SCQM FOUNDATION
Swiss Clinical Quality Management in Rheumatic Diseases

ANNUAL REPORT 2007

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TABLE OF CONTENTS

1 EDITORIAL

Annual Report 2007

Editorial

A challenging 2007 –, technical problems regarding the data base conversion, with personnel changes and last but not least the compiling of a new business plan with important strategic guidelines for the period 2008 to 2011.

The board of the SCQM Foundation decided to in-source the scanning and scoring of the radiographs. In a first step, a scanner was acquired and the internal implementation process is now in the final stage. The project of the data base conversion was pushed to stage two, in which the switch for the RA[1] registry took place. In July 2007 the revised RA questionnaires, which should simplify the administrative workload of the participating rheumatologists, were sent out. The existing data base (RA and AS[2]) is still struggling with some technical problems, which slow down the process of the data input and output. The office team and the external IT partners could solve most problems with their great engagement. Some smaller adaptations still have to take place, which should be completed in the next months. Under these circumstances and with increasing quantity of patient files, unfortunately there is a tailback in the RA register workflow. This particularly concerns the input of the data and the generation of the Feedback Reports.

Furthermore some important changes in the team proceed. Dr. med. Silvia Dehler, the project manager, decided to leave the SCQM FOUNDATION by the end of 2007. The Foundation thanks her for the conscientious engagement and large achievements. The Foundation Board therefore reorganised the Management of the office in two divisions. Ms Sabine von Känel was employed in November 2007 for the position of the executive associate, managing all administrative and personal matters. As former head of the “Rheumaliga Aargau” and as a previous employee of Ms Gisela Dalvit, she has appropriate experiences. On April 1st, 2008, Ms Almut Scherer, Biologist with focus on Immunology and Epidemiology, will be in charge of the scientific project management. Her professional career qualifies her in the best way for this fastidious duty. The Foundation Board is pleased to have recruited the two new managers. They bring the motivation and skills for the demanding work to implement the guidelines of the new Business plan, supported by the office staff, the members of the commissions and the members of the board.
In 2007 Ms Marion Täsch Furger joined the office team for RA X-ray scoring and Ms Rowena Laue for IT support and data management. A special thanks goes to Ms Jacqueline Hirt, Ms Cláudia Cutler and Mr Heinz Wyrsch for their commitment to the work as well as to the members of the commissions. A special thanks also to the chairmen of these commissions: Dr. med. Axel Finckh (RA), Dr. med. Ulrich Weber (AS) and PD Dr. med. Burkhard Möller (PsA[3]).

[1] **R**heumatoid **A**rthriitis = **RA**
[2] **A**nkylosing **S**pondylitis = **AS**
[3] **PsA** = **P**soriatic **A**rthritis

Perspective 2008

The in January 2008 accredited Business plan for the next four years plans in principle to organise the workflow in such a way that the emphasis of the work is shifted from the input to the output, both the level of the foundation itself as well as in the clinics and medical practices. The first and most relevant prerequisite is to realise an online registration. This complex project started in the first quarter of 2008 with the aim to go online as soon as possible, earliest at the end of this year. During the transition period from our current data base to the online data base, a printable version from the online questionnaires will be run parallel. We are convinced, that we decided for a solution that is oriented at the future.

To all participants, in the medical practices, in the clinics, in the SCQM office, in the leading committees and to our Patrons, sincere l thanks for the engagement carried out in 2007 and the work already tackled in 2008.

Dr. med. H.A. Schwarz
Chairman
SCQM FOUNDATION

2 ACTIVITY REPORT (SPECIFIC INFORMATION ON THE REGISTERS)

2.1 REGISTER OF RHEUMATOID ARTHRITIS

2.1.1 PREAMBLE

For the analyses in this year's annual report, it is important to note certain IT-issues behind the data base. In July 2007, the SCQM migrated its data into a new data base. Together with this technical change, new, altered RA questionnaires were introduced, in an attempt to make the forms shorter, and thereby more user friendly. The main changes in the questionnaires include a reduction of the level of detail of information on non-DMARD medical therapy, on types of surgery and adverse drug related events. Because of these changes to the questionnaires, not all queries that were presented in the annual report of 2006 could be reproduced.

2.1.2 OVERVIEW

Compared to the previous year, the enrolment of new patients in the SCQM register of Rheumatoid Arthritis was lower in 2007. Patients at inclusion tend to have higher disease activity levels than follow-up patients, which might be explained by the fact that patients are commonly enrolled prior to major therapeutic changes, such as the initiation of treatment with a biologic.

