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Australian Rheumatology Association

Evolve and the Australian Rheumatology Association

Professor Graeme Jones

Professor of Rheumatology and Epidemiology and Head of the Musculoskeletal Unit

University of Tasmania

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Evolve Leaders: Rachelle Buchbinder, Catherine Hill, Nicola Cook

Working group: Mark Arnold, Les Barnsley, Claire Barrett, Peter Brooks, Graeme Jones, Stephen Hall, Paddy Hanrahan, Pravin Hissaria, Nigel Wood, Srividya Katikireddi, Helen Keen, Rodger Laurent, Geoff McColl, Katie Morrisroe, Ayano Nakayama, Mandana Nikpour, Bita Omidvar, Katherine Poulsen, Philip Robinson, Muriel Soden

RACP Support: Jason Soon

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Evolve: Driving high-value care

- RACP is a founding partner of *Choosing Wisely Australia*
- Partnership between the College and the specialities
- A physician-led movement
- Aim of EVOLVE is to drive safe, high quality patient care through the identification and reduction of low value medical practices and interventions
- Encourages each medical speciality to re-think the clinical circumstances for some of their practices – tests, imaging, procedures or interventions
- Transparent

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Developing Evolve Recommendations

Criteria must be considered

- Evidence of overuse
- High cost
- Evidence that it is inappropriate

Could also consider

- Something rheumatologists do or something that rheumatologists can influence others to stop doing

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Think about…

Key phases

- Ideas generation
- Rating/shortlisting
- Finalisation

Who should be involved

- Working committee/taskforce
- Broader membership?

How can P&A help?

- Desktop research to kick off ideas generation
- Survey design and analysis

MJA
The Medical Journal of Australia

Identifying low-value care: the Royal Australasian College of Physicians' EVOLVE initiative

Challenges and lessons arising from early adoption of a new approach towards determining what is good clinical practice

"A critical Evolve insight is that few practices are unambiguously low value for all clinical indications."

