COMMISSIONER QUALITY METRICS IN RHEUMATOID ARTHRITIS: IMPACT ON CLINICAL PRACTICE AND QUALITY OF CARE

Marwan Bukhari[1,2], Preeti Shah,[5] George Kitas[4], Maureen Cox[7], Alan Nye[6], Anne O'Brien[8], Peter Jones[3]; Ify Sargeant[9] [1]*Royal Lancaster Infirmary, Lancaster, United Kingdom;* [2]*Clinical Sciences, University of Liverpool, Liverpool, United Kingdom;* [3]*Statistics, Keele University, Keele, United Kingdom;* [4]*Rheumatology, Dudley group of hospitals NHS trust, Dudley, United Kingdom;* [5]*Rheumatology, Trafford General Hospital, Trafford, United Kingdom;* [6]*Rheumatology, Pennine MSK partnership, Oldham, United Kingdom;* [7]*Rheumatology, Nuffield Orthopaedic centre, Oxford, United Kingdom;* [8]*School of Health and Rehabilitation, Keele University, Keele, United Kingdom;* [9]*ismedica ltd, Staffordshire, United Kingdom*

Background:

– The importance of the use of performance metrics is highlighted by Department of Health initiatives such as, Liberating the NHS: An Information Revolution.[1] which highlights the need to measure clinically-relevant outcomes that are important to patients (pts) to assess quality of care.[2]

– Greater attention needs to be given to address the use of performance metrics as a mechanism for measuring quality improvements. NICE quality standards are currently being developed for RA with anticipated publication in June 2013.[3]

– A multidisciplinary group (Commissioning for Quality in Rheumatoid Arthritis [CQRA]) was established in 2010 and developed quality commissioning metrics based on 2009 NICE clinical guidelines on managing rheumatoid arthritis[4] to drive implementation of best practice in RA.

– A pilot study (n= 86), *An Audit of Commissioner Quality Metrics in Rheumatoid Arthritis March 2011*, indicated that the metrics are easily administered in existing rheumatology units. Authors now report results of a follow-up study one year later undertaken to assess whether implementation of the metrics can improve RA management in line with best clinical practice.

Methods:

– The CQRA commissioning metrics and associated data collection forms were developed with input from clinicians, patients, academics and commissioners.

– Published evidence on quality measures was analysed in conjunction with NICE guidelines to produce a manageable number of simple, meaningful and clinically-relevant quality commissioning metrics.

– Metrics were prioritised based on clinical, patient and commissioning importance, covering: speed of referral; regularity of disease activity assessment; rapidity of treatment escalation to achieve clinical remission or low disease activity; and regularity of comprehensive patient review. The final four metrics reflect clinically important outcomes that indicate adherence to NICE guidelines resulting in good clinical practice and also reflect key issues important to patients.

– Metrics and data collection forms were developed to include patients with established and recent onset disease (disease duration ≤2 years).

– Patients were involved in the creation of the data collection tools and prioritising of metrics chosen. Data for the follow-up 2011 study were gathered in four units and clinical management scrutinised in both established and recent onset RA pts:
- Dudley Group NHS Foundation Trust
- Royal Lancaster Infirmary
- Trafford General Hospital
- Nuffield Orthopaedic Centre Oxford

RESULTS

Table 1: Patient characteristic data for 2011 and 2010 audit

	2011 audit	2010 audit
Total number of patients	118	73
Recent onset RA, n (%)	37 (31%)	19 (26%)
Established RA, n (%)	81 (69%)	54 (74%)
RA duration >10 years, n (%)*	25 (33%)	15 (58%)
Male, n (%)	40 (34%)	19 (26%)

Patient characteristics were matched in both studies

– The median age range for patients with recent onset RA was 51–60 years; the median age range for patients with established RA was 61–70 years

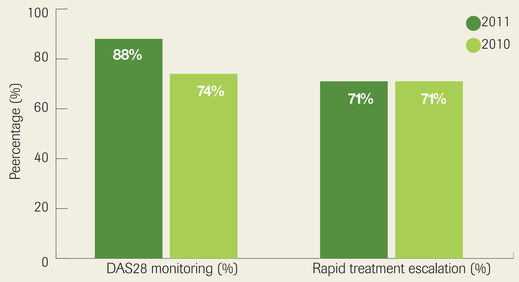
– In the 2010 audit, 73 patients were included in the pilot; 54 (74%) were female; the median age range was 51-60 years (range 20-81 years). Nineteen (26%) had recent onset RA and 54 (74%) established RA of whom 15 (58%) had disease of > 10 years duration.

