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Quality in rheumatoid arthritis care

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ABSTRACT

While most rheumatology practices are characterized by strong commitment to quality of care and continuous improvement to limit disability and optimize quality of life for patients and their families, the actual step toward improvement is often difficult. This is because there are still barriers to be addressed and facilitators to be captured before a satisfying and cost-effective practice management is installed. Therefore, this review aims to assist practicing rheumatologists with quality improvement of their daily practice, focusing on care for rheumatoid arthritis (RA) patients.

First we define quality of care as `the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". Often quality is determined by the interplay between structure, processes, and outcomes of care, which is also reflected in the corresponding indicators to measure quality of care. Next, a brief overview is given of the current treatment strategies used in RA, focusing on the tight control strategy, since this strategy forms the basis of international treatment guidelines. Adherence to tight control strategies leads, also in daily practice, to better outcomes in patients

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with regard to disease control, functional status, and work productivity. Despite evidence in favor of tight control strategies, adherence in daily practice is often challenging. Therefore, the next part of the review focuses on possible barriers and facilitators of adherence, and potential interventions to improve quality of care. Many different barriers and facilitators are known and targeting these can be effective in changing care, but these effects are rather small to moderate. With regard to RA, few studies have tried to improve care, such as a study aiming to increase the number of disease activity measures done by a combination of education and feedback. Two out of the three studies showed markedly positive effects of their interventions, suggesting that change is possible. Finally, a simple step-by-step plan is described, which could be used by rheumatologists in daily practice wanting to improve their RA patient care.

Introduction

Musculoskeletal disorders such as gout, osteoarthritis, and rheumatoid arthritis (RA) are considered to be among the most burdensome medical conditions [1]. This has led to the execution of many randomized controlled trials (RCTs) that have provided evidence for the best therapeutic interventions for these diseases. Despite this constant stream of evidence-based recommendations, the translation into daily practice is often suboptimal [1].

While many practicing rheumatologists will agree that quality of care is an important aspect in rheumatology, the actual step to improve quality of care is often difficult, since rheumatologists do not know where and how to start, and there are no clear strategies available how to approach improvement of quality of care in their clinical practice. This review, with the goal of assisting practicing rheumatologists with their own quality improvement of care, aims to fill this gap. It starts with a brief general introduction on quality of care and its measurement methods. Thereafter, the focus will shift to RA and we will discuss what optimal RA care is, how we can measure whether quality demands are met or not, and how this could be improved. In the latter part, two case descriptions of successful quality improvement projects in RA will be discussed. Finally, we will give practical recommendations to rheumatologists who want to further improve their own performance.

A. What is quality of care and how can you measure it?

Quality of care in itself is a rather abstract term, but more practical descriptions do exist. One of the most commonly used descriptions, developed around 1980 by Donabedian, distinguishes structures, processes, and outcomes of care [2]. The structure of care describes aspects of the setting in which care is delivered, such as the number of rheumatologists or the presence of a treatment protocol. Next, the process of care describes the actions of the health-care professionals, for example, whether the protocol is indeed followed. Finally, the outcome reflects the effect of the given care in terms of mortality, morbidity, and health status. It is believed that more desirable outcomes are obtained if the structure of care provides the opportunity to deliver the most optimal care processes (Fig. 1).

Around 1990, the Institute of Medicine (IOM) defined quality of care as ``the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.'' Furthermore, the IOM formulated the following six criteria that pertain to quality of care: Care should be i) safe, ii) effective, iii) patient-centered, iv) timely, v) efficient, and vi) equitable [4]. When using these criteria, it is important to take into account the different perspectives of the stakeholders (e.g., patients or health insurers) [5].

Knowing how to describe quality of care is a prerequisite for its measurement. Often quality indicators are used to assess quality of care. A quality indicator is ``a measurable element of practice performance for