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| Body System: Musculoskeletal | | | |
| Session Topic: Rheumatoid Arthritis | | | |
| Educational Format | | Faculty Expertise Required | |
| REQUIRED | Interactive Lecture | Expertise in the field of study. Experience teaching in the field of study is desired. Preferred experience with audience response systems (ARS). Utilizing polling questions and engaging the learners in Q&A during the final 15 minutes of the session are required. | |
| OPTIONAL | Problem-Based Learning (PBL) | Expertise teaching highly interactive, small group learning environments. Case-based, with experience developing and teaching case scenarios for simulation labs preferred. Other workshop-oriented designs may be accommodated. A typical PBL room is set for 50-100 participants, with 7-8 each per round table. <u>Please describe your interest and plan for teaching a PBL on your proposal form.</u> | |
| Professional Practice Gap | | Learning Objective(s) that will close the gap and meet the need | Outcome Being Measured |
| <ul style="list-style-type: none"> Poor adherence to RA clinical guidelines. Knowledge gaps with regard to screening and diagnosing RA. Knowledge gaps with regard to utilization of joint injection therapy in their practice. Knowledge gaps with regard to performing joint aspiration. Knowledge gap with regard to and interpretation of diagnostic and laboratory results. Patients often have poor access to specialists and inadequate insurance coverage. Patients often have poor adherence to prescribed RA medication therapies. | | <ol style="list-style-type: none"> Apply appropriate diagnostic strategies for rheumatoid arthritis to facilitate early diagnosis of the disease. Use validated outcome measures to monitor disease activity and progression and ultimately optimize therapy for individual patients with RA. Integrate guidelines and strategies for combination DMARD therapy to facilitate more appropriate DMARD selections for patient therapy. Develop collaborative care plans emphasizing treatment monitoring and adherence to prescribed therapies. | Learners will submit written commitment to change statements on the session evaluation, indicating how they plan to implement presented practice recommendations. |
| ACGME Core Competencies Addressed (select all that apply) | | | |
| X | Medical Knowledge | | Patient Care |
| X | Interpersonal and Communication Skills | | Practice-Based Learning and Improvement |
| | Professionalism | X | Systems-Based Practice |



Faculty Instructional Goals

Faculty play a vital role in assisting the AAFP to achieve its mission by providing high-quality, innovative education for physicians, residents and medical students that will encompass the art, science, evidence and socio-economics of family medicine and to support the pursuit of lifelong learning. By achieving the instructional goals provided, faculty will facilitate the application of new knowledge and skills gained by learners to practice, so that they may optimize care provided to their patients.

- Provide up to 3 evidence-based recommended practice changes that can be immediately implemented, at the conclusion of the session; including SORT taxonomy & reference citations
- Facilitate learner engagement during the session
- Address related practice barriers to foster optimal patient management
- Provide recommended journal resources and tools, during the session, from the American Family Physician (AFP), Family Practice Management (FPM), and Familydoctor.org patient resources; those listed in the References section below are a good place to start
 - Visit <http://www.aafp.org/journals> for additional resources
 - Visit <http://familydoctor.org> for patient education and resources
- Provide recommendations for appropriate diagnostic strategies for rheumatoid arthritis to facilitate early diagnosis of the disease.
- Provide recommendations regarding the use of validated outcome measures to monitor disease activity and progression and ultimately optimize therapy for individual patients with RA.
- Provide recommendations and strategies for implementing guidelines and strategies for combination DMARD therapy to facilitate more appropriate DMARD selections for patient therapy.
- Provide strategies and resources for developing collaborative care plans emphasizing treatment monitoring and adherence to prescribed therapies.
- Provide an overview of current clinical guidelines with strategies for implementation and adherence.
- Provide an overview of current pharmacologic and non-pharmacologic treatment options, including evidence-recommendations for maximizing patient outcomes.

