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When designing public health care services and determining their scope, calculations are made about citizens’ average need for care and rehabilitation. The service system is built on the basis of such calculations. One factor under consideration is which type of ailments people can treat using self-care measures and which situations call for more or longer-term health care services. One calculatory starting point is that approximately 80 percent of the population can usually cope with self care and approximately 20 percent need health care services on a regular basis.

**Influenza crisis?**  
If the need of health care services suddenly increases, for one reason or the other, fundamental questions will arise: Who are the primary objects of care, and how are the remaining people in need of care to be prioritized? In a serious situation, people who need non-urgent care are surpassed to secure sufficient resources for urgent cases. Last spring, news about the H1N1 virus, or the so-called swine flu, created many challenges to politicians and public health care systems throughout the world. The spreading of the disease was followed like the plot of a poor cyber-horror story when the viruses travelled with people from one country to the next. Soon it was considered in Europe, too, how the propagation of the disease could be slowed down and how treatment should be organized for people belonging to risk groups or contracting a more serious form of the illness.

In Finland, the Ministry of Social Affairs and Health determined the risk groups and care practices and issued guidelines to the municipalities for action plans. The Finns learned to disinfect their hands better, and avoiding handshakes became a virtue. Even though we were constantly reminded that the majority of the patients will suffer from the milder form and will recuperate quickly, the spreading of the epidemic has closely been followed in the media, and exaggerated reactions have not entirely been avoided. One columnist remarked sarcastically that the disease spreads most efficiently via the media. However, the predicted horror scenarios have not come to pass, and the first wave of the swine flu is coming to an end.

Why, then, the swine flu epidemics stirred up such a great attention – even though in many estimates it was predicted to have milder effects than, and even to cause only a tenth of deaths compared to, the seasonal flu – is an interesting socio-political question. The swine flu is more important politically than the seasonal flu e.g. because people in the risk group are younger and full participants in the working life. Should serious consequences arise, they could be drastic to members of the risk groups. It was feared that great numbers of swine flu patients would affect the functioning of the society, e.g. the way in which the health care system can tolerate a high load when also people working in health care fall ill. At the same time it was feared that many key sectors of the society might not remain operational if the majority of employees contract the disease simultaneously.
With the swine flu, being ill became a touchstone for the society and its social rest.

**Slowly progressing musculoskeletal epidemic**
The effect of musculoskeletal conditions on national economy and health is significant compared to, for example, the swine flu, but alarm bells have not sufficiently been sounded for this creeping epidemic. It is estimated that more than 100 million Europeans currently suffer from chronic musculoskeletal pain, and musculoskeletal disorders form the largest group of conditions causing sickness absences in Europe. At the same time, Europeans are ageing, and when other risk factors of musculoskeletal conditions are increasing too, the scope of health care services must be considered. Who can manage on their own and who needs various care or rehabilitation interventions which, compared to the swine flu for example, are wide-ranging? Since in many countries the social and health care service system investments already form a significant part of state and municipal budgets, more investments cannot be made to the services, but changes can only be made by means of restructuring and rationalization. The falling ill of even a single individual has an expanding social dimension and a related socio-economic dimension.

**Interest to the EU**
Both national and international efforts are needed to tame musculoskeletal symptoms and conditions. The World Arthritis Day, 12 October 2009, was also the date of the first session of the European Parliament Interest Group on Musculoskeletal Diseases. Good luck and success to the Group! Hopefully the work of the Interest Group will be fruitful, because a matter involving a group of population this big should not be overlooked in European politics. The goal should be nothing short of facilitating the choices that promote the musculoskeletal health of individual citizens, and when people's own efforts are not enough, a sufficient selection of methods should be available irrespective of the age or country of residence of the person suffering from the condition.

Jaana Hirvonen
Editor

PS
You can read the previously published on-line issues of the AHP Newsletter and join the e-mailing list of the newsletter at the EULAR AHP Standing Committee’s website available at www.eular.org/st_com_health_professionals.cfm.

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**In this Issue**
In this AHP Newsletter, we will introduce our new AHP Vice-President Kåre Birger Hagen and under the guidance of our Chairperson Tanja Stamm, we will launch the AHP-member campaign for the 2010.

Pamela Degotardi, President of ARHP 2009, takes us on a tour on how she saw the EULAR Congress from the American perspective. Richard Osborne tells us about an innovative and successful health care reform in Australia and Ann Tyrrell Kennedy, President of FESCA, writes in her eye-opening article about how health professionals could co-operate with people with a rare disease. On pages 16-17, we tell about the new European Parliament Interest Group created to tackle the growing burden of musculoskeletal diseases.

Please do not miss the news flashes on how to apply for an educational visit or the preliminary health professional topics at the EULAR Congress in Rome 2010.

Enjoy the Newsletter!
Interviewing the new Vice-President

Professor, Physiotherapist Kåre Birger Hagen was elected as the Vice-President for Allied Health Professionals in Rheumatology at EULAR’s General Assembly in June 2009. The Vice-President serves a maximum term of four years. Kåre Birger Hagen is the fourth health professional to hold this office continuing the work after Jana Korandová, Jill Lloyd, and Peter Oesch. The new Vice-President was pleased to share his views and thoughts on health professionalism and his plans as the Vice-President with our readers.

How long have you worked as a physiotherapist and how did you start with scientific research?
– I worked as a clinician in private practice and with vocational rehabilitation for some years after I graduated. Since then, I have also been working in an occupational health service in a part time position for some years. The last twenty years, I have been working mainly with research. I started my PhD studies at the Karolinska Institute in Stockholm Sweden in 1990 and defended my PhD thesis in 1994. At that time, there were no master program or PhD programs for health professionals (HPs) in Norway and I’m still grateful for being so generously taken care of and supervised by Professor Karin Harms-Ringdahl in Stockholm. When I went back to Oslo, I was granted a post-doctoral fellowship at a health services research unit at the National Institute of Public Health. At that time, I got involved in the Cochrane Collaboration, mostly within the field of back pain, which I think has had an influence on my view about clinical research and clinical care. After a couple of years in the bureaucracy as a director in the Ministry of Social Welfare and Health, I ‘went back’ to research in 2004 and started as researcher at the National Resource Center For Rehabilitation In Rheumatology. The centre is affiliated to the Department of Rheumatology at the Diakonhjemmet Hospital in Oslo and consists of a rehabilitation unit and a research unit. I am head of the research unit and we have currently some 20 people from all professions working with educational and research activities. In addition, I have a part time position as a professor at the University in Oslo which offers a master and a PhD programme for HPs.

