AMGA

Advancing High Performance Health

AMGA Foundation

Best Practices in Managing Patients with Rheumatoid Arthritis

Colorado Springs Health Partners

Developing a Referral Protocol for Primary Care

Organizational Profile

Colorado Springs Health Partners (CSHP) has a long history of meeting the healthcare needs of residents in the Pikes Peak Region. Started by six physicians, The Colorado Springs Medical Center was formed at a single downtown location in Colorado Springs in 1946. The founding physicians were all World War II veterans and included a general surgeon, two internal medicine specialists, an obstetrics/gynecology specialist, a pediatrician, and an ophthalmologist. The practice grew to become CSHP through a 1995 merger with several local physician practices, and through a major acquisition in January 2015, is now a division of DaVita HealthCare Partners. CSHP was founded on and still holds to the philosophy that multispecialty group practice offers the best means of providing quality medical care. The mission of CSHP is to provide a consumer-oriented, multispecialty healthcare delivery system while making a positive and caring contribution to the Colorado Springs community. Since its inception, CSHP has grown to more than 100 physicians, 20 mid-level practitioners, and over 600 support staff at 11 facilities. The CSHP central facility is the hub for specialty and ancillary services. CSHP currently serves an active population of approximately 106,000 patients with over 500,000 total patient visits in 2015.

Project Summary

CSHP has implemented a "fast track" referral system that allows appropriately identified patients to be seen within a two-week time period in Rheumatology. The group has also developed RA identification and initial treatment protocol to its primary care and community providers including recommended laboratory to include Rheumatoid Factor (RF), Cyclic Citrullinated Peptide (CCP), C-Reactive Protein (CRP), and clinical measures on morning stiffness greater than 30 minutes, as well as symmetric polyarticular swelling as criteria for enhanced referral. This encompassed all of Colorado Springs Health Partners' sites, as it was built into the EHR referral algorithm. CSHP will have paper referral forms in place for community referrals.

Program Goals and Measures of Success

The goal of the CSHP Rheumatology pilot was to develop a referral protocol for primary care to identify and obtain testing prior to referral to Rheumatology. The protocol in Figure 1 was distributed to community primary care partners and also incorporated into the EHR for CSHP Primary Care.

As part of the AMGF Best Practices Collaborative, CSHP also incorporated measures of Functional Status and Disease Activity Assessment into the Rheumatology department. In addition, they also incorporated scores into EHR as a Rheumatology "vital sign." The modification of CSHP's EHR was accomplished by their internal resources. The scoring became part of a flowsheet (Figure 2).

As part of the Collaborative, three PQRS measures were selected for reporting purposes: DMARD Therapy for RA, Periodic Assessment of Disease Activity, and Functional Status Assessment. Initially, CSHP was only able to measure DMARD Therapy. With the addition of the MDHAQ scoring into the EHR, the measures of Disease Activity and Functional Status Assessment were able to be quantified.

Data reporting showed the following results:

- DMARD Therapy: 87.9% to 85.4%
- Disease Activity: 0% (not measured) to 74.6%
- Functional Status: 0% (not measured) to 74.6%

As a result of this pilot, community providers referred appropriate patients to Rheumatology. Patients were seen in an average of 7-14 days once referred rather than 4-6 weeks as

Figure 1

Diagnosis	Information Needed Prior to Consult	Tests Needed Prior to Consult	Treatment Tried	Referral if:
Joint pain/ Rheumatoid Arthritis	• Current medication list • Labs & radiology pertinent to diagnosis • Office notes related to assessment and diagnosis Need to assess the following: 1. Characteristics, location, duration and extent of the present pain complaint 2. Is pain bilateral? 3. Any joint swelling? 4. Assess MCP/MTP joint involvement by doing a squeeze test to assess for (≥ 3 swollen joints) 5. If MTP pain; does it feel like walking on pebbles 6. Morning predominant symptoms > 30 minutes (possible improvement throughout the day/can worsen at night)	LAB TESTING For patients with suspected inflammatory arthritis - CBC, creatinine, liver enzymes, ESR, CRP, RF, ANA WITH PATTERN, uric acid IMAGING If symptoms > 1 year then x-ray using the PA/Open Book Views. (Look for hooked osteophytes and joint erosions)	NSAIDs or other analgesics as a first line drug therapy. • Utilize glucocorticoids as last resort Assess and manage other metabolic conditions such as diabetes or thyroid and assure these are under good control.	Refer patients with osteoarthritis and other musculoskeletal pain syndromes when they are refractory to attempts to treat. Refer if any of the designated lab tests are positive.

before the referral protocols were shared. Patients were also more compliant with treatment as they tracked their scores using the MDHAQ. Patients often remarked that they knew their scores were getting better because they felt better.

