



RHEUMATOLOGY NURSE PRACTICE

NEWSLETTER



WELCOME!

Welcome to our first issue of *Rheumatology Nurse Practice*. This is the first in a series of print and online educational resources that is being developed by the Rheumatology Nurses Society thanks to an unrestricted educational grant from Pfizer. We hope that you find the information in this and subsequent publications of informational and educational value as you progress in your career as a rheumatology nurse. If there are topics you'd like to learn about in the future or if you have any feedback on this education, please don't hesitate to drop us a note at Practice@RNSnurse.org. We'd love to hear from you!

Inside this Issue

- » Which of the current Physician Quality Reporting System (PQRS) measures are most relevant to rheumatology practices?
- » What is meaningful use, and why does it matter for the rheumatology community?
- » How have individual rheumatology practices customized their electronic health records to encourage better alignment with PQRS and other quality indicators?
- » How successful have rheumatology practices been in the adoption of quality standards, and what hurdles remain?

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Learning Objectives

1. Identify measures within the Physician Quality Reporting System (PQRS) that are most relevant to the treatment of patients with rheumatoid arthritis
2. Explain key concepts such as quality improvement, meaningful use, and the Choosing Wisely campaign
3. Determine the current status of your specific practice regarding adherence to PQRS and meaningful use reporting requirements
4. Evaluate opportunities to customize your practice's electronic health records to help improve adherence to quality indicators and potentially ease reporting burdens

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Target Audience

The intended audience for this activity includes rheumatology nurses, rheumatology advanced practice nurses, and infusion nurses.

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Quality Improvement in RA:

How Far Have We Come and How Far Must We Still Go?

One of the most dramatic recent advances in patient safety owes its success to a quality improvement initiative. By using a simple safety checklist in the operating room—similar to what pilots use before takeoff—clinicians at eight hospitals across the globe reduced the risk of postoperative complications by one-third and cut the risk of death nearly in half.¹ Based on this success, this patient safety checklist has been adapted to help reduce procedural complications in operating rooms around the world, as well as in other settings such as interventional radiology.^{2,3}

But what does it mean to improve the quality of care for rheumatology patients? Does it require a single major paradigm shift equivalent to the safety checklist, or will several modest tweaks accumulate enough to improve outcomes? In light of skyrocketing healthcare costs, some experts argue that improved quality must mean increased value, or better outcomes achieved per dollar spent.⁴ Improved efficiency of care will be critical to balance the needs of the aging population with the looming shortage of rheumatology providers.⁵

Rheumatology providers are already feeling the operational and financial squeeze of programs designed to influence the delivery of care, including tiered payment systems and prior authorization programs from payors, and more requirements are coming.⁶

Beginning in 2015, two major quality improvement programs are shifting from voluntary to mandatory participation for eligible healthcare professionals. First, the Physician Quality Reporting System (PQRS)—somewhat of a misnomer, given that nurse practitioners, advanced practice registered nurses, clinical nurse specialists, and other members of the patient care team are eligible to participate along with physicians—will require rheumatology providers to report their performance on a range of quality measures. Second, providers

will be required to report their progress toward meeting the criteria for “meaningful use” of electronic health record (EHR) systems.

Quality improvement programs are already substantially changing the delivery of rheumatology care. The American College of Rheumatology (ACR) supports efforts to measure the quality of care in rheumatology practice and has collaborated with stakeholders to develop PQRS measures specific to patients with rheumatoid arthritis (RA).⁷ In addition to quality measures for RA, the ACR and other stakeholders are also working to define quality measures for osteoporosis, juvenile arthritis, gout, ankylosing spondylitis, and psoriatic arthritis.⁷

The Physician Quality Reporting System

In 2004, the Centers for Medicare & Medicaid Services (CMS) established the PQRS as a mechanism for gathering data on the quality of care delivered to Medicare Part B beneficiaries. The PQRS program has evolved each year to include new measures and disease states, as well as retire quality measures that no longer reflect the standards of care. Quality measures specific to patients with RA first appeared in 2008.⁸ Since 2009, the 6 RA-specific quality measures that appear in the PQRS measures list have remained the same.⁹

In total, the 2015 PQRS program includes 254 quality measures that encompass multiple aspects of patient care.¹⁰ These individual measures also appear in predefined groups that apply to patients with a specific diagnosis. The RA Measures Group encompasses 8 measures, including the 6 measures that apply only to RA patients and 2 additional measures that are shared across several groups (Table 1).¹⁰ BMI Screening and



NEWSLETTER SUMMARY

In this issue of Rheumatology Nurse Practice, we will explore the current status of PQRS and EHR meaningful use requirements and their potential implications, along with additional quality improvement efforts that may impact rheumatology nurses.

Measure Number	National Quality Strategy Domain	Measure Title and Description
<i>RHEUMATOID ARTHRITIS MEASURES GROUP</i>		
108	Effective Clinical Care	Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy —Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD
176	Effective Clinical Care	Rheumatoid Arthritis: Tuberculosis (TB) Screening —Percentage of patients aged 18 years and older with a diagnosis of RA who have documentation of a TB screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic DMARD
177	Effective Clinical Care	Rheumatoid Arthritis: Periodic Assessment of Disease Activity —Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease activity within 12 months
178	Effective Clinical Care	Rheumatoid Arthritis: Functional Status Assessment —Percentage of patients aged 18 years and older with a diagnosis of RA for whom a functional status assessment was performed at least once within 12 months
179	Effective Clinical Care	Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis —Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease prognosis at least once within 12 months
180	Effective Clinical Care	Rheumatoid Arthritis: Glucocorticoid Management —Percentage of patients aged 18 years and older with a diagnosis of RA who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months
128	Community/Population Health	Body Mass Index (BMI) Screening and Follow-Up Plan —Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 65 years and older BMI ≥ 23 and <30 kg/m ² ; Age 18 – 64 years BMI ≥ 18.5 and <25 kg/m ²
131	Community/Population Health	Pain Assessment and Follow-Up —Percentage of visits for patients aged 18 years and older 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
<i>ADDITIONAL MEASURES WITH POTENTIAL RELEVANCE IN RA</i>		
110	Community/Population Health	Influenza Immunization —Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.
111	Community/Population Health	Pneumonia Vaccination Status for Older Adults —Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
130	Patient Safety	Documentation of Current Medications in the Medical Record —Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
182	Communication and Care Coordination	Functional Outcome Assessment —Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.
226	Community/Population Health	Tobacco Use: Screening and Cessation Intervention —Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Table 1
2015 Physician Quality Reporting System¹⁰



