AMGA™

Advancing High Performance Health

AMGA Foundation

Best Practices in Managing Patients with Rheumatoid Arthritis

Summit Medical Group

Standardizing Protocols and Educating Providers

Organizational Profile

Summit Medical Group, established in 1929, is the largest for-profit, physician-owned and -governed multispecialty group in New Jersey. Now in its 87th year of practice, Summit provides comprehensive, integrated primary and specialty care for more than a half-million patients in the area. Employing more than 620 providers representing over 70 specialties, more than 130 primary care physicians, and five rheumatologists, it is composed of a flagship, four hubs, and over 60 satellites in over seven counties.

Project Summary

Participation in the AMGA Foundation Rheumatoid Arthritis (RA) Best Practices Collaborative quality improvement initiative to redesign Summit's RA management program was driven by the clear evidence-based need for early diagnosis and treatment of RA before the onset of irreversible joint damage and disabling deformities in its patients.

Summit implemented two concurrent redesigns of care for RA patients across its group. The first was to standardize protocols for the diagnosis and management of RA for its rheumatologists and the second was to educate its primary care physicians, nurse practitioners, and physician assistants in all its primary care offices on the critical need for early treatment and identification of RA. To achieve this redesign, Summit formed a RA Collaborative committee consisting of the Rheumatology Department care team and members of the Population Health team and took several actions in the one-year Collaborative.

Program Goals and Measures of Success

Summit's goals while participating in this Collaborative included the development of a RA patient registry, building quality metrics in the EHR that would provide actionable data, developing and implementing a treatment algorithm to reduce variability in practice, sharing transparent monthly performance data with rheumatologists, and monitoring variation in medication utilization.

Summit's EHR facilitated improved care coordination for all patients more effectively by automating data collection and presenting reminders to the provider and care teams at the point of care. The process was developed to contain the three measures required by the Collaborative, which included DMARD utilization, patient functional status assessment, and patient periodic assessment of disease activity. The EHR now provides easy-to-use data entry processes for the care team. Summit's rheumatologists set performance goals for each measure and tracked their performance, providing monthly, unblinded reports to the rheumatologists and their care teams on their progress.

This tracking of data (Figures 1-3) validated that the rheumatologists were treating patients appropriately with DMARDs and helped identify a gap in the functional status assessment workflow process that developed in May 2015 when a turnover in staff caused this assessment to no longer be entered. This was corrected with training and collaboration among the care team.