2.1.3 POPULATION

Patients included in the data analysis are selected from the SCQM register of Rheumatoid Arthritis. A written consent was required by all patients prior to study inclusion. The only prerequisite is being able to communicate in French, German or Italian. Participating SCQM rheumatologists are based in private practices, regional and university hospitals.
Overall there were 4'601 patients until the end of 2007 in the data base. However, only 2'948 patients were considered active. This means that these patients had a visit at a rheumatologist within the last two years, either as an inclusion or a regular control visit. The time interval of two years was chosen because of the sometimes not negligible time delay until the questionnaires are arriving in the SCQM Office. The distribution of the so called "active" patients is seen below, showing the actual assignment of the patients to clinics or practices.

Table 1: Summary of RA active patients by institute

Patients	Institution
1'787	Private practice (total 243 physicians)
281	Universitätsspital Zürich
148	Inselspital Bern
105	Kantonsspital Aarau
80	Hôpitaux Universitaires de Genève
52	Centre Hospitalier Universitaire Vaudois Lausanne
49	Kantonsspital Winterthur
48	Kantonsspital Luzern
47	Bethesda Spital, Basel
39	Kantonsspital St.Gallen
37	Felix Platter-Spital, Basel
31	Stadtspital Triemli, Zürich
31	Schulthess Klinik, Zürich
30	Thurgauer Klinik St.Katharinental, Diessenhofen
26	aarReha Schinznach Bad
26	Bürgerspital Solothurn
26	Hôpital régional de Delémont
21	Hôpital de La Chaux-de-Fonds
20	Kantonsspital Schaffhausen
16	Hôpital cantonal de Fribourg
9	Klinik Adelheid AG, Unterägeri
9	Universitätsklinik Balgrist, Zürich
7	Kantonsspital Nidwalden
5	RehaClinic Zurzach
3	Klinik Valens
3	Kantonales Spital Sursee-Wolhusen
3	Klinik Schloss Mammern AG
1	Rheuma- und Rehabilitationsklinik Leukerbad
1	Reha Rheinfelden
2'948	**TOTAL**

2.1.4 SAMPLE

The sampling period was set between 1st January 2006 and 31st December 2007, i.e. all "active" patients. Results on overall statistics were based on all inclusion and control visits. If a patient was recorded with more than one annual control visit, an average of the available data was used.

2.1.5 DATA COLLECTION

A clinical examination and the collection of blood samples are included during initial, intermediate control and annual control visits. Patients are also asked to complete a questionnaire. The collected data (physician and patient) is communicated to the SCQM Office for evaluation. Based on this data individualised patient feedback reports are produced, and sent back to their respective physician.

2.1.6 VARIABLES

Patient information includes gender, date of birth and RA diagnosis. Laboratory tests include rheumatoid factors (RF) and erythrocyte sedimentation rate (ESR). Joint destruction is assessed based on hand and feet X-ray, which should not be older than 6 months. X-rays are scored centrally according to the method proposed by Rau et al[4]. When a part of an image is not scorable, or not all required images are sent in, the last score is used in the data base (last observation carried forward). During clinical assessment, the physician completes a standardised questionnaire recording all prescribed medications with dosage. In addition, clinical assessment includes a 28 swollen and tender joint count, which, together with erythrocyte sedimentation rate (ESR), is used to calculated the Disease Activity Score (DAS28). In addition, questionnaires for drug side effects are used. Patient questionnaires include the RA disease activity index (RADAI), the Stanford Health Assessment Questionnaire (HAQ) and the SF-36[5].

2.1.7 RESULTS

The results of the analysis are shown separately for inclusion and follow-up visits for 2006 and 2007. However, it has to be considered that a patient included in 2006 may also be in the group of the follow-up patients 2007.

2.1.7.1 Patient Characteristics

As mentioned above, the so called „active“ patients of the years 2006 and 2007 were analysed. There were 498 patients enrolled in the RA data base in 2006. For 2007 we received 388 inclusion questionnaires. 1'916 patients had a follow-up visit in 2006, for the year 2007 1'948 follow-up visits are in the RA data base.

Table 2 shows patient characteristics data. Less than a quarter of all patients are male. The newly included patients are on an average 55 years old, whereas the mean age of the follow-up patients is about 57 years.

