

**Developing a patient-centered framework for measuring, monitoring and
optimizing rheumatoid arthritis care**

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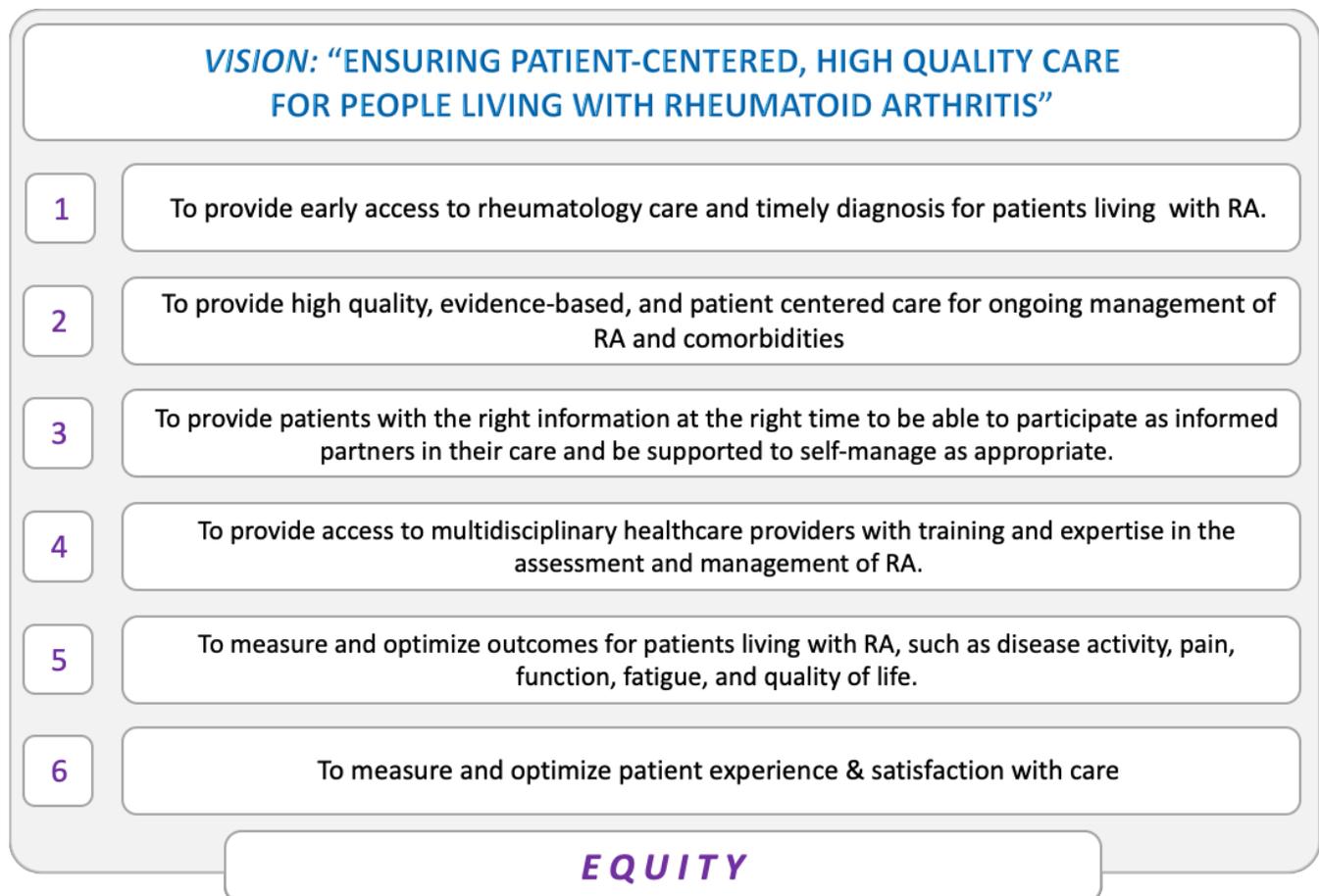
Developing a patient-centered framework for measuring, monitoring and optimizing rheumatoid arthritis care

This Canada-wide study is divided into three phases. Each phase builds toward the goal of implementing and testing a patient-centered framework for quality improvement for rheumatoid arthritis (RA) care. The framework incorporates an existing set of 6 system-level performance measures of early access to care and treatment for patients with inflammatory arthritis¹. We invite you to join us in helping to finalize this project by providing your review and comments on the RA quality framework and selected measures.

Phase 1: Defining the Vision and Strategic Objectives for Quality Improvement

This phase involved 54 stakeholders who participated in focus groups and interviews to define what quality rheumatology care means. We engaged people living with RA, rheumatologist physicians, allied health providers, healthcare managers and policy-makers. This allowed us to develop a vision for quality RA care and 6 strategic objectives to be used as a foundation for the quality framework. As well, equity was identified as an important theme that applied across all 6 strategic objectives. This model is presented in Figure 1.

Figure 1:



Phase 2a: Selection of Performance Measures

A performance measure is a number or a percentage that describes a process, a structure, or an outcome of care. Performance measures help us understand healthcare performance and guide quality improvement. A review of existing, validated performance measures in RA² was used for this phase. A final set of 15 measures was selected from this previously published review by a modified Delphi process³. These were added to the 6 system-level performance measures mentioned above to create a final list of 21 measures.

