Treating Rheumatoid Arthritis to Target: multinational recommendations assessment questionnaire

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ABSTRACT

Aim To measure the level of agreement and application of 10 international recommendations for treating rheumatoid arthritis (RA) to a target of remission/low disease activity.

Methods A 10-point Likert scale (1=fully disagree, 10=fully agree) measured the level of agreement with each of 10 recommendations. A 4-point Likert scale (never, not very often, very often, always) assessed the degree to which each recommendation was being applied in current daily practice. If respondents answered ‘never’ or ‘not very often’, they were asked whether they would change their practice according to the particular recommendation.

Results A total of 1901 physicians representing 34 countries participated. Both agreement with and application of recommendations was high. With regard to application of recommendations in daily practice, the majority of responses were ‘always’ and ‘very often’. A significant percentage of participants who were currently not applying these recommendations in clinical practice were willing to change their practice according to the recommendations. Additional efforts may be needed to encourage application of the recommendations among certain clinicians who are resistant to changing their practice.

Conclusion The results of this survey demonstrated great support of ‘Treating RA to Target’ recommendations among the international rheumatology community. Additional efforts may be needed to encourage application of these recommendations to modify their practice.

INTRODUCTION

Treating to therapeutic targets has become a standard of care for many chronic conditions.1–4 In order to set similar standards for rheumatoid arthritis (RA), an international task force was established consisting of 68 rheumatologists and patients with RA from 25 countries.5 The first phase of this Treat to Target (T2T) initiative focused on defining therapeutic targets and establishing paths to optimal outcomes. Based on a systematic literature review6 and expert opinion, a consensus on a set of 10 recommendations was formulated (see appendix 1 in online supplement).5 The goal of these 10 recommendations is to provide rheumatologists, patients and other stakeholders with clear approaches as to how to reach the set targets and provide patients with RA with the best quality of care available.

The second phase of the T2T initiative aims at acceptance and implementation of these recommendations in daily rheumatology practice. It was deemed important to learn to what extent individual components of the T2T recommendations are accepted (or acceptable) by rheumatologists of individual countries. Here we provide the results from an international survey of rheumatologists performed to this end.

The objectives of the survey were: (1) to evaluate the level of agreement with T2T recommendations on a global scale; (2) to determine whether and to what degree these recommendations were currently applied in daily practice; and (3) to assess the willingness of those clinicians not already applying these recommendations to modify their practice.

METHODS

Recruitment was determined by the steering committees of individual countries. Rheumatologists were contacted by email or fax and asked to anonymously complete a paper- or web-based questionnaire. The first part of the questionnaire gathered demographic information. A 10-point Likert scale (1=fully disagree, 10=fully agree) measured the level of agreement with each of the 10 recommendations. The degree to which each recommendation was being applied in current daily practice was assessed on a 4-point Likert scale (never, not very often, very often, always). Those who answered that they have ‘never’ or ‘not very often’ applied a specific recommendation in their practice were asked whether they would change their practice according to the particular recommendation. Data are presented using standard summary statistics including analysis of variance and χ² analysis.

RESULTS

Demographic data

A total of 1901 rheumatologists participated, representing 34 countries, nine from Western Europe (n=722, 38%), nine from Eastern Europe (n=403, 21%), six from Latin America (n=456, 23%), Australia, Canada and New Zealand (n=107, 6%).
Willingness to change practice according to the recommendations

A significant proportion of responders who were currently not applying T2T recommendations were willing to change their practice according to the recommendations (figure 3). However, 43.1% and 32.8% of participants who were currently not applying recommendations 5 and 6, respectively, indicated that they would not change their practice according to these recommendations. Furthermore, although only 6.7% and 6.5% of participants indicated that they were not applying T2T recommendations 3 and 4, respectively, a high percentage of these (30.5% for recommendation 3 and 45.4% for recommendation 4) indicated that they were unwilling to change their practice to accommodate these recommendations.

Although there were no clear regional differences in terms of willingness to change practice for recommendations 3, 5, 8, 9 and 10, the Canada–New Zealand–Australia group showed greater than expected ‘not willing to change practice’ responses for recommendations 1 (p<0.05), 2 (p<0.05), 4 (p<0.0001), 6 (p<0.0001) and 7 (p=0.0017).
Two elements of the T2T recommendations received the most objections: recommended frequency of monitoring and the use of validated composite measures of disease activity in routine clinical practice to guide treatment decisions. While certain logistical aspects of clinical practice (i.e., high patient volume, lack of support, etc.) may influence clinicians' attitudes towards these two aspects of the T2T recommendations, some participants also commented that a tight monitoring schedule is not necessary as long as the patient is showing improvement (data not shown). These attitudes may inadvertently undermine the quest for remission as a treatment goal, since remission is defined using various individual measures or indices. Thus, efforts should be deployed to help clinicians integrate these validated tools into their routine clinical practice, especially since simple tools like the Simplified Disease Activity Index and Clinical Disease Activity Index are available, which can also be used to define remission according to the American College of Rheumatology (ACR) and European League against Rheumatism (EULAR).

In this regard, it is interesting to note that recommendation 3 received one of the lowest mean scores, which is somewhat at odds with most strategic trials which aimed for low disease activity. One possible explanation is that clinicians strive towards remission, and low disease activity is a second-best outcome.

The data collected from this questionnaire should be interpreted in the context of the survey sample and data collection methodology. One limitation was that the method of survey dissemination was determined by the steering committees of individual countries and was not standardised. It is therefore difficult to ascertain the precise number of rheumatologists from each country who received the survey and consequently the response rates. It is also important to recognise that a selection bias towards rheumatologists more positive towards the T2T recommendations is possible, and responses might not be representative of the global rheumatology community. Finally, determination whether and to what extent these recommendations are currently applied in daily practice might not be accurately assessed with the chosen methodology; practice audits such as...
the Assessment in Rheumatology (AIR) project are better suited to answer the question.\textsuperscript{10} The survey nonetheless identified resistance towards certain aspects of the recommendations and the results can serve as a preliminary guide for future global, national and regional programmes.

These survey results may contribute to: (1) increasing awareness of the T2T concept which is being recommended and advocated by the main organisations EULAR, ACR and several national societies; (2) identifying specific local issues that need to be addressed in order to advance patient care; (3) demonstrating to non-responders to the survey, regardless of the reason for lack of participation, where they stand in comparison to their peers; and (4) focusing on the identification of the specific national basis for the disagreement with certain aspects of the T2T recommendations by steering committees from individual countries and the development of programmes that could address them in a manner that best fits local practices.

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