How and when did you get involved with EULAR?
– I was involved in the AHP Scientific Committee back in 2006-2007, through participation at the annual conferences.

Is there a Norwegian health professional working method which you would like to mention?
– At my hospital, as probably in most hospitals all over Europe, we are continuously exploring and discussing ways to optimize the clinical care and management. Innovative models of care such as extended roles of health professionals may be an even more important option in future rheumatology care given the increasing number of people with rheumatic diseases and the increasing pressure to cut costs.

In your opinion, what kind of status does health professionals (HPs) have in the Norwegian health care system compared with the rest of Europe?
– I do not think the HPs in Norway have a different status than HPs in other countries in Northern Europe.

An offer to health professionals from SAGE

A new journal called Therapeutic Advances in Musculoskeletal Disease was launched in October 2010. The journal is for all professionals involved in research into and the practice of musculoskeletal medicine and it is a forum for all views on related subjects and research into diseases. SAGE is offering free access to all research articles over the first three volumes (until end 2011).

Visit the website at www.uk.sagepub.com/journalsProdAims.nav?prodId=Journal201933
or Scandinavia. However, I have an impression that the HPs in Northern Europe are somewhat better off than in Central and Southern Europe, at least as regards to research and scientific activities.

What kind of themes do you find important in the interdisciplinary approach?
– In my opinion, there are at least two themes in clinical care that are of special interest for health professionals. Number one is the promotion of interdisciplinary work (IW) itself. IW has a long tradition in Europe and initially, most team-based care systems were built on the tradition of long-term inpatient care. Following major changes in healthcare systems, new trends in team care include a more patient-centered approach, a higher degree of flexibility, and facilitation of true interdisciplinary interaction. Thus, the modern form of IW is indeed a complex one and that is why the effectiveness and content of all health service models need to be described and evaluated to give the best outcome. At the moment, there are not many international initiatives to develop frameworks for describing and evaluating complex interventions such as IW, where HPs would be major drivers.

– The second theme with special interest and partly related to IW is ‘the extended roles taken by health professionals’. Extended roles of HPs often correspond with the development of innovative models of care, which I guess is highly relevant in all European hospitals and primary care settings. At my hospital, we are now discussing the extended roles for HPs as a measure to provide safe and efficient service and to decrease the number of patients on waiting lists. However, there is a number of obstacles related to such an innovation and for us it seems that the financial incentives are the main barrier. There is no data on the current situation concerning health professionals performing extended roles in Europe and I am very happy that there have now been initiatives to work on this theme within EULAR.

How could we in practice emphasize the importance of HPs in Europe?
– That is the one million Euro question!! I think the only way is through hard work. The importance of HPs within EULAR and Europe can only be proven through high-quality research, educational activities and defining high-standards for clinical care. I would be pleased to receive any advice for how to improve our activities.

Are you happy with the structure of the EULAR AHP Committee and the way it is working?
– Yes, by and large. There are always some elements that I think can be improved. For example, I think there should be some kind of ‘Vice-President-elect’ position as there is for the Chairpersons. EULAR is a complex organization and jumping straight into it from the outside is not easy. I am so happy that I have worked closely with Peter Oesch, the former Vice-president and can learn from his experiences.

The former Vice-President Peter Oesch (on the right) was nominated as the honorary member of EULAR in the EULAR Congress in June 2009. Also in the picture: the former EULAR President Ferdinand C. Breedvelt (on the left) and Alan Silman, the former Chairperson of Standing Committee on Epidemiology and Health Services Research.

Peter has done an impressive work for HPs within EULAR and I am not really sure if he has been given adequate recognition for his efforts. However, structures will never be perfect and will never function better than the people who work within it.

What about EULAR?
– EULAR represents a unique opportunity for all important stakeholders within rheumatology. We should not forget that the main mission for EULAR is to improve the care and everyday life for people with arthritis, and EULAR has been a driving force behind the progress we have seen the last decades. I am convinced that HPs will play an even more important role in EULAR in the future.

What kind of issues would you like to bring up as the new Vice-President?
– First, I would like to emphasize that I consider the ‘HP work’ in EULAR as a collective effort between the AHP Standing Committee and the Vice-President. I am really lucky that I can work so closely with the present and former Chairpersons Tanja Stamm and John Verhoef.

– In my opinion, in the future, we should focus our work around four pillars: 1) Educational activities, 2) Research activities, 3) Setting standards for clinical care and 4) The annual EULAR Congress. In each of these areas, we need to define aims and activities. My clear message just now is that two or three people (i.e., Standing Committee Chairs and Vice-President) cannot do this work alone. We can only inspire and motivate HPs around Europe to join us and work for the advancement of our roles and status.

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Launching the AHP member campaign 2010

EULAR Standing Committee of the Allied Health Professionals (AHP) is proud to launch a campaign promoting the national health professional organisations’ interest in becoming a member of EULAR and participating in the work of the AHP Committee.

The member campaign will continue through 2010 and will be especially promoted in the EULAR Congress in Rome, June 2010. All interdisciplinary health professional organisations specialised in the care and treatment of rheumatic diseases and musculoskeletal disorders (MSD) in each European country are welcome to join in.

Institutional members of EULAR

EULAR is set up of four types of institutional members: scientific societies, national organisations of people with arthritis/rheumatism (PARE), health professionals’ associations, and corporate members. In addition, EULAR acknowledges a number of individuals as honorary members.

With 44 scientific member societies, 35 PARE organisations and five health professionals associations, EULAR underscores the importance of combating rheumatic diseases and MSD not only by medical means, but also through a wider context of care for people with musculoskeletal conditions and a thorough understanding of their social and other needs. There are also 32 corporate members who support EULAR financially with their membership fees.

The five health professionals associations are the British Health Professionals in Rheumatology (BHPR), the health professionals in rheumatology Switzerland (hpr), the Netherlands Health Professionals in Rheumatology (NHPR), the Swedish Rheuma Forum (SveReFo), and the Norwegian Interdisciplinary Organisation in Rheumatology (NIOR).

One AHP association per country

According to the EULAR bylaws, only one health professionals association or respective league from each country can be admitted as an official member of EULAR. A national health professional organisation may be recognised as such if it is autonomous and has a governing body (Executive Committee, Board of Directors, etc.). A health Professionals association may not be a sub-division

The Finnish case as an example

There is a Finnish saying that Finland is a country of associations meaning that there is no good cause big or small enough which would not have an association of its own.

