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## Core Clinical Data Set Supports High-quality Care for RA Patients in Canada

By Claire Barber, MD, PhD, FRCPC

Variability in clinical data collection has been identified as a barrier to quality measurement, since it creates challenges in terms of maintenance of complete patient records and monitoring the provision of care. The Arthritis Alliance of Canada (AAC) partnered with the Canadian Rheumatology Association (CRA) and individual investigators to develop a Canadian Rheumatoid Arthritis Core Clinical Dataset (CAN-RACCD) to encourage best practices and to facilitate future quality measurement efforts.

The CAN-RACCD was developed through a three-phase program that included an environmental scan to identify a candidate set of core data elements, stakeholder meetings to prioritize elements for inclusion, and a modified-Delphi

process to finalize the core clinical dataset. Broad input was gained from 47 rheumatologists, people living with arthritis, and allied health providers from across Canada.

The CAN-RACCD includes 49 individual data elements across nine categories: (1) demographic; (2) timing - including dates of symptom onset, referral, first visit and diagnosis; (3) clinical data; (4) disease activity; (5) comorbidities; (6) smoking status; (7) patient-reported outcomes; (8) medications; and (9) laboratory and radiographic data

This is an important first step in standardizing measurement that will help improve the quality of care of people living with rheumatoid arthritis.

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Reference:  
Barber CEH, et al. Development of a Canadian core clinical dataset to support high quality care for rheumatoid arthritis patients in Canada. *J Rheumatol* 2017 Dec; 44(12):1813-22.

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## Knowledge Translation and Implementation

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Knowledge Translation (KT) is of critical importance to health research, as it has become clear that the creation of new knowledge often does not, on its own, lead to widespread implementation or impacts on health. KT is important in bridging the gap between research and practice so that patients can benefit optimally from advances in research evidence.

There exist various theories, approaches and models of KT. The Knowledge-to-Action Process Framework<sup>1</sup> is one model. Knowledge application is an important component that represents the "action" phase of the framework, which involves tailoring the knowledge product/tool for implementation, dissemination and quality improvement (QI).

The Model for Improvement is a practical QI approach that can be used to implement the Inflammatory Arthritis or Osteoarthritis Models of Care (MOCs) at the front line of clinical care. According to this model, sequential Plan-Do-Study-Act (PDSA) cycles are executed to guide specific improvement activities. By following a few step-by-step principles, health care providers can apply a QI assessment in their own clinical setting. These steps include performing a gap analysis of the current state to identify ways an individual's practice could be improved to better reflect a MOC.

The second step is to engage stakeholders and conduct a root cause analysis to understand the reasons for the gap in practice and the barriers to implementing the MOC in an in-

dividual setting. To understand the nature of the problem and identify the key drivers of the quality gap, such tools as fishbone diagrams, process maps and Pareto charts can be used. These root causes will be the targets of the QI intervention.

The third step is to implement a change to improve practice and to evaluate the effects of the change to identify what adjustments may be required to refine the process further. Multiple small-scale PDSA cycles are usually necessary to achieve gradual improvements over time.

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2. Chow SL, Shojania K. "Rheum to improve": quality improvement in outpatient rheumatology. *J Rheumatol* 2017; 44(9):1304-10.