Population Identification

CSHP identifies its RA population using ICD coding. Patients have RA as an active problem on their problem list to be included in the population. Current RA population by coding is 640 patients.

CSHP uses analytics tools to generate reports from the EHR to identify patients. These lists have been distributed to both Rheumatology and CSHP primary care to validate the diagnosis of RA and update problem lists appropriately.

The rheumatologist that was part of this Collaborative retired midway through the year-long project. CSHP has recently hired a new rheumatologist who will start in April 2016. The protocols that were developed as part of this Collaborative were a large part of his decision to join us.

Intervention

An increasing shortage of rheumatologists in the community and a growing backlog of patient referrals created access issues. As RA can be an aggressive disease with multiple effective therapies currently available, timely entry into the system is important.

The Rheumatology Department had previously tracked morning stiffness, TB screening, and DMARD prevalence.

There were no methods in place to monitor the patient's functional status or disease activity. Creating the "vital sign" for rheumatology was essential to the success of this program. Schedules were modified to block appointments for new RA patients as a result of the "fast-track" process.

MDHAQ forms (Figure 3) were enlarged to 11" x 17" and laminated for ease of use and sustainability. The forms were given to all rheumatology patients and not just RA patients to speed the flow of patients at check-in. The patients would mark their answers as they were waiting to be seen. CSHP found that training the MA staff on scoring the MDHAQ and RAPID 3 was simple and quickly became part of the rooming process.

CSHP's EHR is Allscripts Touchworks v.11.4.1. They utilize both Precision BI® (PBI) and Optum One® as analytical tools.

Leadership Involvement & Support

CSHP Chief Medical Officer Dennis L Schneider, MD, fully supported this project from the onset.