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INTERNAL MEDICINE JOURNAL

RACP Specialists. Together

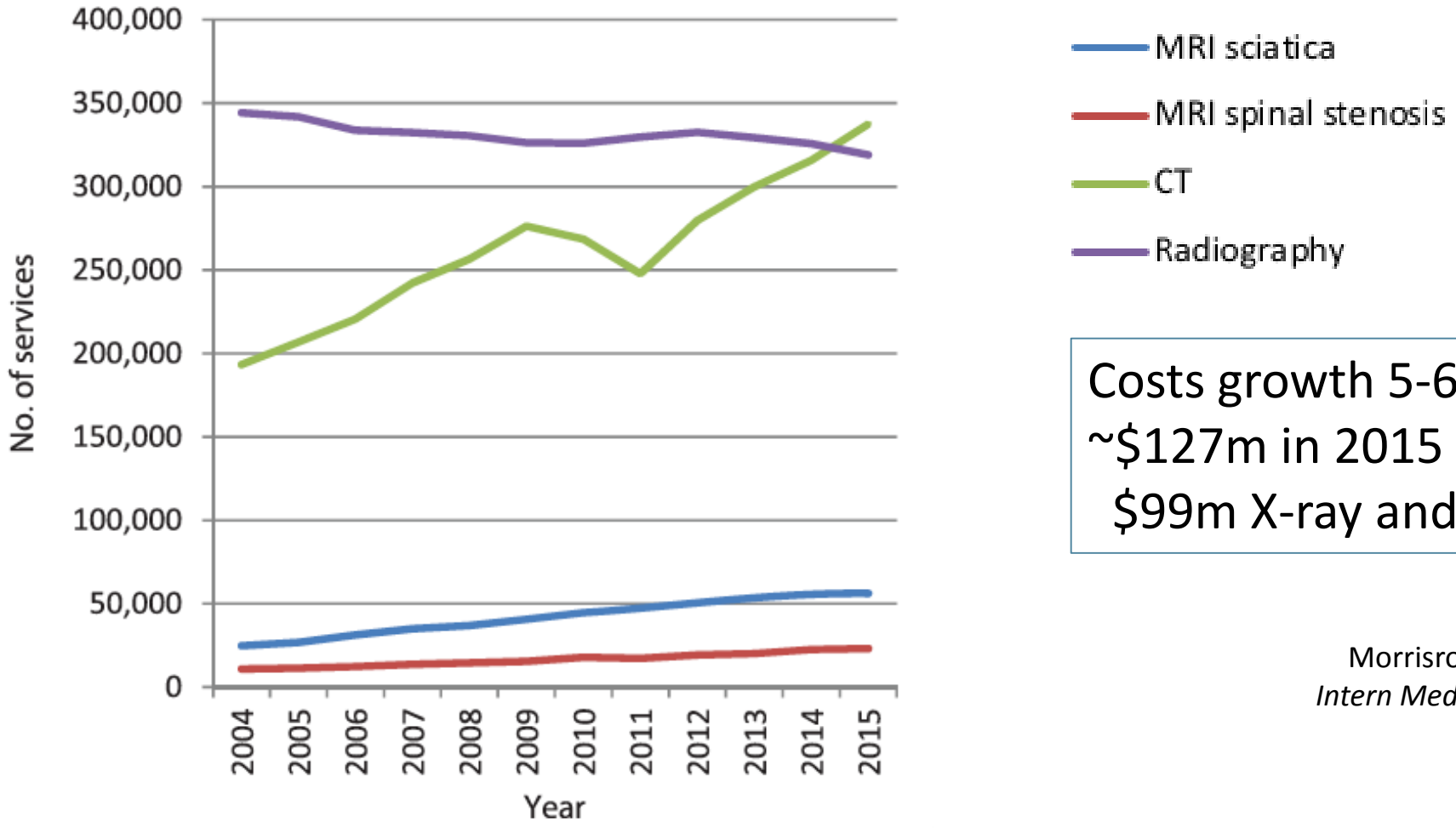
doi:10.1111/imj.13654

ORIGINAL ARTICLES

EVOLVE: The Australian Rheumatology Association's 'top five' list of investigations and interventions doctors and patients should question

Kathleen Morrisroe,[1,2] Ayano Nakayama,[3,4] Jason Soon,[5,6] Mark Arnold,[7] Les Barnsley,[8] Claire Barrett,[9] Peter M. Brooks,[10] Stephen Hall,[11] Patrick Hanrahan,[12] Pravin Hissaria,[13] Graeme Jones,[14] Veera S. Katikireddi,[15] Helen Keen,[12,16] Rodger Laurent,[17] Mandana Nikpour,[1,2] Katherine Poulsen,[15] Philip Robinson,[18] Muriel Soden,[19,20] Nigel Wood,[21] Nicola Cook,[22] Catherine Hill[23] and Rachelle Buchbinder[24,25]

Figure 3 Number of Medicare Benefits Schedule (MBS)-funded plain radiographs and CT scans for low back pain and magnetic resonance imaging (MRI) for sciatica and spinal stenosis in Australia, 2004–2015.



Costs growth 5-6% per annum
~$127m in 2015
$99m X-ray and CT

Morrisroe K, et al. EVOLVE.
Intern Med J 2018; 48:135-43.

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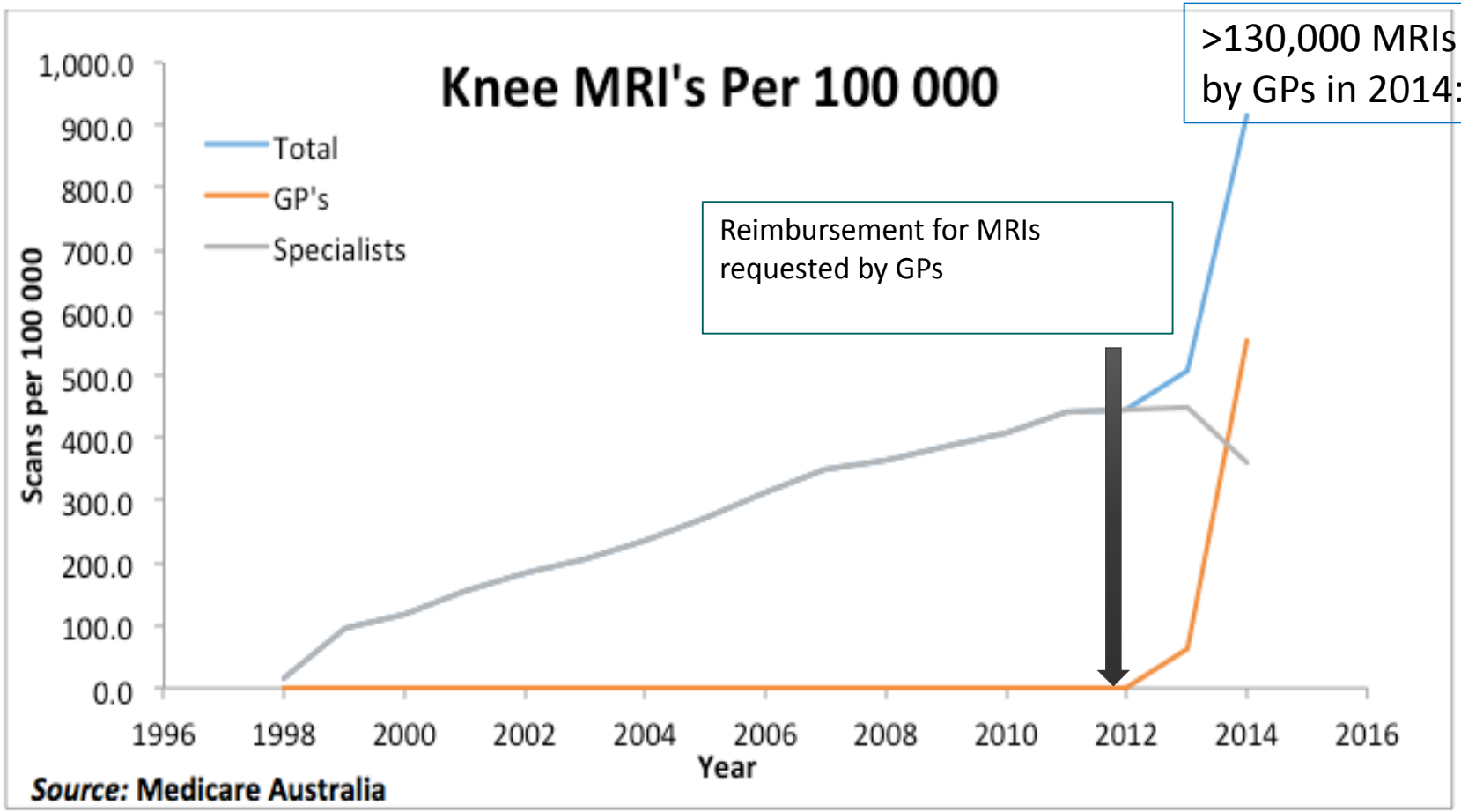
Increasing use of knee MRI

