THE RAPP Sheet
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RAPP PARTNER Q&A

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Skokie, Illinois

No Looking in the Rearview Mirror

Rheumatology Due Champions Change to Improve Patient Care

GREAT PATIENT CARE ISN'T the end game, it's the starting point for rheumatologists William "Bill" Arnold and Erin Arnold, who began their dynamic father-daughter professional partnership when Erin first entered clinical practice 12 years ago. "We prod each other out of our comfort zones in ways that I think only a family member can," Erin says. And together they intend to keep pushing the envelope on patient care.

Their aim is to determine how objective disease activity measures can be used to achieve the best possible care and outcomes. With clinical population management as the foundation, they're combining ultrasound and Vectra® DA in groundbreaking new ways that show great promise for the field. And they've stepped up the intensity of this effort since last June, when they left a sprawling multi-specialty group in suburban Chicago to open their own private practice in nearby Skokie, Illinois.

In a recent Q&A, Erin and Bill talked about their experience with the RAPP Project, clinical population management, and using objective measures to help drive down disease activity. Both participated in the first RAPP meeting, held in Chicago in April 2013.

What happened for you at the RAPP meeting?

Erin: We've been exploring ultrasound for years now, but the RAPP Project inspired us to start formalizing our processes through population management – doing things in consistent ways so we could compare changes over time, compare our whole population, and look at a single patient in comparison to the population. It also motivated us to start doing certain tests at regular intervals when appropriate and to make sure we were following disease activity markers, whether multi-biomarker tests, ultrasounds, RAPID3, a HAQ, or our physician global.

What were the first ideas you began to implement after the meeting?

Erin: We were already used to making decisions based on ultrasound, but RAPP inspired us to look at the Vectra DA as well. As we started to get both an ultrasound and Vectra DA on everybody it wasn't hard getting used to making a decision based on those findings. In patients where those two objective measures kind of ran in parallel we started to make treatment changes right away. The trickier patients were those whose ultrasounds had improved or resolved and their Vectra DA hadn't. It's taken us longer to understand some of them.

> *"These new quantifiable parameters are redefining the illness. We've got so much to learn here."*

Bill: The RAPP Project also taught us it's not necessary to see all rheumatoid arthritis patients at the same interval. We're striving to get to a point where we're focusing our efforts on people with high disease activity and shortening their six-week evaluation period down to a month. We want to aggressively drive their ultrasounds and Vectra DAs down so that we put people with early disease into remission, and maybe in the future get them off their drugs for a period of time. And in people with more chronic disease, drive them to low disease activity and then hopefully minimize their medications in the long term.

Erin: We also started having every patient complete a RAPID3, an extended one that has a review of systems. For patients with inflammatory arthritis we're also typically doing their serologic diagnostic workup, which usually includes a Vectra DA and a baseline ultrasound examination, *before* the visit; having the results in hand makes the physician visit much more productive.

How is the combination of ultrasound and Vectra DA reshaping your patient care?

Erin: It puts the patient and the physician on the same page. Our patients call us and ask, "What's my number?" They want to know their Vectra DA score and what their ultrasound shows. They know the basis on which we're making the decision, and when you have quantitative outcomes that everyone understands, together you can begin to move the arrow in the right direction. So it's allowing us to aggressively treat the people who need aggressive treatment and reduce medications for those who can get away with less.

What is the interplay of Vectra DA and ultrasound?

Bill: That's the million-dollar question. That's why we need big data. It'd be wonderful to have 10 or 20 rheumatologic practices with 10 to 20 thousand RA patients doing Vectra DAs and gathering the same ultrasound information in the same way so we can look at what happens with the relationships over time. We need to know that because it's not going to be some preconceived notion. These new quantifiable parameters are redefining the illness. We've got so much to learn here.

> *"You have to be courageous enough to want to look to see that maybe you're not doing such a good job."*

What's your sense of why RA clinical population management hasn't yet become the norm of the field?

Erin: When patients say they feel good and you feel you're doing a good job, it's frustrating to then see they're not doing well, that they have progression of disease. And when you implement population management this discrepancy becomes much more apparent. It's humbling to see how little we know about the people and illnesses we take care of. You have to be courageous enough to want to look to see that maybe you're not doing such a good job.

Bill: I think the real problem in our field, quite frankly, is that there's no pressure for population management because our patients aren't driving for better care. Compare it to breast cancer detection: With mammography available are women satisfied with just feeling for lumps? Hell no. But our patients with rheumatoid arthritis don't know we can do any better than "feeling for lumps." They can't self-advocate because they don't know what to expect. We need to use objective measures and educate our patients about what they mean and how we use them to inform treatment.

Erin: That's right. Patients need to expect *and participate in* the best possible care we can provide. That's part of population management. Why bother to identify people with high disease activity if you're not going to work with them to aggressively manage it towards the target?

What are your next steps?

Bill: The SGR bill just passed and so we know we're going to be assessed on quality of care. And in three or four years we're going to be paid on quality of care. So the absolute next step for Erin and me is driving that mean Vectra DA score lower and lower in our patient population.

Erin: I'd say we're doing a pretty good job of working toward that, and it's because we have objective data to show people how well they're doing – those numbers give patients confidence in our treatment decisions.

Bill: The other thing about those quantitative numbers is that we can confidently not just increase medications, but also *decrease* them. I bet you any money we spend less on biologics than the average rheumatologist. Let's say a patient has pain symptoms or confounding illness that would prompt other rheumatologists to put them on a biologic drug. If you add up our protocol with Vectra DA and ultrasound at Medicare prices, let's say doing those every three months, after a year that's about the same as one month on a

biologic. If over the course of that year the ultrasound and Vectra DA show quantitatively that the patient is managed with methotrexate mono-therapy and does not need a biologic we've saved almost $30,000 on medication. That's huge.

Erin: And conversely, if we *do* need biologics we've got the objective disease activity data to support that.

What do you believe is best-in-class care for RA disease at this point?

Bill: To get the optimum improvement in the shortest time with the fewest side effects and have the happiest patients. Period. That's what Erin and I are driving for in all of this.

If ultrasound and Vectra DA went away would you still want to manage this disease?

Bill: No. That's driving by looking in the rearview mirror. I don't want to wait to see an erosion or a swollen joint. I don't want to see them at all.

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What would you say to encourage your colleagues to implement clinical population management?

Erin: When we talk to other physicians they often insist they couldn't do what we're doing, but it is absolutely doable, and the added effort ultimately creates greater efficiencies in the practice. It's also tremendously gratifying to make changes in your processes and protocols that lead to better care.

Bill: With the kind of approach we're now taking, what I see for my daughter in the long term is that she's going to experience markedly increased satisfaction by knowing that she's optimally utilizing her expertise to better the lives of her patients. The most important thing about population management is the promise of what's to come. If we all get on the same page with population management and collect the same information we can change the field. We can significantly improve our patients' care and outcomes and that's really exciting. ■

The Rheumatoid Arthritis Practice Performance (RAPP) Project is led by clinician rheumatologists and facilitated by Joiner Associates LLC. Questions about the project or this article? Contact:

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