



Driving musculoskeletal
health for Europe

**EUMUSC.NET project
Work Package 7
2012-2013**

D18 Case study report of examples of good practice

Identification of examples of good practice

Selection criteria for the good practices will be identified based on standards of care (SOC) and health care quality indicators (HCQI) identified by the working group in work package 7.

These examples are intended to inspire for good clinical practice in clinical rheumatology settings throughout Europe.

Example Spain 1

Standard of Care (SOC) related to example: could be OA SOC's from 1 to 6.

Facilitator(s) related to example: Organization (support of patient, professional, health care organization), environmental factors (facilities and equipment), time resources, economical resources.

Background: The ARTROACAS programme was designed to improve knee OA patients' quality of care. When designing this programme, the characteristics and the different care levels of the Spanish health system were taken into account to achieve an appropriate and rational use of human and material resources.

Objectives: To show the feasibility and efficacy of a multidisciplinary health care programme for patients with knee OA.

Methods: A 12-month follow-up care programme for knee OA, based on clinical evidence and expert opinion was implemented in primary care settings. It included recommendations on diagnosis, management and follow-up. Consecutive patients with knee OA and pain were included, classified into mild (21–39 score), moderate (40–69 score), severe disease (70–100 score) in WOMAC pain subscale, and managed according to the multidisciplinary health care programme. Data were recorded using electronic devices or internet at each visit. Primary end points were: OMERACT-OARSI responder criteria; 70% compliance rate of the recommendations.

Results: We included 226 patients, 75% women, mean age 63 years, mean disease duration of 2.4 years, 76% reported Kellgren-Lawrence grade 3-4, and were classified as mild: 17%, moderate: 54% and severe disease: 29%. At the end of the study, 78% of patients achieved pain relief of ≥ 20 points in the WOMAC pain subscale, and 80% OMERACT-OARSI response criteria. Almost 90% of physicians followed the recommendations. WOMAC and SF-36 subscales/dimensions improved ($p < 0.050$), 14% remained classified as moderate or severe disease, 85% of patients attended the exercise training course, and more than 80% of patients and professionals were satisfied with the programme. Compared to usual care the programme seems to use fewer resources.

Take home message on implementation: It is vital to collaborate with primary care physicians and other health professionals. Increased collaboration leads to increased benefit ..

Reference:

1. Loza E, Benito-Ruiz P, Blanco F, de Miguel E, Roman JA. Feasibility and efficacy of a multidisciplinary health care programme for patients with knee osteoarthritis. *Clin Exp Rheumatol*. 2011. Epub 2011/12/03.

Example Spain 2

Standard of Care (SOC) related to example: the program included many different aspects across different SOC for both OA and RA.

Facilitator(s) related to example: Organization (support of patient, professional, health care organization), time resources, and economical resources.

Background: Musculoskeletal disorders (MSDs) such as OA and RA are a frequent cause of work disability, accounting for important productivity losses in industrialized societies.

Objectives: To show the results of the implementation of a population-based clinical program offered to patients with recent-onset work disability caused by MSDs. This program included patients with OA and RA.

Methods: This was a randomized, controlled intervention study performed in Madrid, Spain. The inclusion and follow-up periods each lasted 12 months. Patients with MSD-related temporary work disability in 1998 and 1999 were included. The control group received standard primary care management, with referral to specialized care if needed. The intervention group received a specific program, administered by rheumatologists, in which care was delivered during regular visits and included 3 main elements: education, protocol-based clinical management, and administrative duties. Efficacy variables were 1) days of temporary work disability and 2) number of patients with permanent work disability. All analyses were done on an intention-to-treat basis.

Results: A total of 1,077 patients were included, 7,805 in the control group and 5,272 in the intervention group, generating 16,297 episodes of MSD-related temporary work disability. These episodes were shorter in the intervention group than in the control group (mean, 26 days compared with 41 days; $P < 0.001$), and the groups had similar numbers of episodes per patient. Fewer patients received long-term disability compensation in the intervention group ($n = 38$ [0.7%]) than in the control group ($n = 99$ [1.3%]) ($P < 0.005$). Direct and indirect costs were lower in the intervention group than in the control group. To save 1 day of temporary work disability, 6.00 dollars had to be invested in the program. Each dollar invested generated a benefit of 11.00 dollars. The program's net benefit was in excess of 5 million dollars.