As a matter of fact, there is already an active health professional association in rheumatology which functions in the Northern Finland which is a member of the Finnish Rheumatism association but there is no AHP organisation which would cover the whole country. For the time being on a general level, all major health professional groups have their own well-functioning associations and they have not yet seen a need for an interdisciplinary organisation in rheumatology, although each association co-operates in various fields. In addition to this, there is also a national association for nurses specialised in rheumatology.

Finland has had a representative in the AHP Committee since 1987 which was the very beginning of the Committee. The health professional representative has always worked in, or closely by, the Finnish Rheumatism association. The current co-opted member, Physiotherapist Satu Gustafsson works as an executive manager for one of the largest local branches of the Rheumatism association in the city of Turku. She is fascinated by the idea of having a national interdisciplinary organisation in rheumatology but she is also a realist.

– These things tend to take time. First of all, we should find a common interest for such an establishment and invite all the possible parties around the same table, says Gustafsson.
of the national scientific organisation.

If applications for affiliation are received from more than one organisation in a country, the organisations must come to an agreement as to which one of them shall become a member of EULAR. Several national organisations may also establish a joint association, enabling such an association to become an official member of EULAR.

**Six steps to get involved for a national AHP activist:**

1. If a national interdisciplinary health professionals’ organisation already exists in your country, please find out first whether there is a formal member representing this organisation at the EULAR AHP Standing Committee. If so, please contact this person regarding your involvement in EULAR. You will find the member list of the Committee at www.eular.org/st_com_health_professionals.cfm.

2. In case there is no organisation representing health professionals in your country, you can establish a national organisation first. Bear in mind that this organisation’s bylaws should be in accordance with the EULAR bylaws. The EULAR bylaws can be obtained from the EULAR Executive Secretariat, contact: anja.schoenbaechler@eular.org.

   Importantly, this national organisation should represent different health professional groups (such as nurses, occupational therapists, physiotherapists, podiatrists, nutritionists, social workers, psychologists, and others) and should have a clear interdisciplinary perspective. All the professional groups mentioned above do not have to be represented in the organisation but an open attitude towards all health professionals in the organisation is required.

3. Fill in the application form which you can obtain from the Secretariat together with a letter stating that your organisation wants to join EULAR as a health professional organisation representing your country. Submit this application form to the EULAR secretariat. The General Assembly meeting once a year before the annual EULAR Congress in June will put your application and acceptance within EULAR to the vote.

4. When your organisation is a formal member, the person representing this organisation will also have a right to vote in the General Assembly.

5. If your organisation is accepted, the chairperson of the national organisation is commonly the representative as formal delegate member in the EULAR Standing Committee for AHPs.

6. In the process of establishing such a national organisation and even before this, the Committee welcomes anyone interested in founding a national organisation to become a co-opted member in the EULAR Standing Committee for AHPs. You are then also of course welcome to participate in the meetings of the EULAR Standing Committee for AHPs and in other activities within EULAR. In this case, please contact the Chairperson of the AHP Committee, Dr. Tanja Stamm: tanja.stamm@meduniwien.ac.at.

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**The national representation in the EULAR Standing Committee of Allied Health Professionals in Rheumatology**

Austria  
Czech Republic  
Cyprus  
Denmark  
Estonia  
Finland  
Germany  
Italy  
Lithuania  
the Netherlands  
Norway  
Poland  
Slovakia  
Slovenia  
Spain  
Sweden  
Switzerland  
the United Kingdom

Is your country the next one?
Experiencing EULAR Congress – an ARHP perspective

I’m writing this column in my hotel room in rainy, somewhat chilly Copenhagen. So much for the summer dresses that I packed in preparation for attending this EULAR meeting. It’s been all about layering and trying to stay dry, dodging puddles, and struggling with blown-out umbrellas. The rain has impeded any desire to explore Tivoli gardens, but it has not dampened the friendliness and welcome of our European counterparts in the Allied Health Professionals (AHP).

Kim Kimpton, Past President of the Association of Rheumatology Health Professionals (ARHP), and I were invited to attend both the EULAR AHP Scientific Sub-committee meeting and the AHP Standing Committee meeting which is the equivalent of our ARHP Executive Committee. During these early morning meetings we discussed proposals for the 2010 EULAR meeting in Rome. We also shared common issues of health professionals in rheumatology across the globe, such as the need to improve the visibility, education, and communication between member countries through links on the website and increased distribution of health professional news. Some of these issues seemed familiar to Kim and me, and others were unique to EULAR Allied Health Professionals: the struggle with the challenges of multiple languages, huge variety in health service delivery systems, and varying educational levels and scope of practice for disciplines across the European countries.

Connecting at the networking booth
Kim and I were also invited to help staff the AHP booth between scientific sessions. This booth had a prime location between the posters and the free snacks/souvenirs at the pharma booths, and proved to be a welcome networking spot for all health professionals. I not only shared potato mayonnaise sandwiches (do not ask… apparently it is a Danish delicacy) and convivial conversation with nurses from the UK, physical therapists from Poland, and occupational therapists from Norway; but I also helped distribute information about ARHP e-learning products (such as our fabulous NP & PA Postgraduate Rheumatology Training Course, and the ability to download sessions from our ACR/ARHP Annual Scientific Meeting using Session Select). During one lunch break, I participated in a lively discussion with a group of ten psychologists lead by Eric Taal, PhD. During this meeting, we initiated a collaboration to develop future psychology educational sessions at EULAR. This psychology group has already shared e-mails and we have not even left Copenhagen yet! Today, I witnessed an even larger group of nurses meeting in the booth, and I’m assuming from their lively banter that their meeting was similarly productive.

Guards and folk songs
So what was different about the EULAR meeting? For a start, the opening ceremony was a combination of lectures, award presentation, and entertainment. Although I particularly enjoyed the performance of the Tivoli guards, and the Royal Copenhagen Ballet, I was intrigued by the EULAR rheumatologist’s chorus. This large group performed a delightful selection of Danish folk songs. I would like to challenge our rheumatologist colleagues at the American College of Rheumatology (ACR) to put on a comparable performance for our ACR/ARHP Annual Scientific Meeting…. Let the singing begin!