Australian Rheumatology Association



>130,000 MRIs requested by GPs in 2014: $52M

Reimbursement for MRIs requested by GPs

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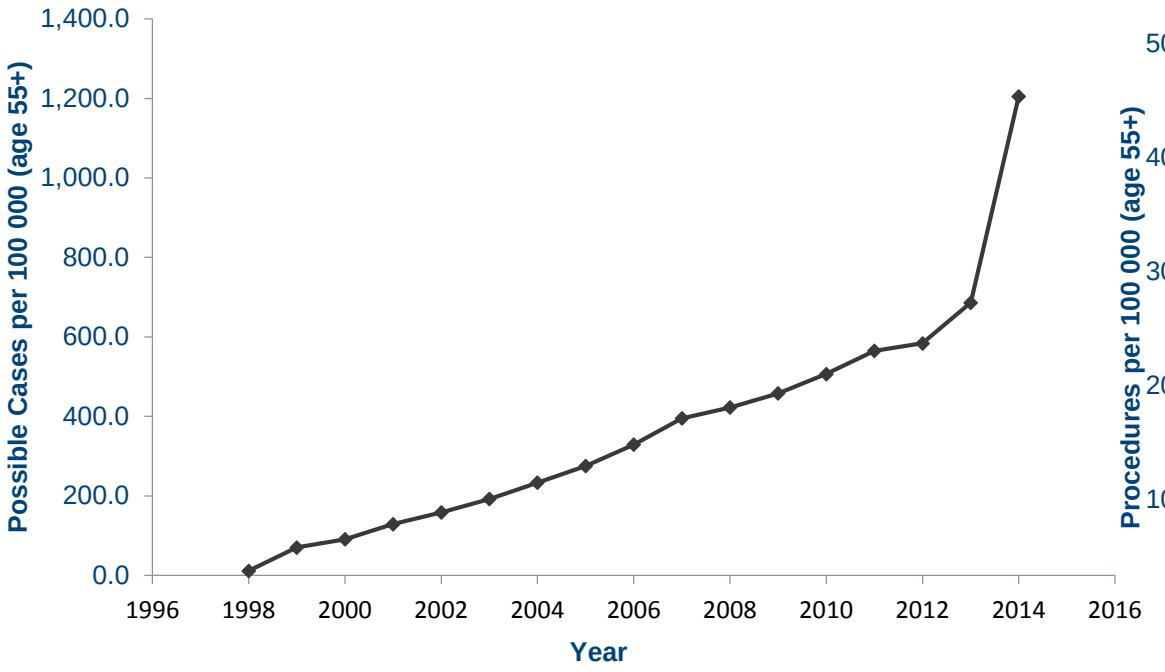
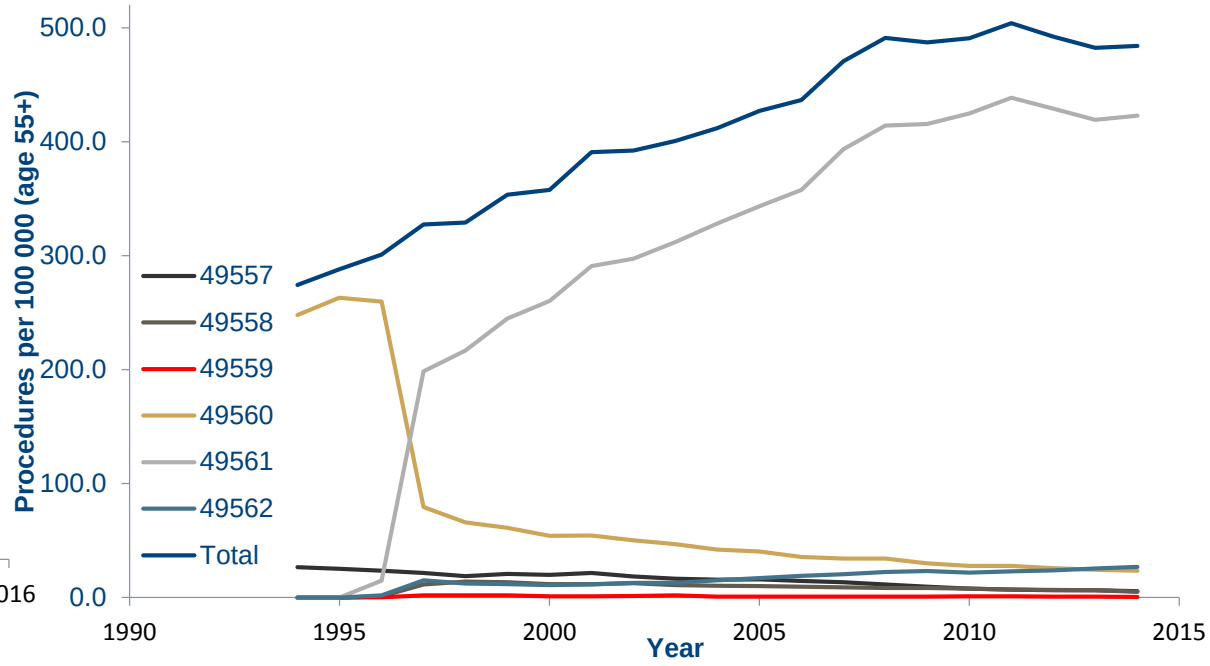
Aged ≥55 years