Needs Assessment

An estimated 52.5 million adults in the United States reported being told by a doctor that they have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia.¹ By 2030, an estimated 67 million Americans ages 18 years or older are projected to have doctor-diagnosed arthritis.² Arthritis and other rheumatic conditions are the most common cause of disability among U.S. adults and have been for the past 15 years. In 2004, there were an estimated 744,000 hospitalizations with a principal diagnosis of arthritis (3% of all hospitalizations). Overall, 5 million hospitalizations had a principal or secondary diagnosis of arthritis.³ There were 78 million ambulatory care visits with a primary diagnosis of arthritis or other rheumatic conditions, or nearly 5% of all ambulatory care visits that year. Overall, there were 66 million ambulatory care visits with a primary or secondary diagnosis of arthritis or other rheumatic conditions.⁴

Data from the 2012 American Academy of Family Physicians (AAFP) CME Needs Assessment Survey indicate that family physicians have a statistically significant and meaningful gap in



knowledge and skills necessary to manage patients with arthritis. The survey showed a medical skill/relevance gap of 0.42 and a p value of 0.00 for arthritis and 0.53/0.00 for Rheumatoid arthritis (RA).⁵ CME outcomes data from the AAFP Chronic Conditions Self-Study Package suggest that physicians have medical knowledge gaps with regard to diagnosing RA.⁶ Additionally, CME outcomes data from 2011 AAFP Assembly: *Arthritis: Clinical Review for Family Physicians* sessions, suggest that physicians have knowledge gaps with regard to the utilization of joint injection therapy in their practice; screening and diagnosis; evidence-based treatment guidelines; performing joint aspiration; and interpretation of diagnostic and laboratory results.^{7,8}

New medications and treatment strategies for rheumatoid arthritis (RA) has led to a decreased need for total joint replacement.⁹ However, studies show that patients are frequently non-adherent to prescribed RA medications.¹⁰ As such, family physicians play an integral role toward improving outcomes of RA. As suggested by the CME outcomes data, family physicians need continuing medical education to increase their ability to diagnose RA, and to develop effective treatment strategies. Early use of disease-modifying antirheumatic drugs (DMARDs) markedly reduces inflammation and joint destruction associated with RA. Therefore, with early diagnosis of RA and appropriate use of DMARDs, there is a window of opportunity to change the clinical course of this disabling disease.¹¹ However, diagnosing RA in the early stages of the disease is difficult.

Studies demonstrate the efficacy of adjusting RA treatment in response to disease activity; however, patients are not always treated according to evidence-based recommendations.¹² Some research also suggests that a *Treat-to-Target Strategy* (T2T) in RA can potentially transform the clinical management of RA into a standardized approach, with the goal of improving both short and long-term goals.¹³ Clinical trials have demonstrated that physician-learners would benefit from evidence-based recommendations for implementing T2T best practices, including strategies for overcoming some of the documented T2T implementation barriers.¹⁴

Physicians may improve their care of patients with RA by engaging in continuing medical education that provides practical integration of current evidence-based guidelines and recommendations into their standards of care, including, but not limited to the following:^{15,16}

- Patients with inflammatory joint disease should be referred to a rheumatology subspecialist, especially if symptoms last more than six weeks.
- In persons with RA, combination therapy with two or more disease-modifying antirheumatic drugs is more effective than monotherapy. However, more than one biologic agent should not be used at one time (e.g., adalimumab [Humira] with abatacept [Orencia]) because of the high risk of adverse effects.
- A guided exercise program can improve quality of life and muscle strength in patients with RA.
- Cardiovascular disease is the main cause of mortality in persons with RA; therefore, risk factors for coronary artery disease should be addressed in these patients.
- Methotrexate monotherapy demonstrated statistically significant and clinically relevant improvement of symptoms and physical function compared with placebo at 12 to 52 weeks.



While methotrexate is generally regarded as a safe and effective medication in the right dose, in 2006 the National Patient Safety Agency issued a safety alert following increasing reports of prescribing errors and toxicity.¹⁷ This suggests that physicians are in need to training to help increase adherence to treatment guidelines.