Scientific sessions
Although there are fewer AHP sessions at EULAR (13 compared to 60 for ARHP) the format of the AHP scientific sessions was familiar, and thankfully, for me, the official language of the meeting was English. It was

ARHP in brief
The Association of Rheumatology Health Professionals (ARHP), a division of the American College of Rheumatology, is committed to advancing the knowledge and skills of health professionals to improve health outcomes for people with or at risk for rheumatic and musculoskeletal diseases. Through its publications and educational programs, ARHP disseminates relevant research findings to health professionals around the world. One of ARHP’s goals is to ensure that ARHP services and products address the needs of our international members. ARHP welcomes opportunities to collaborate and share information with our international colleagues. If you would like more information about ARHP products, services or membership, please visit our website: www.rheumatology.org/arhp.
impressive how complex scientific findings were seamlessly woven together thematically in each session by four speakers representing different countries, different disciplines, and who typically didn’t speak English as their first language. I especially enjoyed a session with speakers from Norway, France, the United Kingdom, and the Netherlands on “How to improve the methodological standards in clinical trials for non-pharmacological treatment.” As a psychologist, I was also fascinated by a joint session of AHP/EULAR/PARE (People with Rheumatic disease in Europe) on “the impact of rheumatic disease on family life.” This session included presentations by both individuals with rheumatic disease (RD) and family members, and a general practitioner (internist) who treats RD patients in his UK rural practice. Providing a platform for the patient’s perspective in a scientific meeting is unique to EULAR, and I was completely won-over after listening to these moving, thoughtful, and often wryly humorous observations by the speakers.

All in all
So, has it been worth the long flight, the jet-lag, and time away from work/family: ABSOLUTELY. This has been a fabulous educational experience, and a wonderful opportunity to network with international colleagues, and develop collaborations with health professionals in a multitude of countries. I have learned so much these past few days, and have come to appreciate our differences, and our shared challenges. The EULAR meeting at Copenhagen truly is “wonderful” even without the sunshine! I look forward to returning in June 2010 to the Rome EULAR meeting to continue the international collaboration.

Pamela Degotardi, PhD (psychologist)
2009 President, ARHP
pdegotardi@gmail.com
A new model of care that is supported by strong government policy, extensive clinical engagement, and an innovative comprehensive clinical and priority assessment tool, has transformed the care of people with osteoarthritis (OA) across the state of Victoria, Australia. Prior to implementation, patients needing joint replacement surgery faced a chaotic system, marked by poor communication between health care professionals and long waiting times for assessment. In addition, the system failed to ensure that proven conservative management was provided to each person with OA who might benefit.

In Australia, universal health care is accessible to all residents. The supply of some elective services, such as hip and knee arthroplasty does not meet the demand, with waiting lists common and with blunt urgency categorisations systems available. A private health insurance system exists in parallel in which about 60 percent of the annual 65,000 total hip and knee replacements are undertaken in an environment without waiting lists.

In this article, I describe the whole-of-system approach to design and implementation of a comprehensive model of care for people with OA.

**Approach to service redesign and implementation**

Service redesign was founded on two key factors; consensus about need for change and clinical leadership. There was genuine clinical engagement, careful observation of care needs from the level of general practitioner (GP) to operating theatre, interrogation of the literature, and a partnership approach between the academic researchers, policymakers (the funders) and clinical leaders.

The initial project leadership group included a health services researcher (Prof Richard Osborne), an orthopaedic specialist (Prof Stephen Graves), a rheumatologist (Prof Ian Wicks) and a policymaker (Ms Maree Roberts). A research and implementation protocol was developed that included wide consultation, evidence-based approaches, processes for clinical services redesign, development of a new questionnaire of individual patient need for hip or joint replacement surgery, and wide piloting. It also included processes for continuous quality improvement during the implementation phase. The piloting and implementation also included commitment from a wide range of experts (Table 1).

The project staff included up to 10 research and clinical staff, and we also brought in two external consultants, Prof Paul Dieppe from England (OA expert) and Prof Peter Fayers from Scotland (questionnaire expert).

**What was going on in the beginning and what innovations were generated?**

To ensure we developed a model of care that worked for people with OA, a new model of care was designed. This model involved a comprehensive assessment tool that allowed for the identification of patients who would benefit from joint replacement surgery. The tool was supported by strong government policy, extensive clinical engagement, and an innovative comprehensive clinical and priority assessment tool. The model transformed the care of people with OA across the state of Victoria, Australia.

**Table 1. A multidisciplinary team from academia, health and government collaborated in developing the Osteoarthritis Hip and Knee Service (OAHKS)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Prof Richard Osborne</td>
<td>Health Services Researchers</td>
</tr>
<tr>
<td>Ms Maree Roberts, Mr Terry Symonds</td>
<td>Policymakers</td>
</tr>
<tr>
<td>Prof Stephen Graves, Mr Richard DeSteiger, A/Pr Andrew Bucknill</td>
<td>Orthopaedic Surgeon</td>
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<tr>
<td>Prof Ian Wicks</td>
<td>Rheumatologist</td>
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<tr>
<td>A/Prof Caroline Brand</td>
<td>Rheumatologist / Clinical Epidemiologist</td>
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<tr>
<td>Ms Jenni Livingston</td>
<td>Program Evaluator / implementation</td>
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<tr>
<td>Ms Tanja Farmer, Ms Brit Gordon,</td>
<td>Physiotherapists</td>
</tr>
<tr>
<td>Ms Kerry Haynes, Ms Catherine Jones, Ms Melanie Hawkins</td>
<td>Project managers</td>
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all parties and across settings, we undertook in depth stakeholder consultation across the continuum at four disparate hospital settings.

Key failings and critical redesign features identified in the current system were: inability to assign surgical priority in an open and equitable manner and the absence of an evidence-based process to ensure conservative management was optimised.

A brief tool was needed that informed, supported and made more systematic the clinician’s clinical encounter and the quantification of the need for surgery. Currently available questionnaires were deemed inadequate because they were limited in their coverage of practical clinical issues, impractical in the clinical setting, not suitable for both hip and knee, or with poor coverage of the issues relevant to surgeons and patients for understanding need for surgery. To generate the indicators for the need for surgery, four workshops, using nominal group techniques, were undertaken with surgeons and a further four with patients. Through modern psychometrics and discrete choice experiment (DCE) weighting processes, a Multi-Attribute Prioritisation Tool (MAPT) was developed. The latter process (DCEs) involved obtaining systematic data from 96 arthroplasty surgeons to ensure the MAPT was clinically valid and precise. The MAPT has 11 items covering pain, sleeping, self care, psychosocial wellbeing, caring roles, income, and recent change in patient’s hip or knee problems.