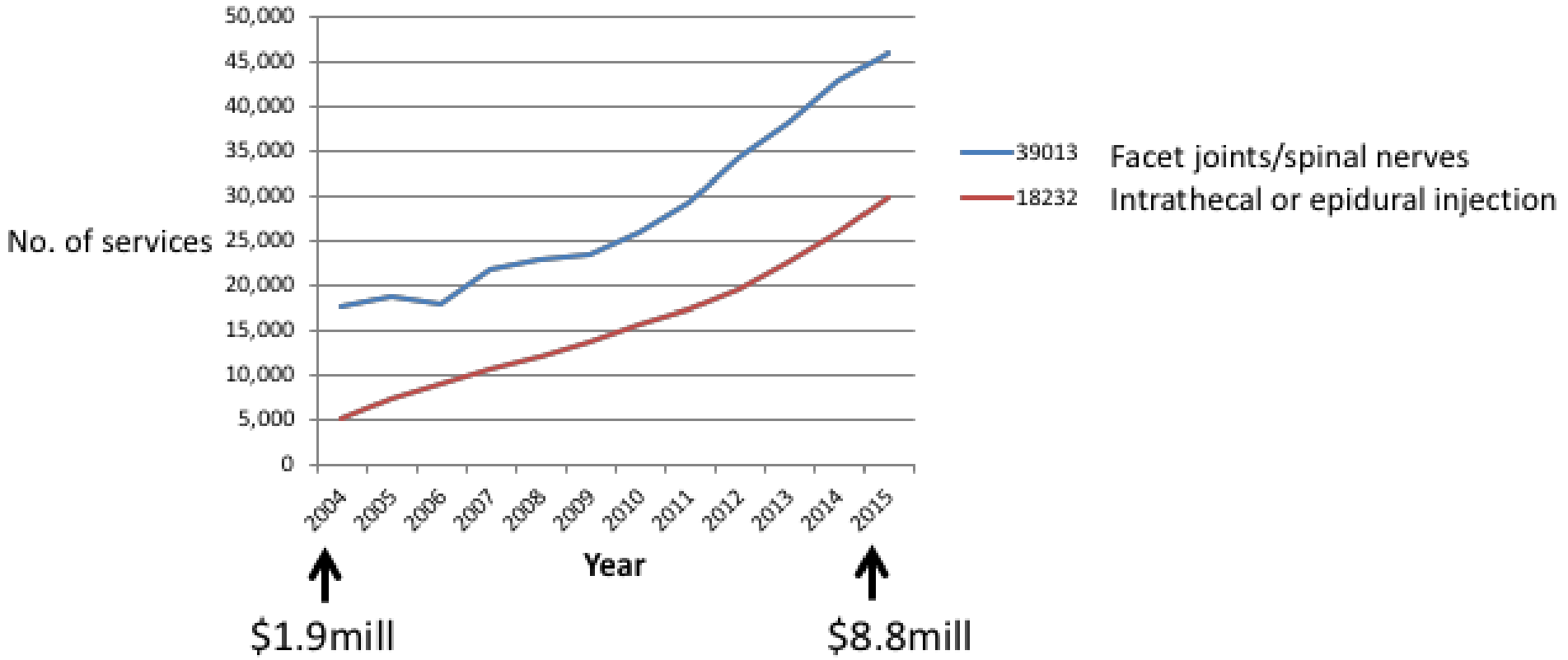
MRIs



Arthroscopies



Government subsidised spinal injections in Australia



Morrisroe K, et al. EVOLVE.
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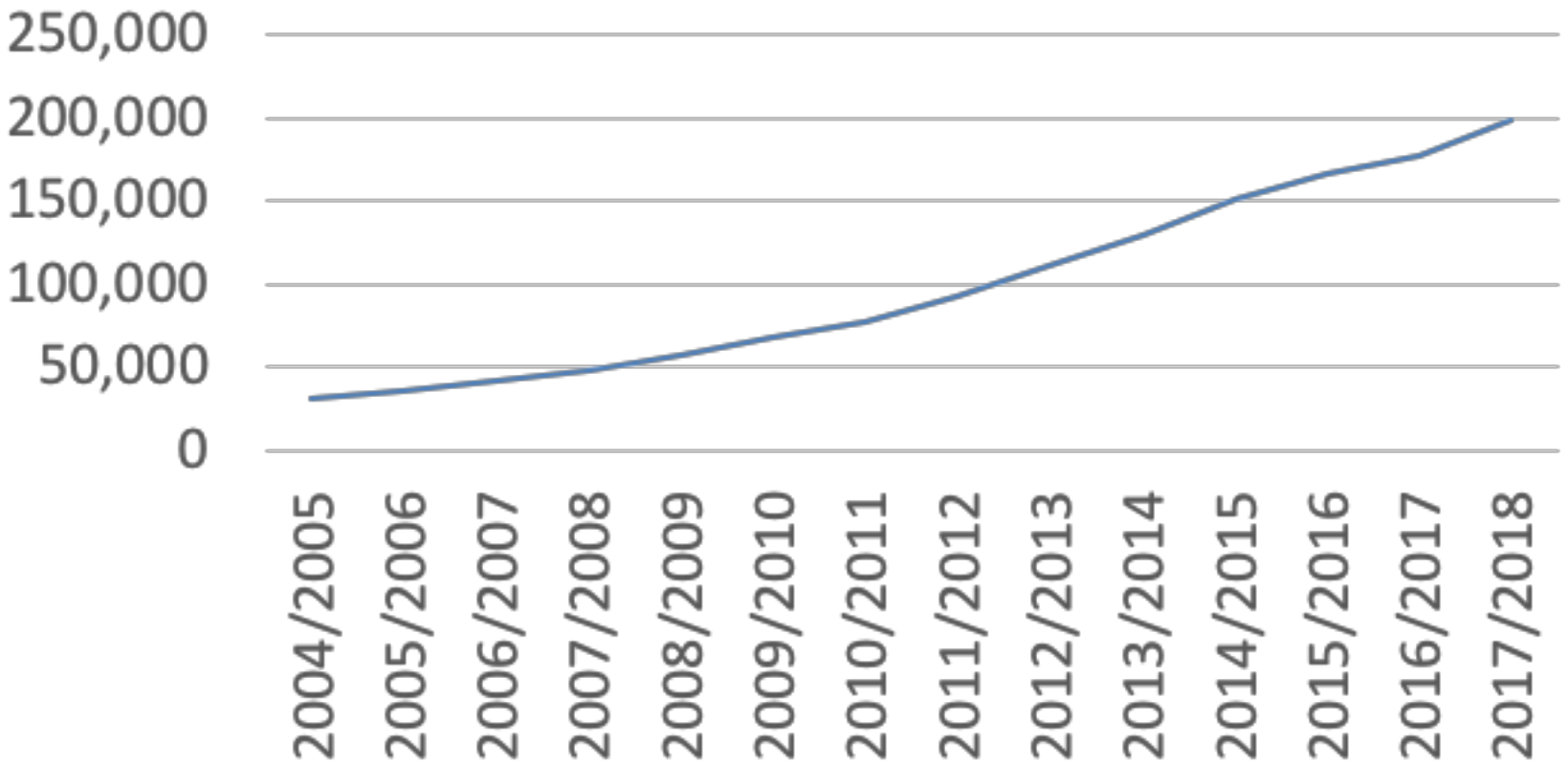