Figure 2

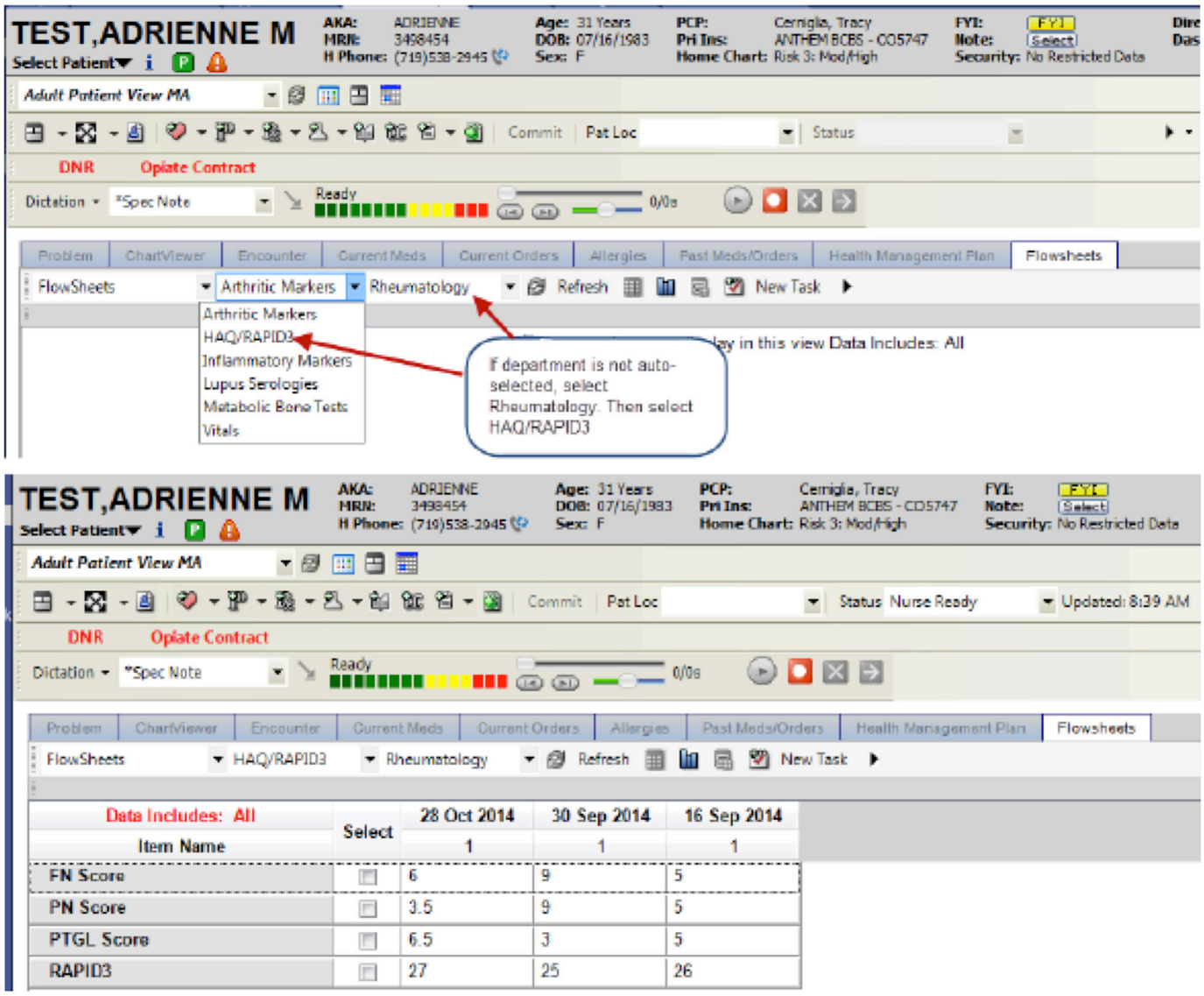

Figure 3

CSHP
COLORADO SPRINGS HEALTH PARTNERS, P.C.

Multi-Dimensional Health Assessment Questionnaire (R808-NP2)

Rheumatology Department
1633 Medical Center Point
Colorado Springs, CO 80907

This questionnaire includes information not available from blood tests, X-rays, or any source other than you. Please try to answer each question, even if you do not think it is related to you at this time. Try to complete as much as you can yourself, but if you need help, please ask. There are no right or wrong answers. Please answer exactly as you think or feel. Thank you.

1. Please check (√) the ONE best answer for your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without **ANY** Difficulty	With **SOME** Difficulty	With **MUCH** Difficulty	**UNABLE** To Do
a. Dress yourself, including tying shoelaces and doing buttons?	0	1	2	3
b. Get in and out of bed?	0	1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	3
d. Walk outdoors on flat ground?	0	1	2	3
e. Wash and dry your entire body?	0	1	2	3
f. Bend down to pick up clothing from the floor?	0	1	2	3
g. Turn regular faucets on and off?	0	1	2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	2	3
i. Walk two miles or three kilometers, if you wish?	0	1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	1	2	3
k. Get a good night's sleep?	0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	2.2	3.3

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1.FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2.PN (0-10):

3.PTGL (0-10):

RAPID 3 (0-30)

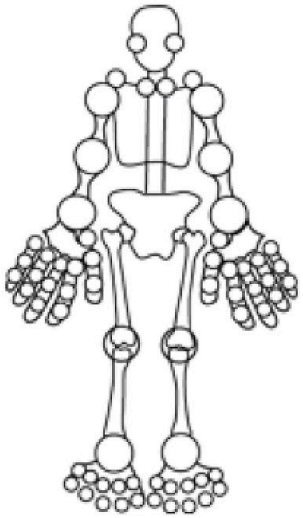
2. How much pain have you had because of your condition OVER THE PAST WEEK? Please indicate below how severe your pain has been:

NO PAIN ○ PAIN AS BAD AS IT COULD BE
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

VERY WELL ○ VERY POORLY
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

4. Please color in the 3 joints that are currently bothering you the most.



Information derived from: Health Report Services, 210 LaVista Drive, Nashville, TN 37215, Telephone 615-936-2151, Fax 61

Lessons Learned and Ongoing Activities

As a result of a specific referral protocol, CSHP had to ensure that schedules were adjusted to accommodate the "fast-track" RA patients. CSHP may have also re-evaluated the logistics of training on identification of RA patients in the schedule so that only RA patients are given the questionnaire. Some non-RA patients expressed concern over why they were given the MDHAQ to complete. Additionally CSHP found that many DMARDs were not being entered in the medication list and thus the rate of patients on DMARD was artificially low. As such, all providers and staff need to be re-educated about importance of entering all medications into the EHR. With unfortunate timing, the retirement of the only rheumatologist stopped all activity, and many longtime rheumatology patients were forced to seek care elsewhere.

Next Steps

CSHP will be bringing the new rheumatologist up to speed on project and goals.

Acronym Legend

CDAI: Clinical Disease Activity Index
DMARD: Disease-Modifying Anti-Rheumatic Drug
HAQ: Health Assessment Questionnaire
MDHAQ: Multi-Dimensional Health Assessment Questionnaire
PQRS: Physician Quality Reporting System
RAPID 3: Routine Assessment of Patient Index Data 3
SDAI: Simple Disease Activity Index

RA Team

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