To deliver the new service, a specific role was created for a clinician (physiotherapist or nurse) to triage care, optimise conservative management and communicate across the healthcare team (from GP to surgeon).

After a pilot phase culminating in a state-wide implementation plan, the model was then applied within a further 10 Victorian hospitals in 2008. The implementation was supported by a team based at Melbourne Health that incorporated an orthopaedic surgeon, a project manager, and a musculoskeletal coordinator. This team played a pivotal role in assisting health services to establish the new model and was overseen by a Steering Committee of representatives from policy, health care and research.

At each of the 14 Victorian hospitals, a local service project team was established, including; orthopaedic leadership, executive sponsor, physiotherapy, nursing, outpatient management and, where available, rheumatology. This team was supported by service change management tools, training, and the generation of a community of practice across hospitals. The extensive consultation and service redesign generated the system as shown in Figure 1. In the following sections, we highlight some key healthcare reform issues for key clinical and management groups.

The Australian primary care system

In Australia, GPs have a key gatekeeper role. Once they decide a patient might require a surgical assessment, a referral is sent to the outpatient department. Patients were referred from primary care directly to surgeons’ private clinics at one hospital, with no outpatient department. There were no standardised procedures for referral letters and the quality of referrals was highly variable. There were reports of GPs referring patients prematurely (i.e., patients not in current need of joint replacement) because they believed that by the time a patient was eventually seen in outpatients (up to one or two years) they would need a joint replacement.

Figure 1. The reformed system of care for people with hip and knee osteoarthritis with principles governing the development and application of the OA Hip and Knee Service.
Outpatients and a musculoskeletal coordinator

The mechanism for processing referral letters received by outpatients also varied widely, ranging from regular triage by consultant surgeons with support by outpatient administrative staff, informal triage by a surgical registrar, to protocol driven triage by a senior musculoskeletal physiotherapist.

The role of the MSC is to coordinate triage, referral, management, and prioritisation of patients referred to orthopaedic outpatient clinics for assessment of hip or knee OA.

The redesign of this part of the system all patients referred for hip and knee primary joint replacement due to OA being assessed using the MAPT questionnaire (available in 13 languages) and, conditional upon its return, patients were informed of the date of their appointment. The MAPT review supported evidence-based triage to a musculoskeletal coordinator clinical reviewer, ‘fast-tracked’ orthopaedic assessment, standard waiting list to see an orthopaedic surgeon, or referral back to primary care without orthopaedic review. At most hospitals, it became mandatory for patients to complete a MAPT prior to access to services. Teams at individual hospitals explored the association between the MAPT scores and developed working groups to generate locally endorsed triage and management protocols.

The result: Osteoarthritis hip and knee service (OAHKS)

The service delivery model, based on chronic disease management principles, provides comprehensive multidisciplinary care, and evidence-based interventions, including patient self-management support. The aims of the OAHKS were explicitly to optimise the management of people with hip and knee osteoarthritis (OA) by: (1) establishing processes for the accurate identification of people with OA of the hip/knee; (2) completing a comprehensive assessment of identified patients in a timely manner; (3) developing a multidisciplinary management plan; (4) assigning an order to the orthopaedic waiting list for patients needing surgery based on the MAPT-based priority score, and (5) establishing processes for the monitoring and review of identified patients. A clear set of principles was established to guide the development of the service (Figure 1). Importantly, the service provided information to patients about why waiting was necessary, and what they should expect in the future.

The OAHKS also offers a new role for health professionals, particularly physiotherapists and nurses, in the management of patients with hip or knee OA – the musculoskeletal coordinator (MSC). The role of the MSC is to coordinate triage, referral, management, and prioritisation of patients referred to orthopaedic outpatient clinics for assessment of hip or knee OA.

Clinical leadership

A critical aspect of the system redesign was strong leadership, not only from orthopaedics, but physiotherapy and rheumatology. The surgeons, by designing triage protocols, supported the MSC in their key triage role and endorsed their autonomy to defer appropriate patients away from orthopaedic clinics, whilst fast tracking those in greater need. Surgeons were therefore assessing fewer patients who did not require orthopaedic intervention. Co-morbidities (e.g., obesity, hypertension and other chronic condition management) were optimised through direct provision of care by the MSC and through GP liaison. The MAPT ensured surgeons were efficiently provided with key clinical prioritisation information. With the support of the MSC, MAPT and clinical judgement, surgeons were able to identify patients with a rapid decline and reprioritise their care.

Waiting lists, in particularly those who should get surgery next – are now strategically managed, with careful prioritisation of patients in the greatest need, balanced with consideration of the time already waited on the list. The service appears to have minimised surgery cancellation rates.

Impact on patients and health care system

Patients with mild or severe OA are receiving effective and appropriate comprehensive care in a timely manner across Victorian hospitals. Risk factors for progression and co-morbidities are being dealt with. Patients receive information tailored to their needs about their condition and co-morbidities are being dealt with. Patients receive information tailored to their needs about their condition and the waiting system, and they are monitored (every 4 to 6 months). Surveys indicate very high satisfaction with the service.

Summary

The Victorian orthopaedic waiting list reform initiative now provides improved services to many thousands of individuals per year. The initiative has been incorporated into State government policy, and other Australian states have begun to incorporate the model of care. An important feature is the transparent and equitable service, greatly reduced waiting times in outpatients (from month or years, to a few weeks), new advanced musculoskeletal clinical roles for health professionals, and more efficient orthopaedic service provision.

Further information can be obtained from the author and via the funder, Victorian Department of Health http://www.health.vic.gov.au/oahks/.

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In September 2008, I had the opportunity to visit Doctor Richard Wakefield at Chapel Allerton Hospital in Leeds. Richard Wakefield is one of the leading professionals in the area of ultrasound imaging in patients with rheumatoid arthritis. He is very active in the OMERACT (Outcome Measures in Rheumatology) group working with ultrasound measures in rheumatoid arthritis. Furthermore, he has an extensive list of publications regarding the use of ultrasound imaging in patients with rheumatoid arthritis.

I am a physiotherapist and Ph.D. student at the Parker Institute in Copenhagen. The Parker Institute is a scientific institution doing research in rheumatic diseases. The topic of my Ph.D. is validation of ultrasound measures in patients with rheumatoid arthritis. Thus, a study trip visiting Richard Wakefield was indeed relevant for my thesis.

