications.
- < Work with neighboring states to compile data to better characterize the needs and experience of racial/ethnic populations.
- < Develop qualitative data to help us shape messages and programs.

Many of those Minnesotans affected by arthritis lack knowledge about their disease and proven means that can help them prevent further disability, and have limited access to services they need. Many people with arthritis believe there is little they can do to affect their disease. Many believe arthritis is just a part of aging. In the young, arthritis is often unrecognized until symptoms become severe. We know that early diagnosis and appropriate management can improve the outcome for young and old. Each of our individual organizations is limited in its ability to broadly reach the populations that need our information. We must develop collective strategies with consistent messages to reach entire populations.

Participation in the Arthritis Self-Help Course is very low. This is an effective intervention that is underutilized. People with arthritis do not know about it and health care providers who work with them do not know about it. This needs to be a priority for communication efforts. In addition, we know that “one size does not fit all.” We need to identify communication channels and methods that reach people in new ways.

Health care providers are a crucial link in communication with people with arthritis and their families. We need to maximize the effectiveness of those health care interactions. Health care providers need communication tools that will support their efforts to provide high quality care. They also need information that can help them use new treatments effectively and coordinate care between specialists and primary care providers. Evaluation of communication and behavior-change programs is crucial. We need information to identify those strategies that work.

**Possible strategies include:**

- < Use radio and television to increase awareness and provide referral to available programs.
- < Target communications through channels that reach those at high risk such as elderly populations.

- < Explore new communication technologies such as the World Wide Web for their feasibility, reach and effectiveness in providing information for consumers and professionals.
- < Engage physicians in providing information to their patients about prevention through healthy behavior choices and control through self-management strategies.
- < Assess consumer's and professionals needs and wants through focus groups and individual interviews to identify communication vehicles, strategies and messages that will reach greater audiences.
- < Expand the use of work sites for communication of information about prevention and effective intervention.
- < Expand the use of faith communities for communication of information about prevention and effective intervention.

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## **Community-based prevention and control**

We know from large scale community-based intervention trials conducted to prevent chronic diseases, multilevel interventions supporting new community norms and policies as well as information and intervention programs can successfully change population risk and outcomes. We need to identify those policy and environmental changes that will be successful in engaging the community to support people with arthritis and support behavior change to prevent this chronic disease. We need to identify and support existing programs directed at policy and environmental support for primary prevention strategies such as promoting regular physical activity

and help communities see that these efforts are also part of the broad agenda of efforts needed to prevent and control arthritis. And we need to identify means for coordinating and integrating community and health care systems to best serve consumers.

**Possible strategies include:**

- < Develop additional methods and channels for training to increase the number of trained group leaders available for self-help programs.
- < Develop worksite programs to provide access to baby boomer populations and encourage them to adopt healthy behaviors that will decrease their risk of arthritis as well as other chronic diseases.
- < Encourage adoption of worksite and school policies about nutrition and physical activity that will help support healthy choices and decrease risk.
- < Engage new community partners in providing information, education and support to people with arthritis and their families. These may include partners like faith communities, local business, schools and recreation centers.
- < Engage communities in assessing and developing coordination and integration of health care and community programs to best serve their populations and maximize their resources.

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**Systems change and quality of care**

Minnesota is known for the quality of its health care, health professional education and health and public health research. We have been on the

cutting edge in developing managed care systems and see great penetration of managed care in our state. In other disease prevention and control areas, particularly diabetes care, Minnesota's health care community has done pioneering work in developing quality improvement efforts. We have the opportunity to come together to apply and extend the knowledge gained from these efforts to improve the quality of care and systems of care for persons with arthritis. We also need to make the opportunity to broaden the view of health care organizations and systems in setting intervention priorities to understand the tremendous personal and economic implications of diseases like arthritis that have major impact on morbidity, but not on mortality. Current focus of intervention efforts on the "killer diseases," while not unimportant, misses opportunities to significantly improve the quality of life, reduce years of disability and decrease the health care costs of a large segment of the population.

**Possible strategies include:**

- < Develop guidelines and standards of care for persons with arthritis that integrate primary and specialty care, community support programs and other self-management strategies.
- < Develop strategies for communicating , implementing, monitoring and evaluating guidelines and standards of care.
- < Develop models for integrating health care and community-based interventions in communities.
- < Develop quality improvement models for arthritis care.
- < Develop systems, methods and tools for communication and action across health and medical care systems across the state to share information, strategies and successes in developing care systems.



## Future Steps

The goals and framework outlined here are ambitious, but we in Minnesota thrive on challenge. Meeting this challenge means we improve the quality of life for many Minnesotans. The impact arthritis will have on our population and many of us personally in the coming decades is clear and significant.

We have the opportunity to participate on a national level, as well. The recently released *National Arthritis Action Plan: A Public Health Strategy* (1) provides the national framework. It will serve to help achieve greater recognition among the general public, people with arthritis and their families, health care providers and policy makers of the impact of arthritis and what can be done to prevent or delay its onset, and what effective interventions are available to reduce disability and improve the quality of life of people with arthritis. As we work together with those at the national level and from other states the integration of the perspectives, values and resources across the country will help all of us to reduce the burden of arthritis.



## Endnotes

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1. Centers for Disease Control and Prevention. Prevalence of disability and associated health conditions - United States, 1991-1992. *MMWR* 1994;43(40):730-731, 737-739.
1. Minnesota Department of Health, Center for Health Statistics, Data from the Behavioral Risk Factor Surveillance Survey.
1. Minnesota Planning. Faces of the future: Minnesota population projections 1995-2025. St. Paul, Minnesota: State Demographic Center, April 1998.  
<http://www.mnplan.state.mn.us>
1. Minnesota Department of Human Services. Aging Initiative: Project 2030 Briefing Book. St. Paul, Minnesota: Minnesota Department of Human Services, 1998.
  1. Arthritis Foundation, Association of State and Territorial Health Officials, Centers for Disease Control and Prevention. National Arthritis Action Plan: A Public Health Strategy, 1999. <http://www.arthritis.org>