MBS item number 55836: Ultrasound ankle or hindfoot



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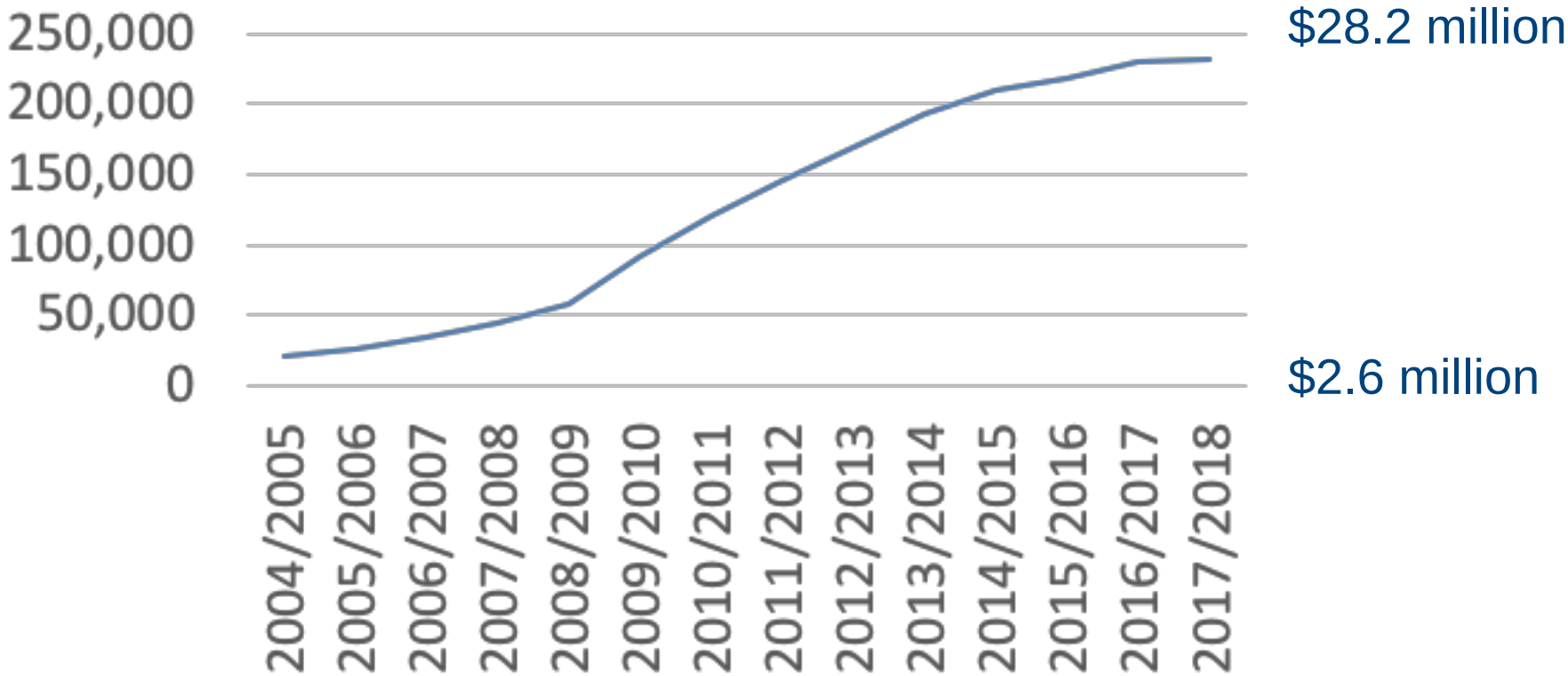
MBS Item Number 55850: Number of ultrasound-guided injections 2004-2018 (site not specified)



