

Abstract

Objectives: The ultimate goals in managing Rheumatoid Arthritis (RA) are preventing or controlling joint damage, preventing loss of function and decreasing pain. Assessment of disease activity is critical; therefore, guidelines recommend that physicians evaluate patients' symptoms and severity. The objective of this study was to examine how often evaluation of disease activity and damage in patients with RA was documented by physicians during office visits.

Methods: We extracted 300 records for RA patients from a unique database of physician-patient interactions (RealHealthData). Using Atlas.ti, we analyzed these records to evaluate how often the recommended assessments of disease activity was documented by physicians during office visits.

Results: Almost all physicians (92%) document the presence of actively inflamed joints (i.e., tender and swollen joint counts) and evidence of disease progression (i.e., loss of motion, deformity). However, only 28% and 18% document duration of morning stiffness and fatigue respectively. And while limitation of function is explored, only 11% documented the degree of joint pain via a visual analog scale. Lastly, it was rare for physicians to document their own global assessment of disease activity (5%) or the patient's global assessment of disease activity (8%).

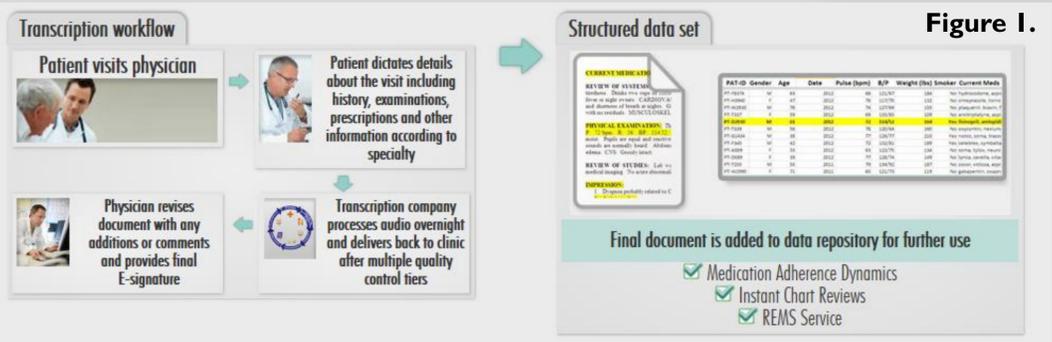
Conclusions: The more we know about patients' reported symptoms and outcomes, the more we can actively plan and organize research, development and outreach that is patient-centric and clinically meaningful. Successful treatment includes systematic and regular evaluation of disease activity and patient assessments to help limit joint damage and functional loss. While many physicians are documenting the number of tender and swollen joints, loss of motion or deformity, a majority of physicians are not documenting patient-reported symptoms that are critical to disease monitoring such as morning stiffness, fatigue or overall degree of joint pain. Our results demonstrate there is room for improvement when it comes to documenting patient-reported outcomes in RA.

Background

The American College of Rheumatology, (ACR) which is an independent, professional, medical and scientific society developed guidelines and recommendations that are intended to provide guidance for particular patterns of practice¹. And while these guidelines and recommendations should not dictate the care of individual patients, they do provide a suggested plan for patient care treatment. Their intent is to promote beneficial and desirable outcomes for patients.

Rheumatoid Arthritis (RA) disease activity monitoring is a key component of providing high-quality patient care. Yet, despite the push from various stakeholders in the health care system to standardized disease activity assessment in RA such as a pay-for-reporting program administered by the Centers for Medicare and Medicaid Services [a quality measure assessing whether physicians measure RA disease activity using a standardized scale or composite index and classify RA disease activity as low, moderate, or high at least yearly] and growing evidence that treating to target is effective, most US rheumatologists do not routinely use standardized measures in clinical practice.²

The ultimate goals in managing Rheumatoid Arthritis (RA) are preventing or controlling joint damage; therefore, the objective of this study was to examine how often evaluation of disease activity and damage in patients with RA was documented by physicians during office visits.



Methods

We extracted 300 patient records that were identified for people diagnosed with RA from a unique database of physician-patient interactions: RealHealthData (<http://www.realhealthdata.com/>). RealHealthData works with medical transcription companies across the country to build a database of detailed narrative medical records, providing a unique perspective on patient conditions and physician interaction. (Figure 1).