Physician Quality Reporting System

In 2004, the Centers for Medicare & Medicaid Services (CMS) established the PQRS as a mechanism for gathering data on the quality of care delivered to Medicare Part B beneficiaries.

Follow-up Plan (Measure No. 128) also appears in the measure groups for preventive care, sleep apnea, asthma, and coronary artery disease. Pain Assessment and Follow-up (Measure No. 131) also appears in measure sets for acute otitis externa and sinusitis.

Documenting the Care Not Provided

One of the unique features of the PQRS compared with other reporting systems is that it allows healthcare providers to report care that was considered but ultimately not provided for reasons such as patient refusal, the cost of medication, and lack of adherence.¹⁰ With this documentation feature, providers can avoid being penalized for 'poor performance' when circumstances are beyond their control.¹⁰

Appropriate documentation can have a major impact on the interpretation of performance data, which in the future may be tied to reimbursement. A 2009 study of performance on PQRS quality measures found that only 88.8% of RA patients received the recommended care regarding DMARD use (Measure No. 108).⁸ Without further documentation, this result suggests that 11.2% of patients did not receive quality care. However, most of these patients had documentation that DMARDs were considered but not prescribed. Reasons for not giving DMARDs included medical reasons, such as the patient being in remission or having contraindications to DMARD therapy, and/or other reasons such as patient preference.

Financial Incentives and Penalties

The PQRS program includes financial incentives to encourage eligible providers to report data on quality measures. Beginning in 2011, CMS provided incentive payments of 0.5% to 1.0% to healthcare providers who voluntarily reported data on PQRS quality measures. In 2013, the

PQRS program shifted to a mandatory program with penalties for non-participation. Based on failure to satisfactorily report PQRS data during the 2013 program year, providers will receive a 1.5% payment penalty for their Medicare Part B patients in 2015. Beginning in 2016, healthcare professionals will receive a payment penalty of 2% for failing to meet the PQRS reporting requirements for the 2014 reporting year and thereafter.^{11,12}

Reporting Options

Healthcare providers who are eligible to participate in the PQRS program include physicians, physician assistants, nurse practitioners (including advanced practice registered nurses), clinical nurse specialists, physical therapists, occupational therapists, clinical social workers, and other practitioners. Providers can participate as independent professionals or as members of a group practice (for practices with 200 or more eligible professionals).¹³

Healthcare providers have some discretion on which PQRS measures to report. Depending on the practice setting, eligible professionals can report data on their pick of individual measures that they believe to be most relevant to their patient population, or report data on a predefined group of measures that apply to patients with a specific diagnosis.

Providers who participate as individual professionals can submit data on individual PQRS measures or on a PQRS measure group (Table 2). When participating in the group practice reporting option, however, providers must report on individual PQRS measures only (i.e., measure group reporting is not an option). As an example of how to meet the criteria of reporting 9 individual measures across at least 3 National Quality Standard (NQS) domains,

Table 2
How to Earn PQRS
Incentives and
Avoid Penalties

	Earn Incentive & Avoid Penalty	Avoid Penalty Only
<i>INDIVIDUAL ELIGIBLE PROFESSIONALS</i>		
Measure Group	Report 1 measure group (per professional) for a 20 patient sample	Report 1 measure group (per professional) for a 20 patient sample
Individual Measures	Report on 9 individual measures across at least 3 NQS domains for 50% of eligible Medicare patients seen in 2014	Report on 3 individual measures across at least 1 NQS domain for 50% of eligible Medicare patients seen in 2014
<i>GROUP PRACTICE REPORTING OPTION</i>		
Individual Measures	Report on 9 individual measures across at least 3 NQS domains for 50% of eligible Medicare patients seen in 2014	Report on 3 individual measures across at least 1 NQS domain for 50% of eligible Medicare patients seen in 2014

providers might choose to include Influenza Immunization (Community/Population Health) and Documentation of Current Medications in the Medical Record (Patient Safety), in addition to any of the RA-specific measures (Effective Clinical Care), in their selection of 9 measures.

Providers must have reported 2014 PQRS data by February 26, 2015, to earn incentive payments and/or avoid payment penalties. Payment adjustments for the 2014 reporting year will occur in 2016.¹²

How to Report Quality Data

Participants can report quality performance data through a range of mechanisms, including Medicare Part B claims submitted to CMS, qualified data registries, and EHR systems with integrated reporting functions. Individual professionals who wish to report data on any PQRS measure group must submit data through an approved registry. The Rheumatology Clinical Registry (RCR) provides ACR members with a framework for tracking quality and drug safety for patients with RA, osteoarthritis, osteoporosis, gout, and juvenile idiopathic arthritis. Providers can also use the RCR to submit data to the PQRS.¹⁴

Quality Reporting: Experiences to Date

The proportion of eligible professionals who are reporting PQRS measures has increased each year.¹³ In 2012—the most recent year studied—51.5% of eligible rheumatology providers participated in the PQRS reporting system. This is an increase from 37% in 2011, 34% in 2010, and 27% in 2009.¹³

Rheumatology providers participating in the RCR have shown a steady improvement in performance on RA quality measures.¹⁵ Between 2011 and 2013, providers submitted data on 24,313 encounters with RA patients. Over the 3-year period, performance rates increased for 4 of 5 measures of RA quality (Table 3). Performance on the fifth measure, which describes DMARD use, reached 97% by 2013. These findings demonstrate an association between the process of reporting quality data and improved performance on quality measures.