Plans for studies
It was a great experience for me to observe the work in another unit working with ultrasound imaging of patients with rheumatoid arthritis. During my stay, we planned two studies we are going to conduct together. It is of great importance and very beneficial to do studies together and, furthermore, it may strengthen the results of the studies. Moreover, it is reasonable to think that it will lead to more scientific collaboration between us in the future. Especially for me as a junior scientist, such collaboration is of great importance and it was very instructive for me to plan studies under supervision of a senior scientist working at another institute.

During my stay in Leeds, I participated in a one-day meeting for personnel working in the rheumatological area in the district of Yorkshire which was also very informative.

Two types of ultrasound
In the rheumatological area, two types of ultrasound are used, i.e., grey scale and Doppler ultrasound. The grey scale images measure morphological changes of the tissue. The Doppler is added to the grey scale image and registers movement in the scanned tissues. The movements in the scanned tissues reflect the blood flow. As the blood flow is increased in the inflamed synovial tissue in rheumatoid arthritis, the Doppler can be used as an indirect measure of disease activity in rheumatoid arthritis. Patients with rheumatoid arthritis are commonly treated with various physiotherapist interventions. The primary goal for the physiotherapeutic intervention, together with pain relief, is to suppress the inflammation and thereby avoid joint damage. Thus, it is very relevant for the physiotherapist to have a valid measuring tool to assess if various interventions have a beneficial effect on the inflammation. Thus, scientific work on validating the Doppler measurement is useful for all personnel working with the treatment of patients with rheumatoid arthritis including physiotherapists.

I would like to thank Richard Wakefield for his hospitality, and I would also like to thank the EULAR Standing Committee for health Professionals for the financial support to my educational visit.

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Educational visits
EULAR awards up to 10 bursaries for educational visits to Allied Health Professionals other than physicians working in the field of rheumatology to enable them to make an educational visit to colleagues in another EULAR member country. The amount of each of the bursaries is between €750 and €1500. The total annual amount granted is €7,500.

The objective is to improve the standard of research and care and to foster collaboration across clinical units in Europe.

The deadline for the next applications is the 31st of March 2010. Applications for 2010 should be e-mailed to Ms. Caroline Pasche at the EULAR Secretariat (caroline.pasche@eular.org). Applications should include a CV with the date of birth, objectives of the educational visit, a budget, a written confirmation from the host hospital or institute, and the tentative time frame of the training visit. The application form and the contract to be signed with terms and conditions are available at: www.eular.org/health_professionals_educational_visits.cfm.

Recipients are required to submit a report to the EULAR Secretariat after the visit, focusing on the results that have been achieved.
Scleroderma: How the health professionals can help

Scleroderma is a disease few know about. A rare disease is defined as having an incidence of no more than 5 per 10,000 people, and according to data recently gathered in the UK, scleroderma has an incidence of 1 in 10,000 people. Most doctors have great difficulty in diagnosing it because it presents with a multiplicity of symptoms in varying patterns, and with variable progress in different people. So the diagnosis odyssey is long and arduous for most people with the disease who have to journey from one doctor to another before they are diagnosed.

After diagnosis, the situation continues as uncertain, and the person struggling to come to terms with the disease finds that nobody can give information about what is going to happen, or how to handle it, or explain why an increasing number of new doctors have to be visited. Often it is a patient support organisation, a nurse, physiotherapist, or occupational therapist who gives the most help during this and ongoing times of difficulty.

Many specialists involved

Why does the doctor not do more to help his or her patient understand? Because there is often no central specialist who treats all the symptoms. Due to the concurrent involvement of many organs in the disease, the needs of the patients are enormous, often requiring the expertise of many doctors and health professionals. The person with scleroderma (also known as systemic sclerosis or SSc) may have to visit all or some of the following: a dermatologist, a rheumatologist, a gastroenterologist, a respiratory consultant, a cardiologist, a nephrologist, a vascular surgeon, a throat surgeon, and more. Many different clinics or hospitals may be involved. The ordinary general practitioner (GP) will not know that many of the symptoms are related, like difficulties in swallowing, reflux, painful joints, diarrhoea, spots on the face, and shortness of breath. A general surgeon may operate on a gangrenous finger or toe without even knowing a diagnosis for the rest of the body. There is a great deal that is not known about this disease, starting with how often it occurs. It is generally considered that 10 percent of any population will suffer from Raynaud’s, a condition in which the circulation in the fingers and toes shuts down when chilled, and which can be damaging in its own right, although it may also be quite mild. Raynaud’s is nearly always the first symptom of scleroderma. Of these Raynaud’s sufferers, in some countries like Ireland, it is predicted that 2 percent will have scleroderma, while in others like Italy it is believed that 7 percent is more likely. We do not know why anyone gets it or why more women get it than men.

What we do know is that it is chronic and incurable, neither contagious nor infectious, not inherited, neither racially or geographically biased, four times as likely to affect women as men, but may also attack children. No causes, or even triggers, have as yet been identified. While it is not genetic, there may be a slight predisposition in families with a history of rheumatic diseases. Scleroderma can develop at any age, although onset is most frequent between 25 and 55.

An umbrella term

But one of the difficulties is the definition itself. Scleroderma is really an umbrella term for a number
of different disease presentations. It is a disease of the immune system, the connective tissue and the vascular system. One form of the disease that attacks children can burn itself out, but after causing permanent damage to the limbs. This is called Localised Scleroderma. In another form, called Limited Scleroderma, the skin effects do not extend beyond the limbs, but there is a specific pattern of 5 other noticeable symptoms, and the organs can be affected.

But the most all-encompassing form of the disease is known as Diffuse Systemic Sclerosis, and the name is indicative of its severity. However, even this form presents differently in different people and progresses at very different rates. This has historically led to late diagnosis and treatment, generally after symptoms are well developed and difficult to control.

If an adjunct health professional recognises or is told that a patient has scleroderma, there is a lot he or she can do to help. For instance, a physiotherapist can find out about many exercises that exist to help the different areas of the body affected, and not only the stiff wrist joints that caused the referral. An occupational therapist can recommend various aids. A nurse can ask about bowel problems or reflux difficulties, in addition to treating the ulcers on the fingers. A rheumatology nurse can explain what is happening and why all the tests are needed. Health professionals can refer patients to their national patient support organisation so that they have someone to talk to who understands. Family problems, the psychological consequences of looking different, departure of a partner, loss of a job, perhaps loss of a home – all these may affect the person with scleroderma and s/he may need a counsellor.