Figure 1: Disease-modifying Anti-rheumatic Drug Therapy for Rheumatoid Arthritis

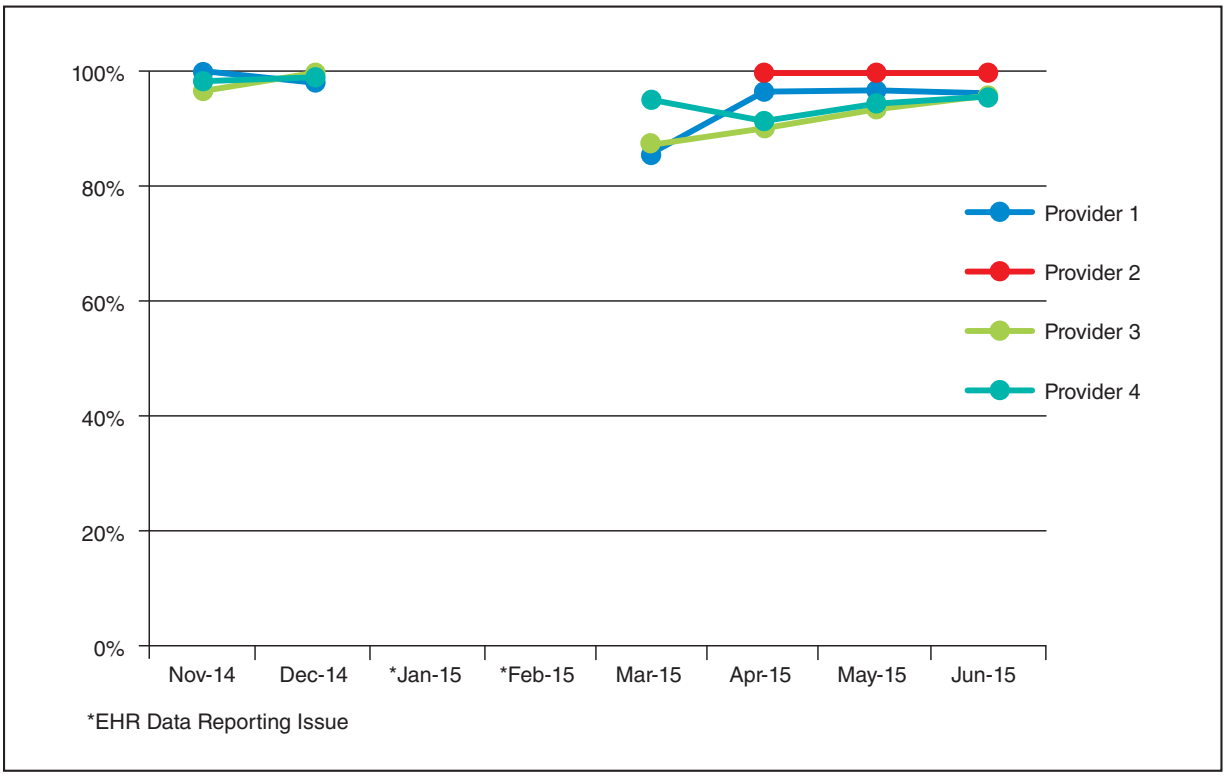


Figure 2: Rheumatoid Arthritis (RA): Functional Status Assessment

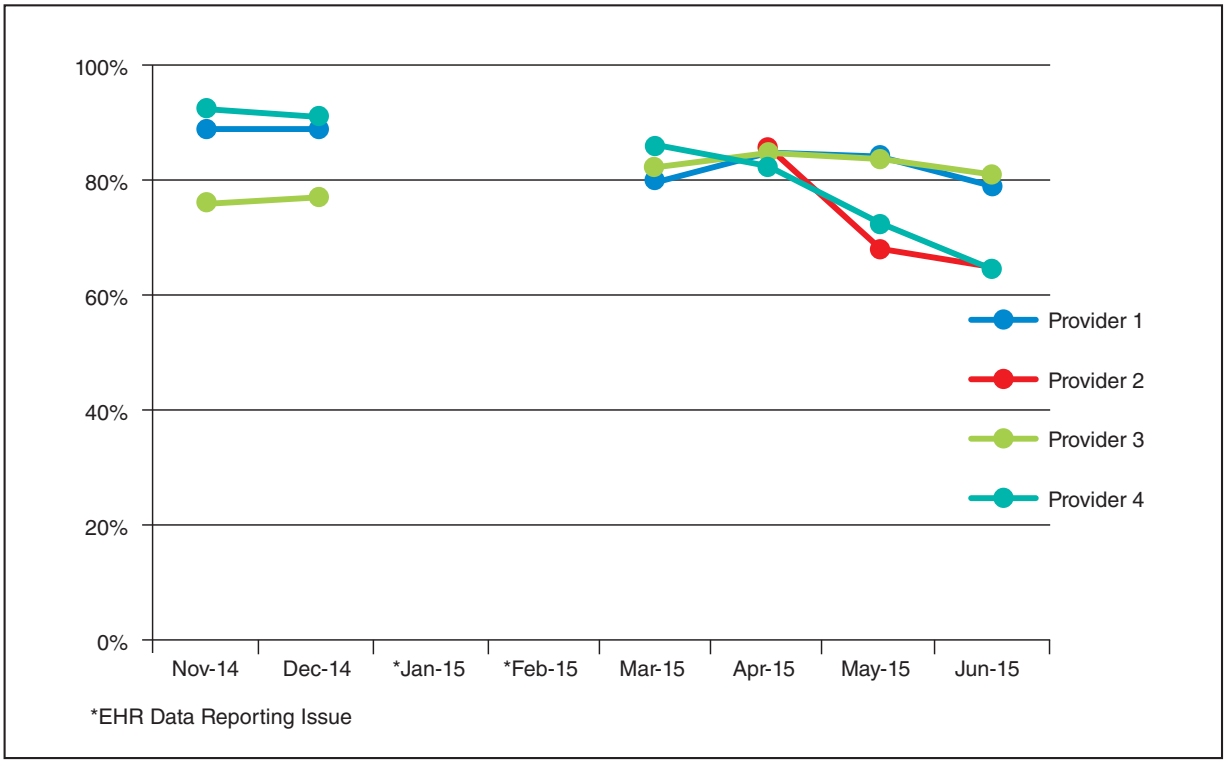
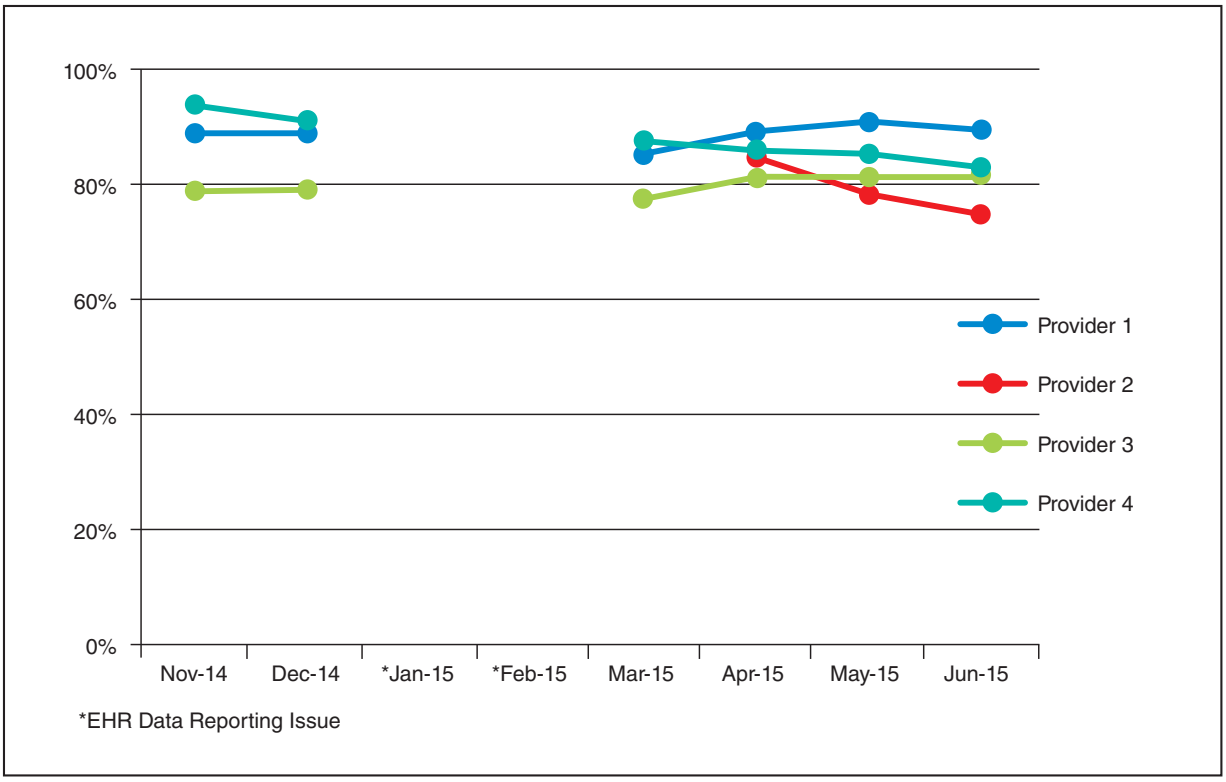


Figure 3: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity



Population Identification

Summit created a group-wide registry for patients with RA and ensured that patients were identified early, adding them to the registry from its EHR and other potential sources:

- Adding all patients with ICD-9 code 714.0 (now converted to ICD-10) on their problem list and claims or diagnosis-linked electronic prescriptions for RA
- Collaboration with radiologists to identify patients with bone erosions who may not yet carry a diagnosis of RA
- Screening patients with positive biomarker lab tests for possible inclusion in the RA registry

Interventions

Patient Access

In order to accommodate patients with timely consultations Summit rheumatologists worked with their office team utilizing a triage tool (Appendix 1) to decrease wait times for new RA patients seeking consultation and early treatment.