Rheumatology providers may encounter challenges as they begin to track quality of care for RA patients as improving quality can increase costs, at least in the short term. One study of RA patients managed within a large managed care system found that

Table 3
Rheumatology
Clinical Registry:
Performance on RA
Quality Measures

Measure	2011	2012	2013
Disease activity assessed at least once within 12 months, using a standardized descriptive or numeric scale or composite index, and classified as low, moderate or high	43%	54%	81%
Functional status assessment performed at least once within 12 months, and documented using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living	71%	87%	87%
Patient prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD within 12 months	98%	87%	97%
Documentation of TB screening performed and results interpreted within 6 months prior to receiving first course DMARD	74%	93%	91%
Assessment and classification of disease prognosis at least once within 12 months	50%	73%	78%

the mean annual cost of care was higher for patients whose care met RA-specific quality measures (\$18,642) than for patients whose care did not meet quality measures (\$14,923).¹⁶ Office expenses, which accounted for 29% of the overall cost, were higher in patients who met the quality measures while inpatient and outpatient costs were both higher in those who did not meet the measure. In the long term, improving the quality of RA care is expected to lessen the financial burden by reducing the need for costly interventions in patients with poorly controlled disease activity.

Electronic Health Records

Certified EHR systems have the potential to support quality improvement efforts in rheumatology through a range of functions, including the following:

- Embedded clinical guidelines that promote evidence-based treatment practices
- Use of checklists, alerts, disease activity score calculators, and other tools at the point of care
- Electronic prescribing and test ordering that reduces errors and redundancy
- Instant access and distribution among all authorized providers involved in a patient's care
- Data fields for collecting and reporting PQRS measures

Selecting the best EHR system is a daunting task, as healthcare providers have an overwhelming array of options. In one recent study, rheumatology providers from 91 clinics reported using 38 different EHR systems.²¹ The ACR maintains an online searchable list of EHR vendors to assist rheumatology practices with implementation (www.rheumatology.org/Practice/Office/Hit/Electronic_Health_Records).

Another challenge to getting started with EHRs involves the lack of customized tools for each specialty within one-size-fits-all EHR systems. Providers working within large health systems have less control over the choice of EHR system, which must accommodate multiple specialties, than a small rheumatology practice. However, several rheumatology groups have demonstrated the benefits of adapting their EHR systems to support their daily rheumatology practice.

PQRS Measures in RA: Focus on Disease Activity Assessment

Within the RA measure group is Measure 177: Periodic Assessment of Disease Activity. According to CMS, acceptable composite measures of RA disease activity include, but are not limited to, the Clinical Disease Activity Index (CDAI), Disease Activity Score with 28 joint count (DAS28), Rheumatoid Arthritis Disease Activity Index (RADAI), Routine Assessment of Patient Index Data (RAPID), and Simplified Disease Activity Index (SDAI).¹⁷ In addition to these options, providers are permitted to use “an alternative, standardized, systematic approach” to assess disease activity.¹⁷ The ACR recognizes CDAI, DAS28, Patient Activity Scale (PAS), PAS-II, RAPID-3, and SDAI as validated composite measures of RA disease activity (Table 4).^{18,19}

Using a composite measure such as DAS28 to track disease activity is an essential component of the Treat to Target (T2T) approach to RA management.²⁰ According to T2T recommendations, patients with RA should be treated with the goal of achieving clinical remission. For patients

Table 4
2015 Physician
Validated Composite
Measures of Disease
Activity in RA¹⁸

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Measure	Components	Scale	Disease Activity			
			Remission	Low	Moderate	Severe
CDAI	<ul style="list-style-type: none"> • Provider joint count • Patient global VAS • Provider global VAS 	0-76	≤2.8	>2.8-0.0	>10.0-22.0	>22.0
DAS28	<ul style="list-style-type: none"> • Provider joint count • Patient global VAS • ESR or CRP 	0-9.4	<2.6	≥2.6-3.2	≥3.2-≤5.1	>5.1
PAS	<ul style="list-style-type: none"> • HAQ • Pain VAS • Patient global VAS 	0-10	≤0.25	0.26-0.70	3.71-<8.0	8.0-10.0
PAS-II	<ul style="list-style-type: none"> • HAQ-II • Pain VAS • Patient global VAS 	0-10	≤0.25	0.26-0.70	3.71-<8.0	8.0-10.0
RAPID-3	<ul style="list-style-type: none"> • Patient global VAS • Multidimensional HAQ • Pain VAS 	0-10	≤1.0	>1.0-2.0	>2.0-4.0	>4.0-10
SDAI	<ul style="list-style-type: none"> • Provider joint count • Patient global VAS • Provider global VAS • CRP 	0-86	≤3.3	>3.3-11.0	>11.0-≤25	>26

CDAI = clinical disease activity index; CRP = C-reactive protein; DAS28 = disease activity score with 28 joint count; ESR = erythrocyte sedimentation rate; HAQ = health assessment questionnaire; PAS = Patient Activity Scale; RAPID-3 = Routine Assessment of Patient Index Data version 3; SDAI = simplified disease activity index; VAS = visual analog scale.