The federation of associations

Without the lifeline of an understanding person, many patients feel lost in a medical world of endless appointments that they do not understand. The Federation of European Scleroderma Associations, or FESCA, was founded to help national support organisations fulfil the need for information, support, and advocacy. The inaugural European Scleroderma Day on June 29th brought awareness and launched the diagnostic program VEDOSS – Very Early Day on June 29th brought awareness and launched the diagnostic program VEDOSS – Very Early Diagnosis of Systemic Sclerosis. This program is aimed at getting doctors to recognise early symptoms and to refer patients to rheumatologists for diagnosis and treatment.

The causes of scleroderma may remain elusive but we do know what happens physically: the auto-immune system malfunctions, so that the body places excess collagen on its connective tissue (the skin and the packing material around the internal organs). Damage to the blood vessels, meanwhile, causes them to constrict and stiffen, perform badly, and so weaken the organs they supply. Raynaud’s is observed clearly in the hands and feet, but its characteristic effect is occurring within the body too. The only organ that has never been known to be affected is the brain.

A health professional advocate

The quality of life of a person with SSc will be improved by treatments for major symptoms. Kidney complications can now be cured if caught early. Pulmonary Hypertension can usually be controlled by endothelin receptor blockers. Lung fibrosis can be treated. But lesser symptoms continue, and in many countries, getting help is the responsibility of the patient who is quite likely to be treated for one symptom without the underlying disease being investigated. What is needed is an advocate who knows about the disease. If no specific doctor or nurse or other health professional is in charge of the patient’s overall care, he or she is isolated with no-one to refer to for advice, comfort, and encouragement.

Therapies like hand and finger-stretching, special dental devices, stretching exercises for microstomia, paraffin hot-wax baths for increasing joint mobility, the use of chemically activated heating devices to keep hands and feet warm, even the right kind of thermal socks and handwarmers can all help too. FESCA suggests that health professionals be as proactive as possible in discussing these, so that the person with scleroderma can feel more comfortable and learn to deal with periods of disease flare and incapacity.

Please visit the FESCA website for more information and for the address of your national organisation, which will be able to give you leaflets in your own language: www.fesca-scleroderma.eu.

Ann Tyrrell Kennedy
President FESCA,
CEO Irish Raynaud’s & Scleroderma Society
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Edgar Stene prize 2009 Rare but not less severe

The theme of Edgar Stene Prize for 2009 was ‘Rare but no less severe: the challenge of coping with a rare rheumatic disease’. The prize was won by Emmi Myöhänen from Finland. For the first time the entries for competition have been gathered in a booklet. Read the inspiring and moving stories from the 15 country finalists and an interview with the 2009 winner at http://www.eular.org/myUploadData/files/Stene%20Prize%202009%20Booklet.pdf.
EU Interest Group tackles the burden of musculoskeletal diseases

A new European cross-party Interest Group on musculoskeletal diseases/disorders (MSD) had its first session at the European Parliament on World Arthritis Day in October 2009 to address the social and economic burden MSDs place on EU member countries.

The new informal Interest Group aims to look at initiatives and legislation the European Parliament and other EU institutions could take to ensure people with rheumatic and other musculoskeletal diseases are more integrated into society. The Health Commissioner Androulla Vassiliou attended the launch of the group. She welcomes the effort of the European Parliament to offer people with MSD the best practices available in the EU. She referred to surveys showing that perhaps as many as 100 million people suffer from arthritis or some form of musculoskeletal disease across the EU. The Commissioner emphasized that all these people may face a constant undermining of their quality of life, and their ability to live and work as they would wish.

— Many people think that arthritis and other similar conditions are inevitable. But they are not. There are simple actions that citizens can take to reduce the burden of arthritis, said Vassiliou.

EU cannot afford to not to help

The health Commissioner referred to the well-acknowledged phrase ‘demographic ageing’. Thanks to the triumph of medicine and healthy living, many Europeans are living longer than ever before. It also means that the proportion of elderly people is rising, and the number of people of working age is falling.

— In short, our economic prosperity and our social solidarity will depend on fewer and fewer people in the years to come. We therefore simply cannot afford to have people unnecessarily incapacitated by chronic conditions such as arthritis, Vassiliou pointed out.

According to the Commissioner, there are easily accessible ways in which public authorities can act to help and give valid information on musculoskeletal health.

— One of our key contributions is to bring together knowledge and best practice across Europe, so that everyone can learn from the best examples. We have done this for musculoskeletal conditions. Through our projects, experts and patients have developed concrete recommendations for action, Vassiliou underlined.

These recommendations are specific and practical. To reduce the enormous impact of musculoskeletal diseases, people of all ages should be encouraged to...
Extended health professionals roles

Extended roles can be defined as tasks which have not been commonly undertaken by health professionals or a certain group of health professionals to date, and which require at least additional training or education in addition to your basic professional training.

Extended roles of health professionals and corresponding innovative models of care have been pioneered in the UK, Canada, USA and Australia, but no data on the current situation in Europe exist. However, the general experiences showed considerable differences between countries, such as what health professionals do, how they are recognized, which educational possibilities they have, etc. Within EULAR, the Standing Committee of Allied Health Professionals will undertake a survey with the aim to gain an overview on extended roles and innovative models of care undertaken by health professionals in Europe.

follow a healthy lifestyle and to avoid the specific risks related to musculoskeletal health.

– In practice, this means physical activity to maintain physical fitness, maintaining a healthy weight, following a balanced diet that meets the recommended daily allowance for calcium and vitamin D, not smoking, and drinking alcohol only in moderation, said Vassiliou.

Raising MSD awareness

The launch of the Interest Group was hosted by Edite Estrela, a MEP from Portugal.

– Our intention is to raise the visibility of rheumatic diseases at a European level and ensure that rheumatic diseases are placed on the agendas of European policy makers, said Edite Estrela who will lead the group.

Earlier, Ms. Estrela has co-presented a written declaration on rheumatic diseases that has been adopted by the majority of members at the European Parliament and she has promoted the creation of the Interest Group.

– MSDs, and most specifically, rheumatic diseases have been one of my priorities for some time now. In 2008, I was invited to host the Women in RA campaign at the European Parliament. Since then, I have been quite active in this domain, working together with different national and international organizations to raise awareness for these diseases that affect about one third of Europe’s population. I sincerely hope that our work may contribute to raise the visibility of rheumatic diseases in EU, Estrela added.