Development of a Treatment Algorithm

Rheumatologists were not utilizing standardized protocols for classification, treatment, or care management of patients with RA. Variable protocols among specialists resulted in over/under-diagnosis, over/under-utilization of certain treatments, and a lack of data collection required to monitor and standardize care.

Summit recognized that this situation presented a tremendous opportunity for the medical group to improve care of its RA patients. Summit's clinical pharmacist assisted rheumatologists in developing an evidence-based RA Treatment Algorithm that included evidence-based pre- and post-DMARD and DMARD medication algorithm (Appendix 2). Summit adopted the American College of Rheumatology's (ACR's) recommendation for the *Choosing Wisely* initiative to not prescribe biologics for RA before a trial of methotrexate or other conventional non-biologic DMARDs. All treatment protocols include treat-to-target endpoints to reduce variability of care by individual rheumatologists.

Medication Utilization and Costs

Summit reported on the utilization and costs of the biologic infusions that it administered within its medical group's Infusion Center and offices. Summit's clinical pharmacist also conducted an analysis of the infusions given over one year, reporting unblinded data to its rheumatologists on their patients' cost of care related to infusions. The medical group identified variability in its approach to treatment with infusions versus injections (Figure 4) and continues to work with its rheumatologists to reduce that variability through the utilization of the evidence-based treatment algorithm.

Leadership Involvement & Support

Summit Medical Group has well-established Departments of Quality, Population Health, and Care Management with a team of professionals skilled at care process redesign. They have demonstrated success with several large-scale, group-wide quality initiatives, such as improving rates of preventive screenings and immunizations to above the U.S. 90th percentile and decreasing length-of-stay and readmissions on the hospitalist service.

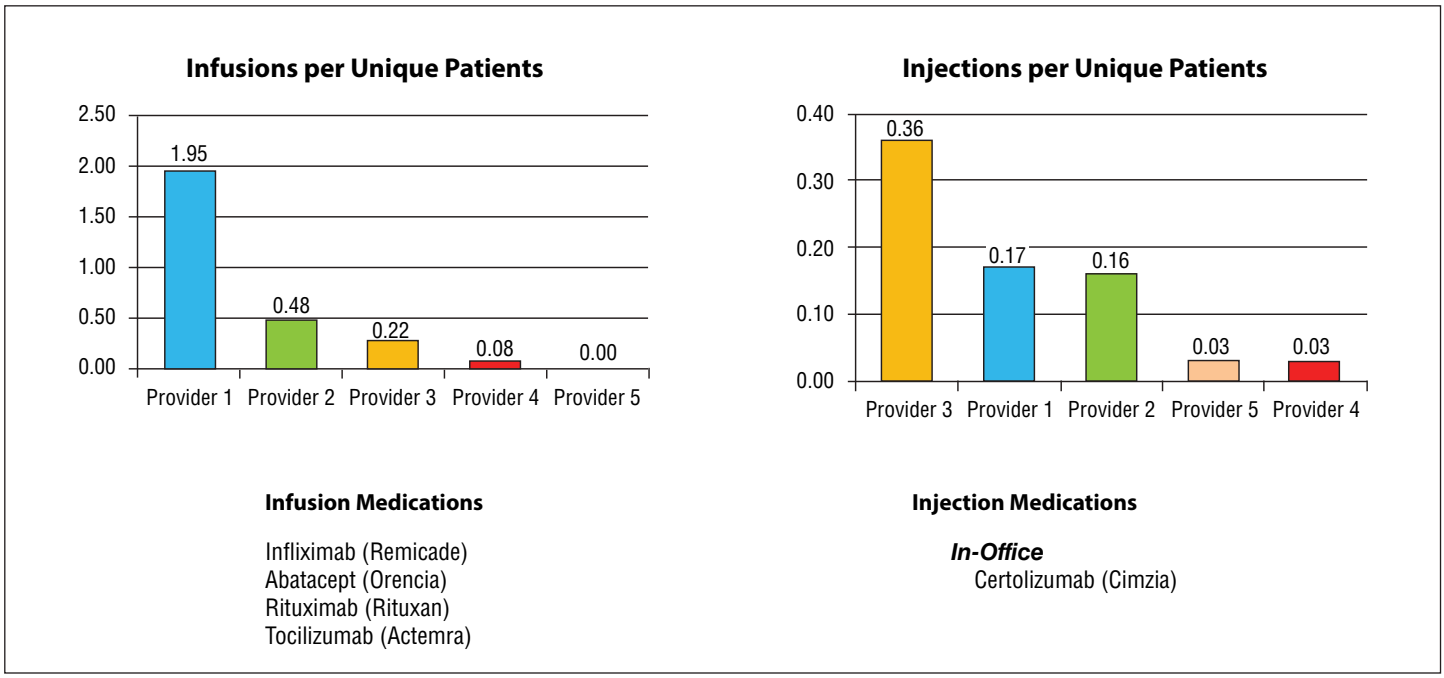
Based on past quality improvement initiative performance, senior leadership was supportive in the group's participation in this Collaborative and dedicated the required resources of the aforementioned departments to develop and implement the interventions they set out to accomplish.