Customized EHR Tools: Composite Disease Activity Scoring

Having an embedded tool for calculating a composite disease activity score is likely on the top of any rheumatology EHR wish list. Rheumatologists at the Dartmouth-Hitchcock Medical Center customized their EHR system to include an electronic version of the RAPID-3 composite score.²⁶ They validated the electronic version of the RAPID-3 by demonstrating no difference in mean total RAPID-3 scores for their patients calculated with the paper and EHR versions (9.57 vs. 9.75; $P=0.46$). Another rheumatology group at the University of California, San Francisco, recently described the process of customizing their EHR system to facilitate the use of composite RA disease activity scores.²⁷ Before launching the project, rheumatologists documented CDAI scores in the EHR at 56.5% of RA patient visits. Within 6 months, this increased to 80.9%.

Customized EHR Tools: Vaccination Reminders

The ACR recommends vaccination against pneumococcal pneumonia, influenza, hepatitis B, human papillomavirus, and herpes zoster in



Vaccination reminders can be added to an EHR system

accordance with guidelines from the Centers for Disease Control and Prevention (CDC) for patients with RA who are starting nonbiologic DMARDs or biologic agents.¹⁹ If not previously done, vaccination is also recommended for all patients who are already on nonbiologic DMARDs or biologic agents, with the exception of the herpes zoster vaccine, which is recommended for patients on nonbiologic DMARD therapy only (i.e., not recommended for patients on biologic therapy).¹⁹

PQRS Measures in RA (continued)

who are unable to reach remission due to issues such as advanced disease, low disease activity is acceptable as an alternate treatment goal.

Each composite measure relies on different aspects of RA to quantify disease activity, resulting in different scoring systems and thresholds to define remission and low, moderate, and severe disease activity. The T2T algorithm encourages clinicians to select a composite measure that is best suited to the needs of the patient and practice. For instance, a disease measure that directly accounts for pain—such as PAS, PAS-II, or RAPID-3—might be appropriate for a patient with substantial pain. Furthermore, a practice that has selected an EHR system with built-in, point-of-care calculators for DAS28 or CDAI may choose these measures for all patients.

Despite strong evidence supporting the use of composite measures to assess RA disease activity and track the effectiveness of therapy, these tools remain underused in current rheumatology practice. In a recent survey of 91 rheumatology practices in the United States, 25% of rheumatologists reported not using any of the validated composite measures to assess RA disease activity.²¹ Others reported a range of preferences, including the RAPID-3

(39%), DAS28 (18%), CDAI (20%), and SDAI (2%). Moreover, although 91% of providers reported using EHRs in their practices, only 11% routinely document a composite disease activity score in the medical record. In contrast, the majority of rheumatology providers (63%) reported documenting disease activity by recording a binary, non-numeric clinical impression (“active” or “controlled”), or by using a 10-point physician global visual analog scale (VAS) (23%). With the inclusion of disease activity assessment as a PQRS quality measure, more rheumatology providers may begin to incorporate these essential tools into their management of patients with RA.

Future Measures of RA Disease Activity

The multi-biomarker disease activity (MBDA) score is a newer measure of RA disease activity based on 12 serum biomarkers.²² The biomarkers included in the MBDA assay represent a comprehensive range of pathologic mechanisms underlying RA disease activity, including cytokine signaling, angiogenesis, cell invasion, cartilage and tissue remodeling, and immune response. In particular, the MBDA biomarkers account for the signs and symptoms of RA measured by the DAS28-CRP score, including tender joints, swollen joints, the patient global assessment, and CRP (Figure 1).²²

Despite the importance of vaccination in patients with autoimmune diseases, who may be further susceptible to infection as a result of immunotherapy, vaccination rates have historically been poor in patients with RA. In a 1999–2006 study of 141,140 patients with RA, only 33% received pneumococcal vaccination and 22% received influenza vaccination each year.²⁸

Several rheumatology groups have modified their EHR systems to improve vaccination rates among their RA patients. Rheumatologists at the University of Pittsburgh Medical Center introduced an automated alert to remind providers at the time of the patient encounter of the need for vaccination and to order the vaccine for appropriate patients. Pneumonia vaccination rates for patients with RA increased from 44.4% at baseline to 50.8% within 3 months of implementing the EHR alert. Documentation regarding immunization, which is a critical component of PQRS reporting, likewise increased from 51.4% to 58.4%.²⁹ At the same institution, a similar point-of-care alert increased vaccination rates against herpes zoster from 9.9% to 15.7% ($P=0.001$) in patients with RA.³⁰

At Northwestern University, incorporating vaccination alerts into the EHR also significantly increased immunization rates against

pneumococcal pneumonia (from 23.3% to 41.8%; $P<0.001$) and herpes zoster (from 2.8% to 5.0%; $P<0.01$) among patients with RA.³¹

EHR “Meaningful Use” Incentive Programs

The concept of “meaningful use” describes the use of EHR systems in ways that result in meaningful improvements in the process and outcomes of care. In 2009, CMS launched the Medicare EHR Incentive Program to encourage healthcare providers to adopt, implement, and demonstrate meaningful use from certified EHR systems. The Medicaid EHR Incentive Program is a similar program that is run by state Medicaid agencies. Eligible healthcare professionals can participate in either program, but not both.³²

In the first several years of the Medicare EHR Incentive Program, eligible professionals who demonstrated (or “attested to”) meaningful use were eligible for incentive payments. The maximum payments started at \$44,000 over 5 years for program participation in 2012 before decreasing to \$39,000 in 2013 and \$24,000 in 2014. Beginning in 2015, eligible professionals who do not attest to meaningful use will be subject to payment adjustments. The Medicaid