Additionally, physicians should be familiar with current American College of Rheumatology (ACR) clinical guidelines for treating RA, as well as the ACR's *Choosing Wisely*[®] recommendations for reducing health care costs while also improving the quality of care.¹⁸⁻²⁰

Physicians can improve patient satisfaction with the referral process by using readily available strategies and tools such as, improving internal office communication, engaging patients in scheduling, facilitating the appointment, tracking referral results, analyzing data for improvement opportunities, and gathering patient feedback.^{21,22}

These recommendations are provided only as assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations. These recommendations are only one element in the complex process of improving the health of America. To be effective, the recommendations must be implemented. As such, physicians require continuing medical education to assist them with making decisions about specific clinical considerations.

Resources: Evidence-Based Practice Recommendations/Guidelines/Performance Measures

- Predicting rheumatoid arthritis risk in adults with undifferentiated arthritis¹¹
- Diagnosis and management of rheumatoid arthritis¹⁵
- PUTTING EVIDENCE INTO PRACTICE: Methotrexate Therapy for Rheumatoid Arthritis¹⁶
- ACR recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis¹⁸
- ACR Choosing Wisely²⁰
- Adding health education specialists to your practice²³
- Envisioning new roles for medical assistants: strategies from patient-centered medical homes²⁴
- The benefits of using care coordinators in primary care: a case study²⁵
- Engaging Patients in Collaborative Care Plans²⁶
- Health Coaching: Teaching Patients to Fish²⁷
- Medication adherence: we didn't ask and they didn't tell²⁸
- Encouraging patients to change unhealthy behaviors with motivational interviewing²⁹
- Integrating a behavioral health specialist into your practice³⁰
- Simple tools to increase patient satisfaction with the referral process²¹
- Juvenile Rheumatoid Arthritis | Overview (patient education)³¹
- Rheumatoid Arthritis | Overview³²



References

1. Centers for Disease Control and Prevention. Arthritis-Related Statistics. 2011; http://www.cdc.gov/arthritis/data_statistics/arthritis_related_stats.htm#2. Accessed June, 2013.
2. Centers for Disease Control and Prevention. Arthritis: Data and Statistics. 2015; http://www.cdc.gov/arthritis/data_statistics/index.html. Accessed June, 2015.
3. Kozak LJ, DeFrances CJ, Hall MJ. National hospital discharge survey: 2004 annual summary with detailed diagnosis and procedure data. *Vital and health statistics. Series 13, Data from the National Health Survey*. Oct 2006(162):1-209.
4. Sacks JJ, Luo YH, Helmick CG. Prevalence of specific types of arthritis and other rheumatic conditions in the ambulatory health care system in the United States, 2001-2005. *Arthritis care & research*. Apr 2010;62(4):460-464.
5. AAFP. 2012 CME Needs Assessment: Clinical Topics. American Academy of Family Physicians; 2012.
6. American Academy of Family Physicians (AAFP). Chronic Conditions Self-Study Package: Arthritis CME outcomes report. Leawood KS: AAFP; 2015.
7. American Academy of Family Physicians (AAFP). 2011 AAFP Scientific Assembly: CME Outcomes Report. Leawood KS: AAFP; 2011.
8. Hetland ML, Jensen DV, Krogh NS. Monitoring patients with rheumatoid arthritis in routine care: experiences from a treat-to-target strategy using the DANBIO registry. *Clinical and experimental rheumatology*. Sep-Oct 2014;32(5 Suppl 85):S-141-146.
9. Khan NA, Sokka T. Declining needs for total joint replacements for rheumatoid arthritis. *Arthritis research & therapy*. 2011;13(5):130-130.
10. Zwikker H, van den Bemt B, van den Ende C, et al. Development and content of a group-based intervention to improve medication adherence in non-adherent patients with rheumatoid arthritis. *Patient education and counseling*. Oct 2012;89(1):143-151.
11. Mochan E, Ebell MH. Predicting rheumatoid arthritis risk in adults with undifferentiated arthritis. *American family physician*. May 15 2008;77(10):1451-1453.
12. Fraenkel L, Cunningham M. High disease activity may not be sufficient to escalate care. *Arthritis care & research*. Feb 2014;66(2):197-203.
13. Ruderman EM. Treating to target in rheumatoid arthritis - challenges and opportunities. *Bulletin of the Hospital for Joint Disease (2013)*. 2013;71(3):214-217.
14. Vermeer M, Kuper HH, Bernelot Moens HJ, et al. Adherence to a treat-to-target strategy in early rheumatoid arthritis: results of the DREAM remission induction cohort. *Arthritis research & therapy*. 2012;14(6):R254.
15. Wasserman AM. Diagnosis and management of rheumatoid arthritis. *American family physician*. Dec 1 2011;84(11):1245-1252.
16. Vega IL. Cochrane for Clinicians - PUTTING EVIDENCE INTO PRACTICE: Methotrexate Therapy for Rheumatoid Arthritis. *American family physician*. 2015;91(1):26-27. <http://www.aafp.org/afp/2015/0101/p26.html>. Accessed June 2015.