Lessons Learned and Ongoing Activities

Summit identified the critical need for staff and IT support to drive quality improvement initiatives. Unfortunately, throughout this one-year Collaborative it experienced a high turnover of care providers. As a result, its team staff and IT team could not develop a structured documentation flowsheet in its EHR tailored for additional efficient RA data collection and trending analysis. These challenges slowed the progress it anticipated achieving by the close of the Collaborative. Summit has since established a consistent care team with an office supervisor who is familiar with the objectives of its RA quality improvement commitments, and continues to work with its IT team to find solutions that facilitate high-quality outcomes for patients with RA.

Engaging patients in chronic illness management and shared decision-making is challenging and will continue to be a top priority for Summit. While it engaged patients throughout

Figure 4: Medication Utilization



the Collaborative through the many social media outlets currently used by its marketing department, Summit also plans on utilizing its patient portal. In addition, Summit has a care management team with expertise in patient engagement strategies, and a Patient and Family Advisory Council with which it will consult. Its rheumatologists will use shared decision-making tools regarding typical medications for RA, which will facilitate dialogue with patients and allow for informed decisions regarding treatment options and related costs. It will also train the in-office care team on concepts of health coaching and patient education—such as the "teach back technique"—which will improve their ability to partner with patients to improve outcomes.

Participation in the AMGF RA Learning Collaborative engaged and challenged Summit Medical Group's rheumatology team to provide patients with an improved quality of care associated with earlier diagnosis and treatment of RA before the onset of irreversible joint damage.

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

DATE: _____ PRIORITY:

TRIAGED BY: _____

PROVIDER REVIEW: _____ Urgent 1 2 3

APPT DATE: _____

RHEUMATOLOGY TRIAGE WORKSHEET

Name: _____ Age: _____ MRN:_____

Referral Source: Self / Doctor: _____

(Needs referral from Provider unless established diagnosis)

REASON FOR REFERRAL: _____

PREVIOUS DIAGNOSIS: _____

DATE OF ONSET: _____ Do you prefer a particular rheumatologist? _____

Have you seen a rheumatologist before? ___ If yes, who? _____

Any abnormal blood work test? _____ If yes, please fax to office if possible.