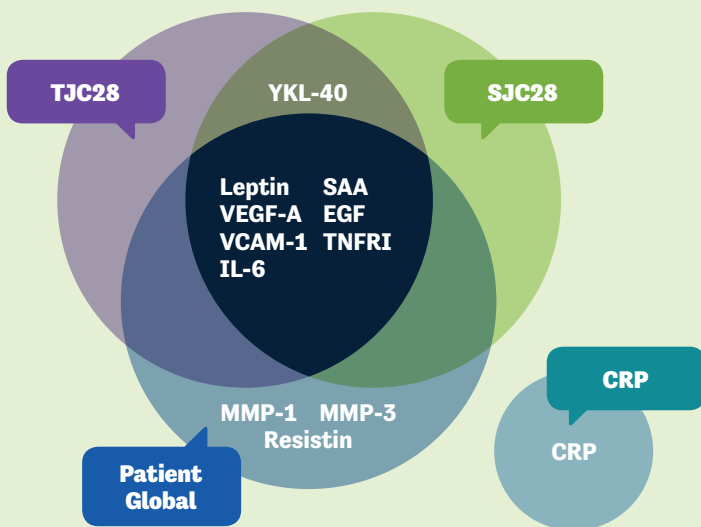


Figure 1
MBDA Biomarkers and Components of the DAS28 Score²²
Biomarkers used to predict each DAS28-CRP Component

The MBDA score significantly correlates with several standard composite measures of RA disease activity, including DAS28–CRP, DAS28–ESR, CDAI, and SDAI.^{22–24} However, compared with other measures of disease activity, only the MBDA score significantly predicts the risk of radiographic progression in patients with early RA who have not started DMARD therapy.²⁵ Therefore, the MBDA score may have a role in risk assessment and selecting an initial treatment strategy for patients with RA. Patients with a low risk of radiographic progression may benefit from a less intensive treatment approach, while more intensive treatment may be appropriate for patients at high baseline risk for radiographic progression.²⁵ In the future, as additional novel biomarkers are identified and developed into laboratory assays, rheumatology providers may have additional opportunities to evaluate multiple aspects of RA disease activity with simple blood tests.



EHR Incentive Program has a different payment structure, with a maximum payment of \$63,750 over 6 years and no payment penalties.³²

The meaningful use requirements are being rolled out in stages, with the goal of building EHR functionality in clinical practice (Table 5).³³ Stage 1 requirements focus on collecting structured patient data in the EHR such as patient demographics, vital signs, lab results, medications, and allergies. The collected data should be used to support clinical practice with tools such as drug-interaction checks, drug-allergy checks, and clinical decision support tools. The EHR data should also be used to facilitate patient engagement through patient reminders, patient education, encounter summaries, and chart export. Ultimately, EHR systems should be used to improve the coordination of care through functions such as medication reconciliation, summaries of care for transitions and referrals, and data exchange among the multidisciplinary care team.

To receive incentive payments and avoid penalties, providers must meet the objectives of each stage of meaningful use within the specified reporting period.³³ The requirements apply to both the Medicare and Medicaid EHR incentive programs.³²

EHR Meaningful Use: Challenges and Opportunities

Although use of EHRs has increased substantially in recent years, many providers are falling behind the designated milestones. Approximately 50% of eligible professionals will face a payment penalty in 2015 because they did not fulfill the Stage 1 meaningful use requirements in 2013.³⁴ In total, approximately 257,000 providers will face a 1% reduction in their 2015 Medicare payments.³⁴

Progress towards fulfilling Stage 2 requirements has also been slow. Of the 269,000 healthcare providers who successfully met the Stage 1 requirements, only 3,655 (1.4%) attested to Stage 2 by the end of 2014.³⁵ Eligible professionals must have attested to Stage 2 requirements by February 28, 2015, to be eligible to receive a Medicare incentive payment for their participation in 2014.³⁵

Several medical societies are reacting to the burden of meaningful use requirements. In January 2015, the American Medical Association (AMA) ranked the administrative load of competing regulatory programs, including the EHR meaningful use requirements, as a leading concern that healthcare professionals will face this year.³⁶ The AMA, the American Academy of Family Physicians, the American College of Cardiology, and other organizations are urging CMS to modify the current requirements for EHR meaningful use.^{34,37} Based on feedback from these physician groups, CMS may make additional changes to the Stage 2 and 3 requirements for meaningful use.

Other Rheumatology Quality Programs

While PQRS and meaningful use are among the most high-profile quality improvement initiatives, there are other efforts emerging in rheumatology. In the United Kingdom, the National Institute for Health and Care Excellence (NICE) has published a set of 7 quality measures for patients with RA.³⁸ The NICE quality standards emphasize the importance of timely referral, assessment, treatment initiation, and disease control. Other ongoing projects are evaluating novel approaches to improving the quality of rheumatology care.

Table 5
EHR Meaningful Use Requirements³³

Stage 1 Reporting Period: 2011-2013	Stage 2 Reporting Period: 2014-2016	Stage 3 Reporting Period: Begins 2017
<ul style="list-style-type: none"> Electronically capture health information in a coded format Use that information to track key clinical conditions Communicate that information for care coordination purposes Initiate the reporting of clinical quality measures and public health information 	<ul style="list-style-type: none"> Stage 1 criteria AND Disease management Clinical decision support Medication management Support for patient access to their health information Quality measurement for research Bi-directional communication with public health agencies 	<ul style="list-style-type: none"> Stage 1 and 2 criteria AND Improvement in quality, safety and efficiency Decision support for national high priority conditions Patient access to self-management tools Access to comprehensive patient data Improving population health outcomes

European Musculoskeletal Conditions Surveillance and Information Network (eumusc.net)

With support from the European League Against Rheumatism (EULAR), the eumusc.net project is working to elevate the quality of RA care across the European Union (EU) by establishing patient-centered standards of care.³⁹ In 2014, the eumusc.net project published a set of 16 standards for RA care that were translated into all 23 official languages of the EU. In addition to the familiar measures regarding disease assessment, treatment, and timely control of RA disease activity, the eumusc.net measures also emphasize the importance of physical activity, occupational therapy, lifestyle interventions, patient self-management, and other aspects of supportive care. Furthermore, the eumusc.net quality standards were adapted into patient checklists to empower patients to be more involved in the management of their RA.