Take home message on implementation:

It is vital to collaborate with primary care physicians and other health professionals. Increased collaboration leads to increase benefit.

References:

1. Abasolo L, Blanco M, Bachiller J, Candelas G, Collado P, Lajas C, et al. A health system program to reduce work disability related to musculoskeletal disorders. *Ann Intern Med.* 2005;143(6):404-14.
2. Abasolo L, Carmona L, Hernandez-Garcia C, Lajas C, Loza E, Blanco M, et al. Musculoskeletal work disability for clinicians: time course and effectiveness of a specialized intervention program by diagnosis. *Arthritis Rheum.* 2007;57(2):335-42.
3. Abasolo L, Carmona L, Lajas C, Candelas G, Blanco M, Loza E, et al. Prognostic factors in short-term disability due to musculoskeletal disorders. *Arthritis Rheum.* 2008;59(4):489-96.
4. Abasolo L, Lajas C, Leon L, Carmona L, Macarron P, Candelas G, et al. Prognostic factors for long-term work disability due to musculoskeletal disorders. *Rheumatol Int.* 2011.
5. Candelas G, Abasolo L, Leon L, Lajas C, Loza E, Revenga M, et al. Diagnostic concordance between primary care physicians and rheumatologists in patients with work disability related to musculoskeletal disorders. *Rheumatol Int.* 2011;31(12):1549-54.
6. Leon L, Jover JA, Candelas G, Lajas C, Vadillo C, Blanco M, et al. Effectiveness of an early cognitive-behavioral treatment in patients with work disability due to musculoskeletal disorders. *Arthritis Rheum.* 2009;61(7):996-1003.

Examples Germany

Outcome Benchmarking in acute rheumatology care (Outcome Benchmarking in der rheumatologischen Akutversorgung (OBRA)“ – Projekt des Verbandes Rheumatologischer Akutkliniken)

Patients were asked several weeks after their treatment in hospital with the help of a questionnaire how they were satisfied with their treatment, the clinic, the staff etc. So this approach aims at improving the patient's satisfaction, the quality of the treatment, the communication of the staff members and the lasting effect of the hospital treatment.

The Treat2Target principles and recommendations for RA can be downloaded from www.rheuma-liga.de/, the homepage of our patient organization. We hope that this will contribute to a patient awareness telling them what Standards of Care should be achieved. Our local volunteers should support this e.g. by inviting doctors who inform patients. Certainly, this is the trouble, this is not measurable. The only feedback we get from doctors is that patients who are active members of Deutsche Rheuma-Liga are much better informed.

Educational programmes organized by "Rheumaakademie" (<http://www.rheumaakademie.de>) that seemingly was very successful and raised the knowledge of doctors' assistants.

Examples Austria

1. In Austria there is often limited access to rheumatologists with long waiting times. At the Medical University of Vienna an immediate access clinic was established. People with symptoms of a rheumatic disease can self initiate a consultation or can be referred from the GP/ MD. A consultation with a rheumatologist is offered to the patients usually within one week. The aim is to offer a quick and direct access to an experienced rheumatologist.

Reference:

1. *Gartner M, Fabrizii JP, Koban E, Holbik M, Machold LP, Smolen JS et al. Immediate access rheumatology clinic: efficiency and outcomes. Ann Rheum Dis 2012; 71(3):363-8.*
2. According to the EUMUSC.net SOC for OA an innovative interdisciplinary intervention for the treatment of hand OA was developed and implemented by an interdisciplinary team consisting of a nurse, an occupational therapist, a physiotherapist and a rheumatologist (IIHOA). The intervention is delivered in two to three personal consultations with the multidisciplinary team and at least one telephone call with one of the health professionals. The intervention focuses especially on exercise, functioning in daily life, self-efficacy and physical methods. The objective of the present project is to evaluate the functional outcome and satisfaction of patients of an interdisciplinary model of care, based on the EUMUSC.net SOC, for people with hand OA compared to routine clinical care in a randomised controlled trial

In 2011 a rheumatology text book called "Praktische Rheumatologie" for professionals/practitioners in German language was published. In the appendix Michaela Stoffer, Tanja Stamm & Klaus Machold wrote a part about guidelines for RA showing results from the EUMUSC.NET literature review (Empfehlungen, Konsensuspapiere und Leitlinien für die

rheumatoide Arthritis). The aim is to raise attention to existing guidelines and recommendations.