The preliminary AHP programme at the EULAR Congress 2010

The next EULAR Congress will again be the venue of high-quality Scientific Sessions introducing health professional research and issues of interest in the practical health professional work. In 2010, there will be 2 abstract sessions. There will also be joint sessions organized together with rheumatologists and the Standing Committee of People with Arthritis/Rheumatism in Europe (PARE). The final programme will be launched in spring 2010 on EULAR website.

The Allied Health Professionals Programme

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<td>Ulla Nordenskjöld’s honorary lecture: past, present and future of Health Professionals within EULAR 1. speech: Ulla Nordenskjöld - The history of health professionals within EULAR - how we started 2. speech: Peter Oesch - The future of HPs from the past Vice-President's perspective 3. speech: Kåre Birger Hagen - What will happen the next year(s) – from the Vice-President's perspective</td>
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<tr>
<td>Abstract Session (1) scientific</td>
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<td>Allied Health Professionals Workshop Session</td>
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<td>EULAR Rheumatology Update</td>
<td>What is the current level of implementation of extended roles of health professionals in Europe?</td>
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Planning the EULAR Congress 2010

The next EULAR Congress will be held in Rome, Italy from 16 to 19 June 2010.

The aim of the Congress is to provide a forum of the highest standard for scientific, educational and social exchange between physicians, health professionals and researchers involved in rheumatology and liaising with patient organizations to achieve progress in the care of patients with rheumatic diseases.

Abstract submission for Rome 2010

The health professional abstract submission process is open until the 31st of January 2010.

Health professionals can choose to submit their abstract either for practice and clinical care (topics A1 – A5) or for health professional research work (topics 7 – 27).

For further information see the EULAR website www.eular.org.

AHP travel bursaries

EULAR offers travel bursaries for AHPs presenting their work during the congress. These travel bursaries will only be granted to the first author of an accepted oral or poster presentation. The application can be sent before a decision on acceptance of the abstract is made, as long as the reference number is given. The application forms are available at http://www.eular.org/edu_travel_bursaries_ahp.cfm.
Confirmation of the AHP scientific proposals for EULAR Congresses

There have been repeated inquiries on how AHP scientists retrieve information on the approval of their proposal for the next EULAR Congress. According to the AHP Chairperson Tanja Stamm, there is no actual confirmation of the proposals prior to the letter of expectation sent by the EULAR Executive Secretariat. The official process of AHP scientific proposal submission goes as follows: First, the EULAR Programme Planning Committee in charge of the whole scientific programme for the coming Congress submits the final session proposals to the EULAR Steering Committee which makes the official approval of submission. At this point, the EULAR Executive Secretariat sends out the invitation letters for the speakers and chairpersons in question.

– However, before this official process takes action, the AHP-scientific session proposals sent by various AHP-scientists are informally viewed by the health professionals’ programme planning team in the AHP Committee, Stamm says.

This informal procedure was introduced by the past AHP Vice-president Peter Oesch to get a wider scope of the themes and to receive more proposals from the AHP research community. All AHP session proposals are scored by the health Professional Scientific sub-committee. Based on these scores, the EULAR Programme Planning Committee suggests the submission of the proposals for the EULAR Steering Committee or can also decide to join two proposals into one.

– This can be done for example, if incomplete proposals have been sent in, or if too many proposals targeted specifically at one health professional group are submitted, clarifies Stamm.

The whole procedure, taking into account the informal and formal process, takes from the end of March until the meeting of the Programme Planning Committee in early September.

The EULAR Health Professionals Research Grant

Every year EULAR funds one health professional’s research project in the field of arthritis/rheumatism that is in line with the mission, objectives and goals of EULAR. Projects will be funded up to a maximum of € 30,000.

Recipient of a research grant must submit a mid-term report to the Scientific Committee of the EULAR Health Professionals on the progress of the research project. After completion of the project the recipients must report to the EULAR Executive Committee on the results achieved. Furthermore, the recipients are expected to present their project in the EULAR AHP newsletter and may be invited to present their findings at the annual EULAR congress.

Application process
Applicants must complete the official application form (including detailed budget), and include the full CV of the project leader as well as a project plan. For further instructions see the official application form available at: http://www.eular.org/health_professionals_research_grants.cfm.

Applications for 2010 should be e-mailed to Ms. Caroline Pasche at the EULAR Secretariat (caroline.pasche@eular.org) to arrive no later than the 31st of December 2009. Applications will be evaluated by the Scientific Committee of the EULAR Health Professionals in early 2010. Applicants will be informed by e-mail.

The following evaluation criteria will apply:
- Scientific value
- Implementation and relevance for EULAR Health Professionals (i.e., how the project may improve the non-pharmacological management of patients in a short and/or long-term perspective, and/or whether the project may foster the development of a research network of relevance for the future beyond the period of the project)
- Quality of the work plan and methods
- Feasibility of the study within the planned timeframe
- Patient-centered approach (if applicable)
- Budget realistic for the planned project
- Planned dissemination and implementation of the research results

Do you have good news for the newsletter?

Since 2000, the AHP newsletter has functioned as the main information channel of the Allied Health Professionals in Rheumatology within EULAR. The newsletter is published twice a year featuring the work of Allied Health Professionals and all aspects of multidisciplinary collaboration in rheumatology.

Let us know about recent AHP dissertations, health professional projects, research plans on AHP-fields (nurses, occupational therapists, physiotherapists, podiatrists, nutritionists, social workers, and psychologists). Also news about the multidisciplinary development on the European level would be an interesting theme or an interview with a specialist on AHP approach. Contact the Editorial office of AHP newsletter for further information at www.eular.org/st_com_health_professionals.cfm.
EULAR Standing Committee of Allied Health Professionals in Rheumatology

EULAR's Standing Committee of the Allied Health Professionals' (AHP) main function is to promote interdisciplinary collaboration in the treatment of rheumatic and musculoskeletal diseases in Europe. The AHP Committee is composed of health care professionals, such as nurses, occupational therapists, physical therapists, psychologists, social workers, nutritionists and podiatrists and other health professionals.

The AHP committee encourages health professional research in rheumatic and musculoskeletal diseases and works also to improve the patient's role as the key expert of his/her own treatment. The AHP Committee was established in 1989 as a European platform for collaboration and shared information among the different health professionals working with rheumatology.

More information is available at www.eular.org/st_com_health_professionals.cfm.