AIM FARTHER

In 2012, rheumatologists at the Geisinger Health System in Central Pennsylvania launched a new care model designed to improve the quality and cost-effectiveness of RA treatment. At the 2014 ACR annual meeting, they reported progress among 2,378 RA patients treated within the model, called AIM FARTHER (Attribution, Integration, Measurement, Finances and Reporting of Therapies).⁴⁰ The care model includes 8 RA quality measures:

- RA patients on DMARD therapy
- Active RA patients on DMARD therapy

- RA patients with a documented CDAI score
- RA patients at low disease activity
- TB testing among patients on biologic therapy
- Influenza vaccination among RA patients
- Pneumococcal vaccination among RA patients
- Low density lipoprotein (LDL) checked within RA patients

Using a customized EHR, all quality measures were captured electronically and displayed on a patient scorecard. The scorecards provided a clear snapshot of quality of RA care for each patient, including areas needing additional intervention (Figure 2). Within 22 months of launching the program, performance significantly improved on all of the individual measures except for active RA patients on DMARDs, which hovered at 92–93%. Furthermore, the proportion of RA patients with scores of 100% on all 8 quality measures increased from 22% to 40%. The program also resulted in a total cost savings of \$720,000 due to a de-escalation of costly biologic therapies in 2013. According to the presenters, the projected cost savings in 2014 was \$1.2 million.

The Choosing Wisely Campaign

The American Board of Internal Medicine developed the Choosing Wisely campaign, which now operates in collaboration with more than 35 specialty medical societies, including the ACR.⁴¹ The goal of the Choosing Wisely initiative is to reduce the costly and potentially harmful overuse of certain tests and procedures. To facilitate conversations between providers and patients about overuse, the Choosing Wisely campaign

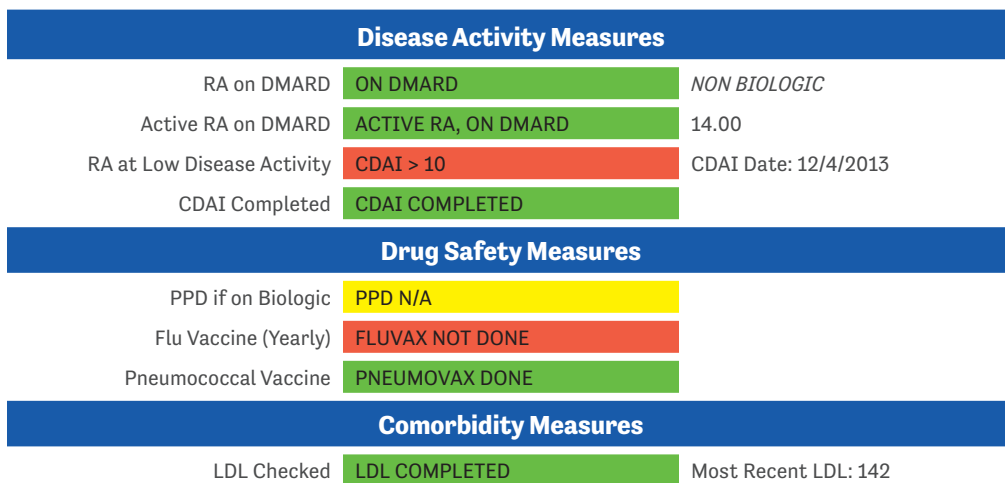


Figure 2
AIM-FARTHER: RA Patient Quality Scorecard⁴⁰
This color-coded scorecard provides real-time feedback on 8 aspects of RA care, indicating whether the RA quality measures have been met (green), are pending or non-applicable (yellow), or require action to complete (red).

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asked each specialty society to develop a Top 5 list of commonly overused tests and procedures. The ACR's Top 5 list includes the following recommendations:

1. Don't test antinuclear antibody (ANA) subserologies without a positive ANA and clinical suspicion of immune-mediated disease.
2. Don't test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate exam findings.
3. Don't perform magnetic resonance imaging (MRI) of the peripheral joints to routinely monitor inflammatory arthritis.
4. Don't prescribe biologics for RA before a trial of methotrexate (or other conventional non-biologic DMARDs).
5. Don't routinely repeat dual x-ray absorptiometry (DXA or DEXA) scans more often than once every two years.

The costs of not choosing wisely can be substantial, as shown in a study that evaluated the financial consequences of ordering ANA subserology tests at the same time as the initial ANA test (i.e., without waiting for a positive ANA result).⁴² A total of 22,596 tests for ANA and ANA subserologies were ordered at a single medical center between 2011 and 2012. In 2,246 instances (9.4%), the subserologies were ordered unnecessarily because ANA results were normal. Rheumatologists ordered one-third (32.8%) of the unnecessary tests, while primary care providers ordered the remaining tests. During the 2-year study period, the total cost of the unnecessary subserology tests was \$39,091. Given that healthcare resources are finite, it is important for all providers to make treatment choices that improve the quality and safety of patient care while reducing wasteful spending.

The Choosing Wisely website (www.choosingwisely.org) hosts patient education materials that may be helpful to support discussions around cost-effective treatment choices in rheumatology and other specialties.