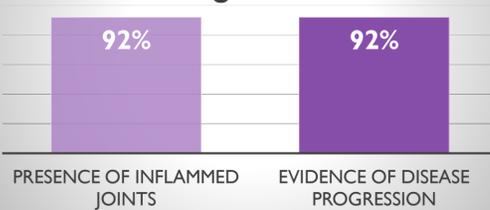
In order to be included in the database, patients needed to be at least 18 years of age, diagnosed with Rheumatoid Arthritis and had an office visit with at least one physician in the past 12 months.

Using Atlas.ti and Excel, we analyzed these patient records to evaluate how often the recommended assessments of disease activity was documented by physicians during office visits.

Results

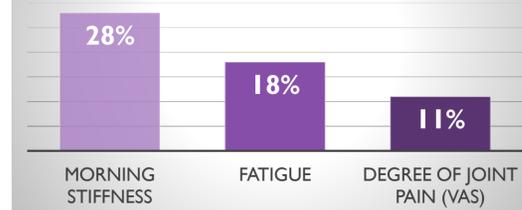
Of the 300 records included, almost all of the physicians (92%) documented the presence of actively inflamed joints (i.e., tender and swollen joint counts) and evidence of disease progression (i.e., loss of motion, deformity) for their patients (Figure 2).

Figure 2. Documentation of Inflamed Joints and Disease Progression



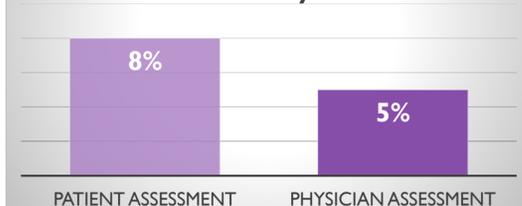
However, only 28% and 18% document duration of morning stiffness and fatigue respectively. And while limitation of function is explored, only 11% documented the degree of joint pain via a visual analog scale (Figure 3).

Figure 3. Documentation of Morning Stiffness, Fatigue and VAS



Lastly, it was rare for physicians to document their own global assessment of disease activity (5%) or the patient's global assessment of disease activity (8%) (figure 4).

Figure 4. Documentation of Physician or Patient Global Assessment of Disease Activity



Direct Quotes

A unique feature of the data from RealHealthData is the ability to catch a glimpse of the physician-patient interaction the same day it happens – without having to survey the patients or physicians. Data is recorded as it happens without having to be concerned about recall or bias. In this section, we present excerpts from the notes so you have a better understanding of the narrative provided in the medical records.

“She is to return to clinic in 2 to 3 months. She is to notify me if she has worsening of her symptoms prior to her next visit. She may be a candidate for switch from Orencia to either Cimzia to Simponi primarily because over time she may not be gaining as much benefit from the Orencia.”

“I spent a great deal of time with this patient and her daughter and her sister discussing the pros and cons of more aggressive treatment. At the present time, the patient is essentially incapacitated. She has been admitted multiple times within the last several months because of flares of her arthritis and she is essentially miserable. It is my feeling that she needs to have more aggressive treatment.”

“Showed active synovitis involving MCPs, PIPs, and both wrists, pain with abduction of his shoulders. Slight swelling over the right knee with a healed wound from his recent total knee replacement. No synovitis affecting her left knee. There is synovitis of the fingers with minimal swelling over MTP joints with no tenderness. STUDIES: Normal albumin, AST, creatinine. Mild normal.”

Conclusions

The more we know about patients' reported symptoms and outcomes, the more we can actively plan and organize research, development and outreach that is patient-centric and clinically meaningful. Successful treatment includes systematic and regular evaluation of disease activity and patient assessments to help limit joint damage and functional loss. While many physicians are documenting the number of tender and swollen joints, loss of motion or deformity, a majority of physicians are not documenting patient-reported symptoms that are critical to disease monitoring such as morning stiffness, fatigue or overall degree of joint pain. Our results demonstrate there is room for improvement when it comes to documenting patient-reported outcomes in RA.

References

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- National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), American College of Rheumatology (ACR). Rheumatoid arthritis physician performance measurement set. 2008. URL: <http://www.ama-assn.org/ama/pub/upload/mm/pcpi/rheumatoidarthritis.pdf>

ACKNOWLEDGEMENTS

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