Comparison of data for 2011 and 2010

Comparison of data for patients with recent onset RA

– For recent onset pts in the current study:
  – 24/34 pts (71%) had DAS28>2.6: of these, 88% were seen every 4–6 weeks and DAS28 score assessed at every visit in 88%
  – 71% had rapid escalation of treatment until clinical remission or DAS28≤2.6 was achieved.
– Compared to 2010, improvement in DAS28 monitoring was noted (88% vs. 74%) and the proportion of patients given rapid treatment escalation to achieve remission was unchanged (71% vs. 71%) (Figure 1).

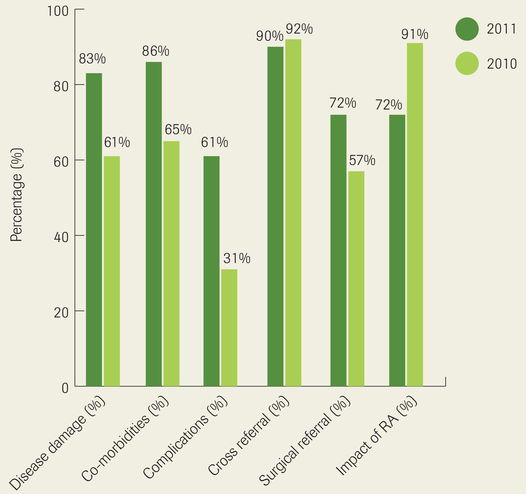
Figure 1: DAS28 monitoring and rapid escalation for 2011 vs. 2010



Comparison of data for patients with established RA

– For established pts in the current study:
  – 27/78 pts (35%) had high/moderate disease activity according to DAS28: of these 37% had regular DAS28 assessment every 4–6 weeks
  – 45/57 pts (80%) had low disease activity (DAS28<3.2): of these, 67% had DAS28 assessment every 3–6 months
  – 71% of eligible established pts had treatment modification until sustained low disease activity or remission was achieved
  – 16% received biologics, of whom 92% had an adequate response within 6 months.
– Compared to 2010, improvement in tight control was noted (71% vs. 45%).

Figure 2: Annual review data for 2011 vs. 2010



Comparison of annual review data for recent onset and established RA patients

– For both recent onset and established RA pts in the current study at annual review:
  – disease damage was measured in 83% of eligible pts (compared with 61% in 2010)
  – co-morbidities were assessed in 86% (compared with 65% in 2010)
  – complications were assessed in 61% (compared with 31% in 2010)
  – the need for cross referral within the multidisciplinary team was assessed in 90% (compared with 92% in 2010)
  – the need for surgical referral was assessed in 72% (compared with 57% in 2010)
  – the impact of RA on pts was assessed in 72% (compared with 91% in 2010).
– Compared to 2010, improvements were noted in 4 of 6 annual review categories (Figure 2).

Conclusions:

– There is improvement in DAS28 monitoring with potential to further optimize therapy and minimize the potential for long-term joint damage.

– The improvement in tight control observed is encouraging and demonstrates the benefits that can be achieved with implementation of the CQRA metrics.

– CQRA metrics facilitated measurement of improvement in 4 of 6 annual review categories.

– Lack of improvement in 2 categories illustrates that the metrics can be used as indicators to identify areas for further improvement and focus.

– Implementation of the metrics can facilitate improvement of quality of care as assessed by measuring alignment of actual clinical practice to best practice as defined and advocated by NICE.

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CQRA Commissioning for Quality in Rheumatoid Arthritis