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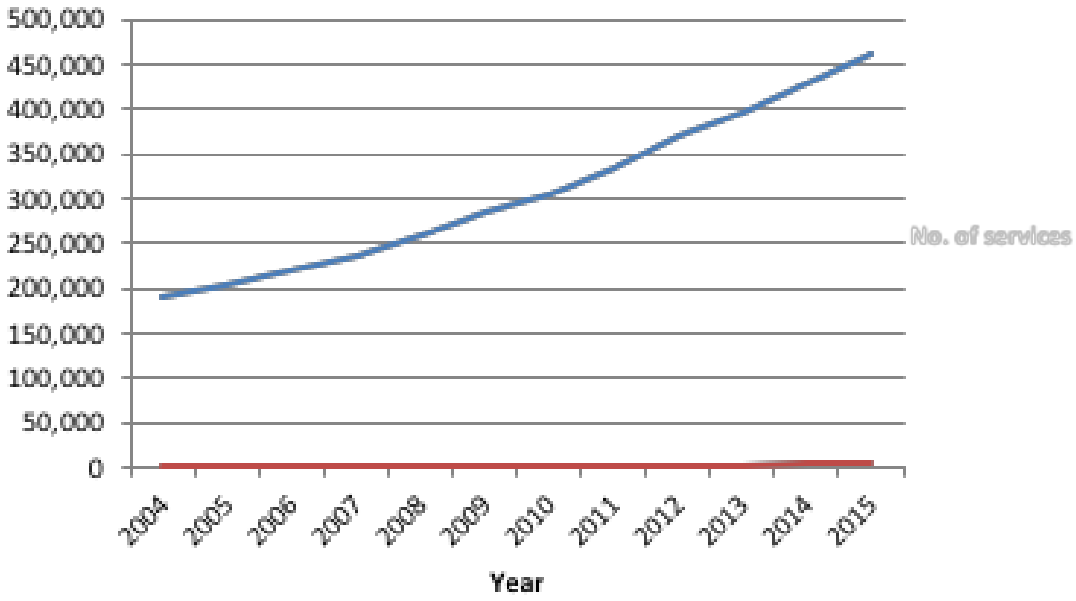
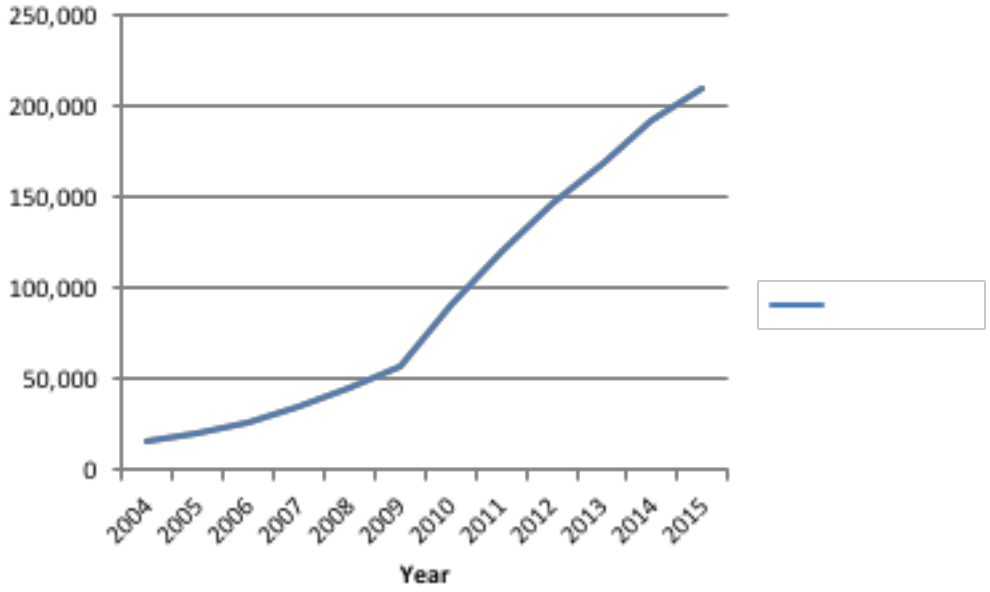
Number of MBS-funded shoulder ultrasounds 2004-2015



Numbers more than doubled
Costs almost tripled: $16.4M to ~$47.15M

Number of ultrasound-guided injections 2004-2015 (site not specified)



Annual increase 26.8% 2014/5 - $27.5M
(landmark-guided 2008/9 - $12.8M)

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Morrisroe K, et al.. *Intern Med J* 2018; 48:135-43.

