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Health care quality indicators for RA
HCQI RA 1: If a patient presents with suspected rheumatoid arthritis (RA) then he/she should be referred to and seen by a specialist (preferably a rheumatologist) for confirmation of diagnosis within 6 weeks after the onset of symptoms.
HCQI RA 2: If a patient is newly diagnosed with RA, then, he or she should be given individually tailored education by relevant health professionals about the natural history, treatment, and self management of the disease within 3 months.
HCQI RA 3: Rheumatology practices should provide information (written or website) on how a patient can contact the practice for urgent consultations (in case of flares/worsening of the disease, serious side effects.
HCQI RA 4: If a patient is diagnosed with RA and the target (=remission or low disease activity) is not attained then follow up visit should be scheduled by a rheumatologist within 3 months and when the target is attained a rheumatologist or a specialized nurse in rheumatology should schedule follow up visits at least once a year.
HCQI RA 5: If a patient is diagnosed with RA and there are joint damage/soft tissue problems that may be solved by surgery then the patient should be assessed by an orthopedic surgeon within 3 months
HCQI RA 6: If a patient is diagnosed with RA, then a rheumatologist and/or relevant health professionals from the multidisciplinary team should assess and document the following variables: 1) a measure of disease activity such as composite scores like DAS 28 or any of its variants CDAI or S-DAI, 2) structural damage (using the best available method, e.g. x-ray, MRI, ultrasound), 3) functional status, (e.g.HAQ), and 4) labor force participation. The assessment and documentation should occur at baseline and thereafter at appropriate time intervals, at least annually for 1, 3 and 4.
HCQI RA 7: If a patient has RA, then he/she should have a treatment plan developed between him/her and his/her clinician/ health professionals at each visit.
HCQI RA 8: If a patient is diagnosed with RA then review of comorbidities, adverse events and risk factors related to pharmacological therapy should be performed at least annually.
HCQI 9: If a patient is diagnosed with RA and therapy with a biologic disease-modifying antirheumatic drug (DMARD) is prescribed then a tuberculosis screening should be performed and results interpreted before therapy start.
HCQI RA 10: A rheumatologist should intensify disease modifying medication when disease activity is moderate* or high*. *According to the EULAR recommendations
HCQI RA 11: If a patient is newly diagnosed with RA then a referral to a relevant health professional for instruction on an individualized exercise program including advice for physical activity, range of motion-, muscle strengthening- and aerobic exercises should be provided within 3 months.

HCQI RA 12: If a patient is diagnosed with RA and reports difficulties in ambulatory and/or non ambulatory activities of daily living then the need of assistive devices, appropriate orthoses and environmental adaptations should be assessed and addressed.
HCQI RA 13: Rheumatology practices should have the ability to at least annually calculate and record (electronically or on paper) composite scores like DAS 28 or any of its variants CDAI or SDAI, for all patients with RA.
HCQI RA 14: If a patient is diagnosed with active RA (i.e. DAS* 28 over 3.2) then the disease activity should be low (i.e. DAS28 below 3.2) 6 months after treatment has started. *or another composite score for disease activity