ANA RF CCP ESR CRP

Any joint pain? Y N Where: _____

Wrist / hand pain? Y N

Trouble making a fist? Y N

Swelling in joints that other people can see? Y N

Which joints? _____

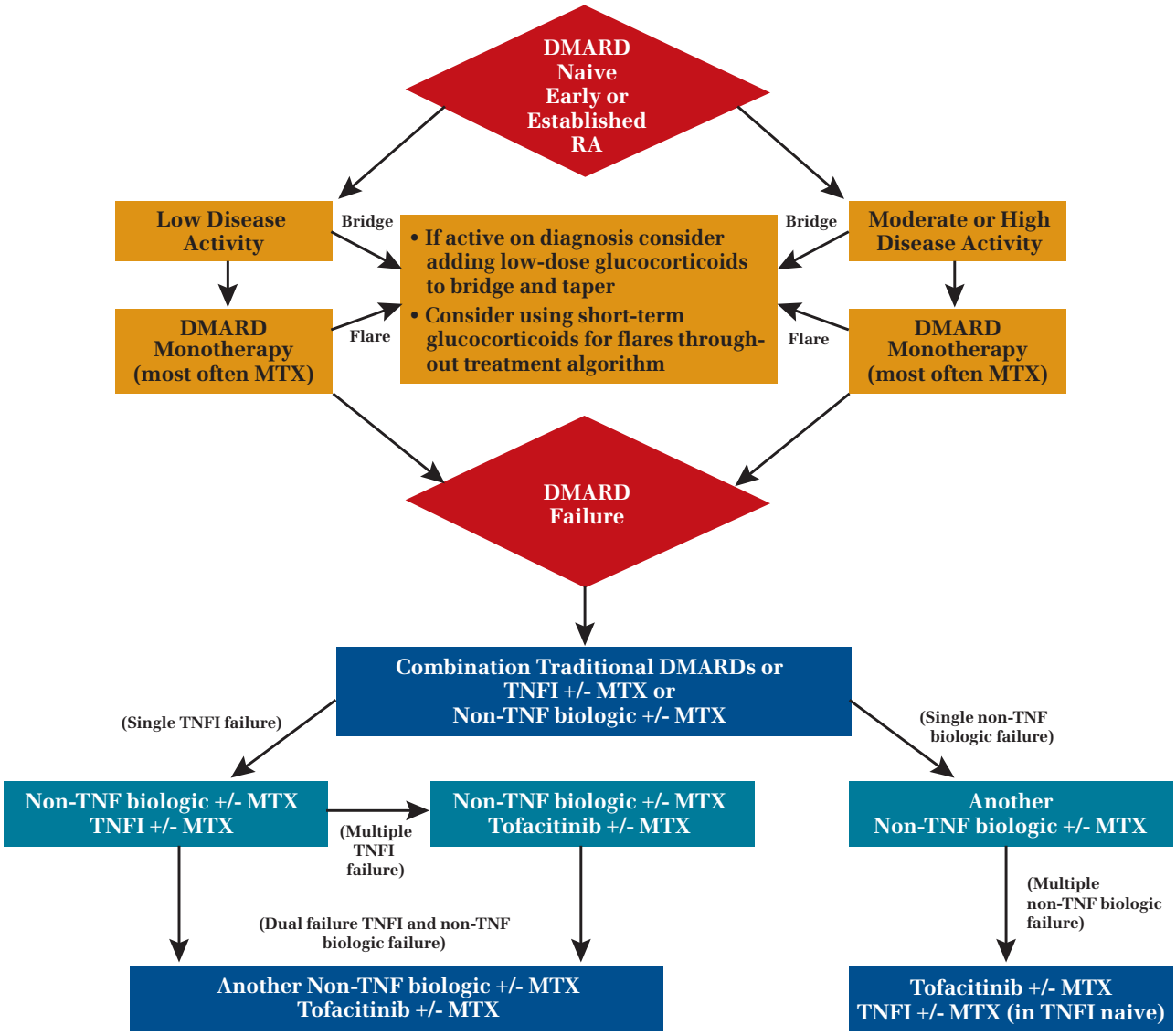
Are same joints involved on both sides of the body? Y N

Joint stiffness > 1 hour in AM? Y N

Does joint pain feel better with ACTIVITY or REST? _____

Any family history of RA, Lupus? Y N _____

Rheumatoid Arthritis Treatment Algorithm



RA Team

Team members from Summit Medical Group

Eric S. Lieberman, MD
Rheumatologist

Lauren Kennish, MD
Rheumatologist

Linda K. Lee, MD
Rheumatologist

Robert Aaron Lehmann, MD
Rheumatologist

Anna C. LaTorre, MSN, RN, APN
Rheumatology Department

Ann Welenofsky, RN
Clinical Coordinator Oncology and Infusion Center

Jamie Reedy, MD, MPH
Senior Vice President of Population Health and Quality

Gary Pien, MD, PhD
Director of Research, Division of Allergy, Asthma, and Immunology

Laura Balsamini, PharmD, BCPS
Director of Pharmacy Services

Deborah Molina, MBA, MPA
Manager, Quality Management

Elizabeth A. Caruso, BSN, RN
Population Health Educator

AMGA Foundation

One Prince Street
Alexandria, VA 22314-3318

amga.org/foundation

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