17. Byng-Maddick R, Wijendra M, Penn H. Primary care attitudes to methotrexate monitoring. *Quality in primary care*. 2012;20(6):443-447.
18. Singh JA, Furst DE, Bharat A, et al. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis care & research*. May 2012;64(5):625-639.
19. American College of Rheumatology. Clinical Practice Guidelines. 2014; http://www.rheumatology.org/Practice/Clinical/Guidelines/Clinical_Practice_Guidelines/. Accessed October, 2014.
20. American College of Rheumatology. Focus on Patient Care: Choosing Wisely. 2014; <http://www.rheumatology.org/FiveThings/>. Accessed June, 2015.
21. Jarve RK, Dool DW. Simple tools to increase patient satisfaction with the referral process. *Family practice management*. Nov-Dec 2011;18(6):9-14.
22. American Academy of Family Physicians (AAFP). FPM Toolbox: Referral Management. 2013; <http://www.aafp.org/fpm/toolBox/viewToolType.htm?toolTypeId=26>. Accessed July, 2014.
23. Chambliss ML, Lineberry S, Evans WM, Bibeau DL. Adding health education specialists to your practice. *Family practice management*. Mar-Apr 2014;21(2):10-15.
24. Naughton D, Adelman AM, Bricker P, Miller-Day M, Gabbay R. Envisioning new roles for medical assistants: strategies from patient-centered medical homes. *Family practice management*. Mar-Apr 2013;20(2):7-12.
25. Mullins A, Mooney J, Fowler R. The benefits of using care coordinators in primary care: a case study. *Family practice management*. Nov-Dec 2013;20(6):18-21.
26. Mauksch L, Safford B. Engaging Patients in Collaborative Care Plans. *Family practice management*. 2013;20(3):35-39.
27. Ghorob A. Health Coaching: Teaching Patients to Fish. *Family practice management*. 2013;20(3):40-42.
28. Brown M, Sinsky CA. Medication adherence: we didn't ask and they didn't tell. *Family practice management*. Mar-Apr 2013;20(2):25-30.
29. Stewart EE, Fox CH. Encouraging patients to change unhealthy behaviors with motivational interviewing. *Family practice management*. May-Jun 2011;18(3):21-25.
30. Reitz R, Fifield P, Whistler P. Integrating a behavioral health specialist into your practice. *Family practice management*. Jan-Feb 2011;18(1):18-21.
31. FamilyDoctor.org. Juvenile Rheumatoid Arthritis | Overview 2011; <http://familydoctor.org/familydoctor/en/diseases-conditions/juvenile-rheumatoid-arthritis.html>. Accessed July, 2013.
32. FamilyDoctor.org. Rheumatoid Arthritis | Overview. 2006; <http://familydoctor.org/familydoctor/en/diseases-conditions/rheumatoid-arthritis.html>. Accessed June, 2015.