Future Quality Initiatives

Current RA quality measures maintain a heavy focus on the process of care—for example, by tracking what assessments were performed and what medications were given. Future quality measures may evolve to focus more on the outcomes of care—for example, by measuring a decrease in disease activity or an improvement in functional status.⁴³ Other aspects of patient management, such as access to care, cost-effectiveness, and quality of life, may also play a prominent role in measuring quality.⁴³ Findings from other worldwide programs, including eumusc.net, will likely shape future rheumatology quality measures defined by the ACR. In the near future, EHR systems will collect massive amounts of data on real-world rheumatology practice, providing new opportunities to define best practices in patient care.



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Are We Creating a Culture to Support Quality Improvement?

by Sheree C. Carter, PhD, RN

6 Key Elements to Quality Care

1. Safety
2. Effectiveness
3. Patient-Centeredness
4. Timeliness
5. Efficiency
6. Equity

In 2000, the Institute of Medicine (IOM) published its landmark report, *To Err is Human: Building a Safer Health System*, upon which the current trend toward quality care and measurable outcomes is largely grounded.¹ Since then, additional IOM reports have delved further into healthcare quality and safety, providing objective, evidence-based data on the current state of patient care in the United States.²⁻⁴

In these reports, the IOM presented and defined the following six key elements to quality care—safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Furthermore, the IOM proposed the concept of aligning financial reimbursement with quality improvement, setting into motion various multidisciplinary consensus groups to determine and define the specific metrics that should be tracked and measured.

IOM reports have also identified areas where our healthcare system both underperforms and is wasteful, which is

particularly applicable to chronic disease care such as rheumatology. In fact, a 2001 IOM report identified rheumatology as one of the chronic disease areas having the greatest potential to improve access to care, service, and disease outcomes.

One more recent IOM report also bears revisiting—the 2010 *Future of Nursing: Leading Change, Advancing Health*. This landmark report declared that nurses are to be full partners with physicians and other healthcare professionals in the design and structure of innovative healthcare strategies.⁴ It is unclear, however, where NP's, DNP's, and CNS's fit into the process.

As one of the initial dominoes from the IOM's work, in 2005, the Robert Wood Johnson Foundation gathered a group of experts in quality and safety to begin a national study of nursing faculty and nursing students focused on patient safety and healthcare. In 2007, this group—called the Quality & Safety Education for Nurses (QSEN) committee—defined six



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competencies and the associated Knowledge, Skills, and Attitudes (KSAs) nurses must possess to master these competencies. They are similar in nature to those previously identified by the IOM, though with some clear differences — safety, quality improvement, patient-centered care, teamwork and collaboration, evidence-based practice, and informatics.

The ongoing phase III of the QSEN's work aims to instill these competencies in textbooks, licensing, accreditation, and certification standards, as well as supporting innovative teaching techniques of the competencies and KSAs. Additional work is being done to develop a new group of nursing leaders focused on the emerging science of quality and safety in the interprofessional arena.⁵

The concept of quality care is certainly not new to rheumatology nurses. The concept of safety and quality care has always been threaded throughout formal nursing curricula. As nurses, we have learned to evaluate clinical issues through a comprehensive and holistic assessment of our patients, leading to a diagnosis and treatment

plan. We are then often responsible for helping to implement that plan and evaluate short- and long-term patient outcomes.

So if and when you hear others in your practice discussing quality improvement and how these efforts may be incorporated into your systems, it is important to not be shy and to ask for a seat at the table during the consensus-building process for quality care, safety, patient satisfaction, optimal outcomes, and payment systems. The QSEN and its KSAs have laid a blueprint that can be buffeted with rheumatology-specific evidence-based practices and research. All it takes for our voice to be heard is to speak up.

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What *Quality Improvement* Means To Me

Jacqueline Fritz, RN, MSN, CNS

In rheumatology, we are challenged with the formidable task of simultaneously improving quality, enhancing equity, and ensuring value in the care we provide for our patients. One of the ways we can do this is by being involved in research to help establish quality measures and outcome goals.

In 2015, the Physicians Quality Reporting System includes 254 quality measures across a range of medical specialty areas that touch on a variety of aspects of patient care. The six PQRS measures that are most specific to rheumatology are mentioned in the core article within this newsletter. While these measures all meet National Quality Standards (NQS) for effective clinical care, it is important to note that they are *process-based* and do not touch on patient outcomes.¹

In the last 10 years, a number of researchers have designed user-friendly tools for use in research and clinical settings. Some of these tools reflect the significant gains we have made with our patient populations. For instance, drug research used to focus on improvements in ACR scores of only 20%. Now, 40% and 60% ACR improvement is a typical goal.

In addition, there are a number of validated quantitative tools at our disposal, including things like the MHAQ, CDAI, SDAI and Treat to Target guidelines that give us objective data by which to measure effective or ineffective patient care.² While care of the RA patient is multidimensional and cannot be captured by one simple numeric outcome rating alone, these tools are at least starting points on the path toward quality improvement. While it has taken time even for some of these simpler tools to gain a foothold in rheumatology, now that there are financial incentives to use them, they are slowly becoming more commonplace in practice.

The question then is how do we move beyond these starting points and begin to define outcome-based quality measures in a chronic and complex disease such as RA? There are so many variables that need to be considered—including things like disease chronicity, treatment adherence, comorbidities, and access to care—that it seems a Herculean task to design a reliable outcomes tool.

Perhaps we need to include a variety of facets, such as radiographic stability and lack of progression (Sharp score), improvement of functional status, and reduction of DAS28 values. These are each certainly outcome-based dimensions, but none of them can stand alone as a measure of RA quality care.

“Care of the RA patient is multidimensional and cannot be captured by one simple numeric outcome rating.”