Reference:

1. *Praktische Rheumatologie, Dunky Graninger Herold Smolen Wanivenhaus, Springer ISBN 978-3-211-88982-4*
- 2.

Example Norway

A very early arthritis clinic in Norway (NOR-VEAC)

Standards of care related to example:

SOC1: People with symptoms of RA should have timely access (6 weeks according to EULAR recommendations) to a clinician/ health professional competent in making a (differential) diagnosis.

SOC3: People with RA should receive a treatment plan individually developed between them and their clinician at each visit.

Facilitator related to example:

Motivation (personal effort, drive, willingness to get engaged)

Economical resources

Outcome expectancy (belief that recommendation will be used)

Background: Inflammatory rheumatic joint diseases include rheumatoid arthritis and axial or peripheral spondyloarthritis, and there is an agreement that these patients should be treated early and actively. A problem has been delay in referral to specialist rheumatology care.

Methods: With symptom duration of less than 4 months and at least one swollen joint patients are by their general practitioner routinely referred to one of 6 collaboration rheumatology departments in the Southeastern part of Norway, covering a population of 1.7 million inhabitants. Patients are followed by their rheumatologists in a clinical setting with broad spectrum of clinical assessment, radiographs, MRI and cardiovascular outcomes, with controls after 3, 6, 12, and 24 months and then yearly. More than 1000 patients with arthritis of less than 16 weeks have been included since 2004 in a very early arthritis clinic in Norway (NOR-VEAC). Enrolment continues as part of a regional rheumatology network.

General practitioners were informed about the study by letter and the apartments arranged evening courses for general practitioners, focusing on recognition of the swollen joint and the importance of early referral to a rheumatology department. Data collection performed by research nurses in collaboration with all rheumatology doctors in the outpatient department

Results: The early arthritis clinics provide valuable data regarding the epidemiology and pathophysiology of early arthritis, as well as information about prognostic factors.

Cooperation with primary health care is strengthened, and awareness of the importance of early referral is enhanced

The early arthritis clinics provide valuable data regarding the epidemiology and pathophysiology of early arthritis, as well as information about prognostic factors.

Cooperation with primary health care has been strengthened, and awareness of the importance of early referral is enhanced .

Conclusion: The study increased the collaboration with general practitioners for early treatment of patients with early arthritis symptoms, and relevant patients receive specialist treatment very early. Patients are followed regularly also with respect of development of rheumatoid arthritis or other rheumatic diseases. Further, the study provided research data,

useful for the classification of rheumatoid arthritis as well as epidemiological information on patterns of joint manifestation and biomarkers for disease prediction in patients with early arthritis.

References:

1. Mjaavatten MD, Uhlig T, Haugen AJ, Nygaard H, Sidenvall G, Helgetveit K, Kvien TK. Pattern of joint involvement and other disease characteristics in 634 patients with arthritis of less than 16 weeks duration. *J Rheumatol* 2009;36:1401-6.
2. Mjaavatten MD, Uhlig T, Haugen AJ, Nygaard H, Sidenvall G, Helgetveit K, Kvien TK. Positive anti-citrullinated protein antibody status and small joint arthritis are consistent predictors of chronic disease in patients with very early arthritis: results from the NOR-VEAC study. *Arthritis Res Ther* 2009;11:R146.
3. Mjaavatten MD, van der Heijde D, Uhlig T, Haugen AJ, Nygaard H, Sidenvall G, Helgetveit K, Kvien TK. The likelihood of persistent arthritis increases with the level of anti-citrullinated peptide antibody and immunoglobulin M rheumatoid factor: a longitudinal study of 376 patients with very early undifferentiated arthritis. *Arthritis Res Ther* 2010; 12:R76.