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Evolve: ARA Methodology

- Three ARA Board Members designated Leaders
- Call for interested members to form a working party (20 full members and 3 trainees)
- Face-to-face meeting at ARA Annual Scientific Meeting 2015
- Decided on a ‘long-list’ by looking at other lists, discussion
- Broke into small ‘teams’ of 2-4
- Built on evidence provided by RACP
- By consensus, list was reduced to 12 items
- Survey of membership by email which included links to the full evidence
- Choose your top 5
- 5 items with most votes by full members

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Evolve: Final 12 items

Australian Rheumatology Association

1. Do not perform arthroscopy with lavage and/or debridement in patients for symptomatic osteoarthritis of the knee nor partial meniscectomy in patients with a degenerate meniscal tear
2. Do not order ANA testing without symptoms and/or signs suggestive of a systemic rheumatic disease
3. Do not undertake imaging for low back pain of patients with no indications of an underlying serious condition
4. Do not use ultrasound guidance to perform injections into the subacromial space as it provides no additional benefit in comparison to non-image guided injection
5. Do not order anti dsDNA antibodies in ANA negative patients unless clinical suspicion of SLE remains high
6. Do not repeat dual energy x-ray absorptiometry (DEXA) scans more often than every 2 years
7. Do not use ultrasound guidance to perform injections into the trochanteric bursa as it provides no additional benefit in comparison to non-image guided injection
8. Do not undertake shoulder ultrasound for diagnosis of non-specific shoulder pain
9. Do not use ultrasonography to investigate lateral hip pain thought on clinical assessment to be related to gluteal tendon pathology
10. Do not order ENA testing in patients with negative ANA
11. Do not order ANCA testing for diagnosis of vasculitis unless one of the consensus guideline indications is present
12. Do not order glucocorticoid injections for non-specific low back pain, facet joint arthritis or spinal canal stenosis

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Evolve: Excluded items

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1. Do not order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms.
2. Do not prescribe bisphosphonates for patients at low risk of fracture.
3. Do not perform whole body bone scans for diagnostic screening for peripheral and axial arthritis in the adults

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Evolve: ARA Survey

198 people completed the survey

(response rate 46.3%)

179 full ARA members (50.3%)

19 trainees (26.4%)

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Evolve: Final 5 items

Australian Rheumatology Association

1. Do not perform arthroscopy with lavage and/or debridement in patients for symptomatic osteoarthritis of the knee nor partial meniscectomy in patients with a degenerate meniscal tear (74.2%)
2. Do not order ANA testing without symptoms and/or signs suggestive of a systemic rheumatic disease (56.4%)
3. Do not undertake imaging for low back pain in patients with no indications of an underlying serious condition (50.8%)
4. Do not use ultrasound guidance to perform injections into the subacromial space as it provides no additional benefit in comparison to non-image guided injection (50.3%)
5. Do not order anti dsDNA antibodies in ANA negative patients unless the clinical suspicion of SLE remains high (45.3%)

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		Fellow N=179 (50.3%)	Trainees N=19 (26.4%)
1	Arthroscopy	73.2	84.2
2	ANA testing	56.4	73.7
3	imaging for low back pain	50.8	42.1
4	ultrasound guidance to perform injections into the subacromial space	50.3	36.8
5	anti dsDNA antibodies in ANA negative patients	45.3	52.6
6	Do not repeat DEXA scans more often than every 2 years	44.1	31.6
7	ultrasound guidance to perform injections into the trochanteric bursa	39.1	42.1
8	shoulder ultrasound for diagnosis of non-specific shoulder pain	36.3	31.6
9	ultrasonography to investigate lateral hip pain	31.3	21.1
10	ENA testing in patients with negative ANA	27.9	42.1
11	ANCA testing for diagnosis of vasculitis	24.6	26.3
12	glucocorticoid injections for non-specific low back pain, facet joint arthritis or spinal canal stenosis	20.7	15.8

		*Male N=115	Female* N=60
1	Arthroscopy	80	63.3
2	ANA testing	56.5	53.3
3	imaging for low back pain	47.8	60
4	ultrasound guidance to perform injections into the subacromial space	52.2	46.7
5	anti dsDNA antibodies in ANA negative patients	44.4	45
6	Do not repeat DEXA scans more often than every 2 years	39.1	55
7	ultrasound guidance to perform injections into the trochanteric bursa	39.1	38.3
8	shoulder ultrasound for diagnosis of non-specific shoulder pain	40.9	28.3
9	ultrasonography to investigate lateral hip pain	32.2	30
10	ENA testing in patients with negative ANA	28.7	25
11	ANCA testing for diagnosis of vasculitis	22.6	25
12	glucocorticoid injections for non-specific low back pain, facet joint arthritis or spinal canal stenosis	16.5	30