Of course, some may argue that our primary goal in the treatment of RA should be to provide value: the health care outcomes achieved per dollar spent.³ If we diagnose RA earlier and treat it more aggressively with a combination of nonbiologic and biologic DMARDs, would it reduce the overall cost of patient care and improve overall patient outcomes? It is these questions that researchers are continuing to explore.

As rheumatology nurses, we must know and understand that PQRS, along with other measurement tools that we use to maximize payment and reimbursement rates, is important, but it does not truly represent an outcome-based improvement in quality patient care. Future RA quality measures must strive to reach this level and provide

multidimensional components that can be easily integrated into daily practice. It is not an easy task. Electronic health records will help, but with the variety of systems in place and the amount of data that would need to be captured, moving quality goals in RA to an outcome-based level is going to require time and patience.

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What *Quality Improvement* Means To Me

Elizabeth Kirchner, CNP

In the clinical setting, the topic of quality improvement (QI) is often met with groans.

One more thing to keep track of. One more thing to be “dinged” for if it isn’t done to some faceless agency’s standards. More paperwork.

However, if you think about it, “quality” and “improvement” are two things that should be brought to every patient encounter. While nobody appreciates having their work scrutinized and picked through by strangers, when you think of QI as something that can only benefit patients, it becomes much more palatable.

The “quality” aspect of QI is fairly straightforward: provide the highest possible level of care to our patients. The “improvement” part is not quite as intuitive. What

is it we’re trying to improve? Our care? Our communication? Our ability to empathize? Our documentation? Our patients’ outcomes? It could mean any or all of these things at any given moment. When we improve as clinicians—whether through research, continuing education, or experience—our care improves and, therefore, so do our patients’ outcomes. If we’re not continually trying to improve, we’re just treading water, and that isn’t fair to the people who come to us for help.

So what does QI mean to me when I’m in an exam room with a patient?

It means protecting my patients with appropriate vaccinations. It means screening them to avoid dangerous, even life-threatening, complications before starting a new medication. It means measuring—consistently and accurately—their level of disease activity.

I would like to think I would do all these things anyway (and I did even before they became reportable metrics), but it never hurts to have a standard to live up to. The metrics we strive to reach in clinical practice have been debated and rigorously researched by the top experts in our field, so I am confident they are appropriate for my practice. While I am not entirely beholden to these metrics and still take time with my patients to focus on topics that aren’t included in current QI guidelines or requirements (nutrition and exercise come to mind), I know that when I aim to reach current QI standards, I am providing the best care for my patients.

“When we improve as clinicians our care improves and, therefore, so do our patients’ outcomes.”

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My Most Memorable Patient

by Iris Zink, MSN, NP

In the winter of 1994, I was working as a young nurse in the respiratory ICU at a hospital in Lansing, MI. Upon my arrival one morning, I reviewed the records of the two patients I would be responsible for that day. One of them was Mary, a 54-year-old Mennonite woman with rheumatoid arthritis (RA) who had been put on a ventilator.

As with many of you, my formal education regarding rheumatologic conditions was sparse. I knew that RA was a disease that could rapidly deteriorate the bones and joints, but it was a mystery to me as to why an RA patient as young as Mary would need a ventilator to support a basic life function. At the time, I simply didn't know the damage that RA could do.

Mary's treatment regimen was simple but appropriate for the era – intramuscular gold and steroids. She had been admitted to the ICU after complaining of shortness of breath. It was clear that RA had affected her lungs, causing pulmonary fibrosis.

In the week that I took care of Mary, I learned a lot about her and her family. One morning, I was busily getting her medications crushed to put in her naso-gastric tube along with checking her vital signs and reading her ventilator settings when Mary's husband came into the room and told me a story I have never forgotten.

I can still picture him today. Wearing a blue shirt and suspenders, it was somehow very important to him that I, as Mary's nurse, understand her background and her life's journey that brought her into this hospital room.

He told me that Mary was a simple woman who never wanted or asked for anything for herself. With two

teenaged daughters and a loving husband, she always put the needs of her family first.

That's why Mary's husband was surprised when she approached him a few weeks before being admitted to our hospital and asked if he could take her to a local store to buy a bolt of fabric. At first, he couldn't understand why. While he could see that Mary was increasingly fatigued and complained often of being short of breath, he didn't yet know how serious her condition was. Nonetheless, he took her to the store the next morning and bought her the fabric she wanted.

Over the next few days and weeks, every night that her husband came into the house after a day of farming, he found Mary sitting in her rocking chair with that bolt of fabric, sewing and crying. It wasn't until she was admitted to the hospital and attached to the ventilator that Mary's husband understood that she was sewing the dress she wanted to be buried in.

Mary knew how seriously her RA had compromised her health, and she was doing the only thing she could to take control of the situation. Later that week, surrounded by her family, we took Mary off of life support and she died peacefully.

What made Mary memorable to me, and why I recall her story so vividly 20 years later, wasn't the bond that she and I shared. In fact, she and I never actually spoke a word to each other. What I know of her came only in stories told to me by her family.

Instead, it was the toll that RA can have on the life of a young mother that resonates with me. I left the ICU and took a job as a nurse practitioner in a rheumatology office in 2000, so today my hours are filled with RA patients of all ages and sizes. Every once in a while, I even see a "Mary" who talks to me about her teenaged children and how she wants to do everything she can to be there for them as they blossom into adulthood. I'm grateful that we've progressed in the era of biologics where I can offer patients much better options that can help avoid major deficits in quality of life and even death.

All of our patients have stories, and we learn about the lives of many during the course of our careers. As nurses, we are taught to be compassionate and to listen. It's inevitable that there will be days when we may not be at our best and our patience will be tested, but we should never forget that the needs of our patients must always come before ours.

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