This modified Delphi process involved a group of 17 experts including clinicians, researchers, and patients living with RA. Group members worked together to choose the measures that best aligned with the vision and strategic objectives defined in Phase 1. Measures were chosen because they ranked highest in terms of importance for RA care and feasibility of measurement. Finally, they were matched with the Canadian Institute for Health Information (CIHI) quality themes⁴ shown in Figure 2.

Figure 2:



Phase 2b: Public Comment

We invite you to participate in this phase by sharing your review and comments on the framework and the measures. The components of the framework are shown in Table 1. The performance measures are grouped according to each of the 6 strategic objectives. As well, the coloured boxes show which CIHI theme is linked to each measure.

Measures have been adopted from the primary sources shown in the linked references; however, we have worded each as a performance measure so the original wording may have been changed to create a harmonized terminology throughout our framework.

Phase 3: Testing the Measurement Framework

Once this phase of public comment is complete, we can begin Phase 3, which is to test an electronic version of the framework in rheumatology clinics in Alberta.

Table 1:

VISION: Ensuring Patient-Centered, High Quality Care for People Living with Rheumatoid Arthritis*	
STRATEGIC PRIORITY 1: To provide early access to rheumatology care and timely diagnosis for patients living with RA	
A ⁱ	Number of days patients waited, between the date the initial referral was received and the date of consultation with a rheumatologist for patients with new onset RA, where the diagnosis of RA is made or confirmed by a rheumatologist ¹
A	Percentage of patients with new onset RA with at least 1 visit to a rheumatologist in the first year of diagnosis, regardless of who makes the diagnosis ¹
A	Number of rheumatologists per 100,000 population ¹
A	Number of referrals received (in the measurement period) ⁵
STRATEGIC PRIORITY 2: To provide high quality, evidence-based, and patient centered care for ongoing management of RA and comorbidities	
A	Percentage of RA patients seen within 3 months when remission has not been achieved ⁶
A	Percentage of RA patients under the care of a rheumatology team seen in follow-up by a rheumatology team member at least once per year ¹
S	Percentage of RA patients who have documentation of a tuberculosis (TB) screening performed within 12 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD) ^{7,8}
S	Percentage of patients aged 18 and older seen for a visit between October 1st and March 31st who received an influenza immunization OR who reported receiving an influenza immunization ^{9,10}
S	Percentage of patients 65 and older who have ever received a pneumococcal vaccine ^{9,10}
AE	Number of days between the diagnosis of RA and the time that a disease-modifying anti-rheumatic drug (DMARD) medication was prescribed or dispensed, where the diagnosis of RA was made or confirmed by a rheumatologist ¹
AE	Percentage of RA patients with a disease-modifying anti-rheumatic drug (DMARD) medication prescribed or dispensed during the measurement year ¹
AE	Percentage of RA patients with moderate or high disease activity for whom treatment was intensified with disease modifying therapy ¹¹
AE	Percentage of RA patients with a blood pressure measurement documented in the medical record at $\geq 80\%$ of clinic visits in the measurement year ¹²
AE	Percentage of RA patients aged 50-90 years who have had an assessment of fracture risk using a risk assessment tool adjusted for RA in the measurement period ¹³
AE	A) Percentage of RA patients with a formal cardiovascular (CV) risk assessment according to national guidelines at least once in the first 2 years after evaluation by a rheumatologist; AND B) Percentage of RA patients at low risk, with a repeated risk assessment once every 5 years; OR C) Percentage of RA patients at intermediate or high-risk with documentation of risk factors according to national guidelines should be recommended. ¹²
SD	A) Percentage of RA patients with a body-mass index (BMI) documented at least once every year, AND B) Percentage of RA patients who are overweight or obese according to national guidelines, who are counseled to modify their lifestyle ¹²

STRATEGIC PRIORITY 3: To provide patients with the right information at the right time to be able to participate as informed partners in their care and be supported to self-manage as appropriate					
PC	Percentage of RA patients with a treatment plan developed between him/her and his/her clinician / health professionals at each visit ¹¹				
STRATEGIC PRIORITY 5: To measure and optimize outcomes for patients living with RA, such as disease activity, pain, function, fatigue, and quality of life					
AE	Percentage of RA patients with active RA (i.e. disease activity score-28 (DAS-28 ⁱ) > 3.2) who have low disease activity (i.e. DAS28 ⁱ < 3.2) achieved 6 months after treatment has been initiated ¹¹ <i>or other composite score for disease activity</i>				
AE	Percentage of RA patients in remission (DAS28 < 2.6) during the measurement period ⁶				
AE	Percentage of RA patients with >=50% of total number of outpatient encounters in the measurement year with assessment of disease activity using a standardized measure ^{7,8}				
HS	Percentage of visits for RA patients with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present ^{9,10}				
No PMs meeting criteria for inclusion addressed STRATEGIC PRIORITY 4 or STRATEGIC PRIORITY 6.					
ⁱCIHI Quality Themes					
Access (A)	Safety (S)	Appropriateness & Effectiveness (AE)	Person - Centeredness (PC)	Social Determinants (SD)	Health Status (HS)

* Refers to adults age 18 years and older, unless otherwise specified

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