		*Public/ academic N=78	*Private N=95
1	Arthroscopy	66.7	82.1
2	ANA testing	57.7	52.6
3	imaging for low back pain	64.1	43.2
4	ultrasound guidance to perform injections into the subacromial space	46.2	52.6
5	anti dsDNA antibodies in ANA negative patients	43.6	44.2
6	Do not repeat DEXA scans more often than every 2 years	47.4	43.2
7	ultrasound guidance to perform injections into the trochanteric bursa	32.1	45.3
8	shoulder ultrasound for diagnosis of non-specific shoulder pain	37.2	34.7
9	ultrasonography to investigate lateral hip pain	30.8	32.6
10	ENA testing in patients with negative ANA	21.8	31.6
11	ANCA testing for diagnosis of vasculitis	24.4	22.1
12	glucocorticoid injections for non-specific low back pain, facet joint arthritis or spinal canal stenosis	28.2	15.8

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American College of Rheumatology: Top 5

1. Do not test ANA subserologies without a positive ANA and clinical suspicion of immune-mediated disease
2. Do not test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate examination findings
3. Do not perform MRI of the peripheral joints to routinely monitor inflammatory arthritis
4. Do not prescribe biological agents for RA before a trial of MTX (or other conventional nonbiological DMARD)
5. Do not routinely repeat DXA scans more often than once every 2 years

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Canadian Society of Rheumatology Choosing Wisely Top 5

1. Don’t order ANA as a screening test in patients without specific signs or symptoms of systemic lupus erythematosus (SLE) or another connective tissue disease (CTD)
2. Don’t order an HLA-B27 unless spondyloarthritis is suspected based on specific signs or symptoms
3. Don’t repeat dual energy X-ray absorptiometry (DEXA) scans more often than every 2 years
4. Don’t prescribe bisphosphonates for patients at low risk of fracture
5. Don’t perform whole body bone scans (e.g., scintigraphy) for diagnostic screening for peripheral & axial arthritis in adults

American Academy of Orthopedic Surgeons (AAOS) Choosing Wisely Top 5

1. Avoid performing routine post-operative deep vein thrombosis ultrasonography screening in patients who undergo elective hip or knee arthroplasty.
2. Don’t use needle lavage to treat patients with symptomatic osteoarthritis of the knee for long-term relief.
3. Don’t use glucosamine and chondroitin to treat patients with symptomatic osteoarthritis of the knee.
4. Don’t use lateral wedge insoles to treat patients with symptomatic medial compartment osteoarthritis of the knee.
5. Don’t use post-operative splinting of the wrist after carpal tunnel release for long-term relief.

Future steps

Implementation strategy

- Intended aims and actions needed
- Key messages for different audiences (rheumatologists, GPs, other clinicians, consumers)
- Types of communication products (conference presentations, *Med J Aust*, 1pg summaries, podcast, webinar)
- Channels of delivery (personal communications, NPS, newsletters, twitter, educational resources for GPs, consumers)
- Resources (who will deliver?)
- Branding (RACP, ARA)
- Timing of delivery (Plan when, seek opportunities)

Future steps

Evaluation of success

Implementation strategies likely to differ by item

Predetermined short-term outcomes

- Evidence of dissemination
- Media uptake
- Times accessed and downloaded, etc.

Pre-determined long-term desired outcomes

- Evidence of use in guidelines
- Reduced usage

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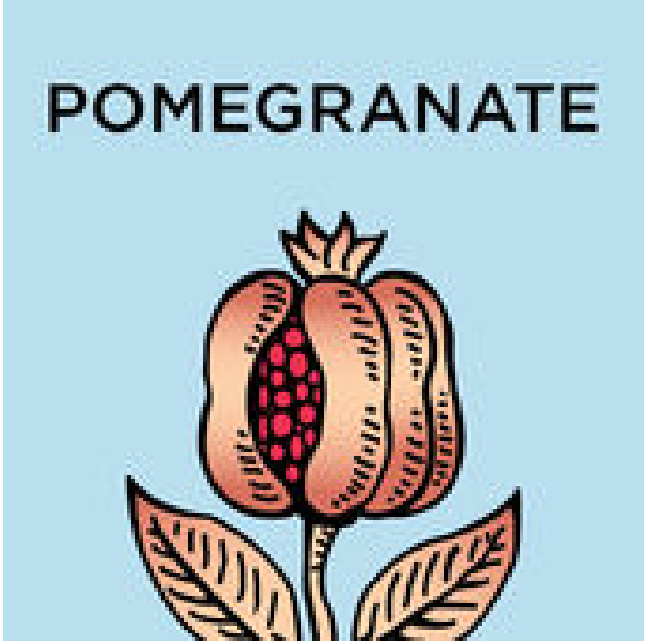
RACP Pomegranate Podcast

Episode 10: Evolving Your Practice

http://apple.co/1TdabcT

https://evolve.edu.au/resources

- Pomegranate Health: Diagnostic Error Part 2 - Systems (RACP, Mar 2018)
- Growing body of research shows potential risks of arthroscopic knee surgery (3AW, Feb 2018)
- Pomegranate Health: Diagnostic Error Part 1 - Cognitive Bias (RACP, Dec 2017)
- Pomegranate Health: Drug Interactions and Deprescribing (RACP, Sep 2017)
- Pomegranate Health: Evolving Your Practice (RACP, Apr 2016)



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