[4] Rau R, Wassenberg S, Herborn G, Stucki G, Gebler A , A new method of scoring radiographic change in rheumatoid arthritis

[5] SF-36 is a measurement of Quality of Life

Table 2: patient characteristics of inclusion and follow-up patients 2006 and 2007

		inclusion 2006	inclusion 2007	follow-up 2006	follow-up 2007
number	n	**498**	**388**	**1916**	**1948**
male	%	**23.69**	**21.20**	**23.43**	**22.70**
age (in years)	mean	**56.29**	**54.50**	**58.44**	**57.90**
	SD*	13.94	13.60	13.36	13.43
time interval: first symptoms to diagnosis (in months)	n	371	238	-	-
	median	**8**	**9.5**	**-**	-
	IQR*	3-25	3-22.75	-	-
Rheumatoid factor percentage positive	n	473	349	1615	1301
	%	**68.5**	**69.91**	**69.85**	**71.9**

* SD = standard deviation, IQR = inter quartile range

2.1.7.2 Variables of Disease Activity

The following table presents several variables of disease activity. Since, for some patients, more than one questionnaire is entered into the SCQM per year, an average of the visit data was used for the analysis of the follow-up patients. In all tables and figures the data are separately shown for inclusion and follow-up in 2006 and 2007. For the different scores the number of the availabe data for analysis, the mean and the standard deviation are listed. These are the global health assessment by patient, the RADAI, DAS28 and HAQ.

Table 3: variables of disease activity of inclusion and follow-up patients 2006 and 2007

		inclusion 2006	inclusion 2007	follow-up 2006	follow-up 2007
global health assessment by patient 0 = bad /10 = excellent	n	457	355	1816	1870
	mean	**5.44**	**5.55**	**6.35**	**6.29**
	SD*	2.30	2.30	2.40	2.37
RADAI 0 = no disease activity 10 = max. disease activity	n	485	375	1816	1845
	mean	**4.47**	**4.27**	**3.18**	**3.19**
	SD*	1.95	2.11	2.11	2.13
DAS28 0 = no disease activity 10 = max. disease activity	n	481	380	1856	1840
	mean	**4.22**	**4.18**	**3.26**	**3.14**
	SD*	1.40	1.40	1.36	1.25
HAQ 0 = no functional disability 3 = max. functional disability	n	491	377	1833	1909
	mean	**1.06**	**1.18**	**0.97**	**1.18**
	SD*	0.72	0.79	0.76	0.84

* SD = standard deviation

Figure 1: mean score of the global health assessment by patient

(0 = bad, 10 = excellent)

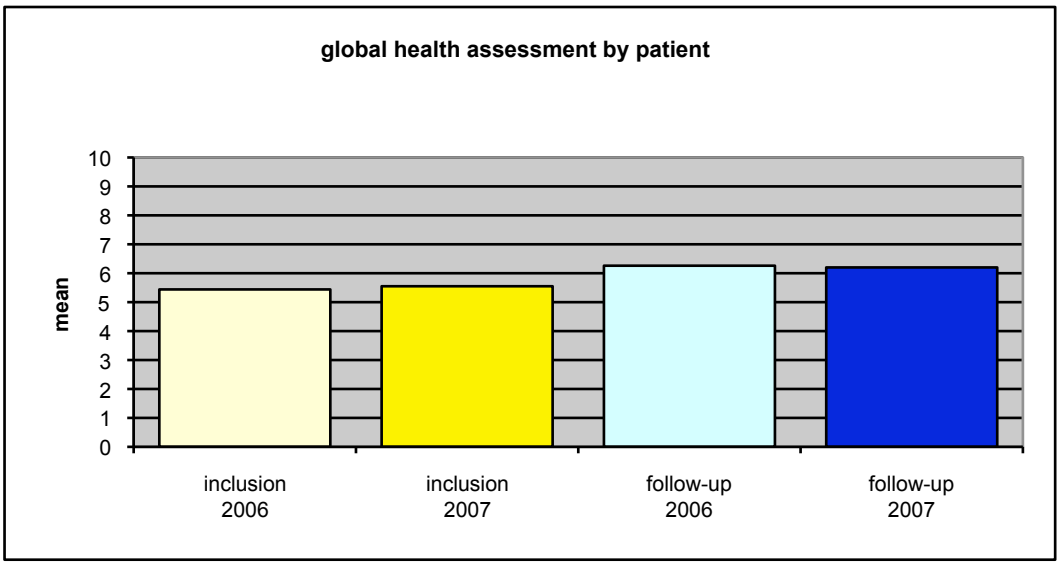


Figure 2: mean score of the RADAI (Rheumatoid Arthritis Disease Activity Index)

(0 = no disease activity, 10 = max. disease activity)

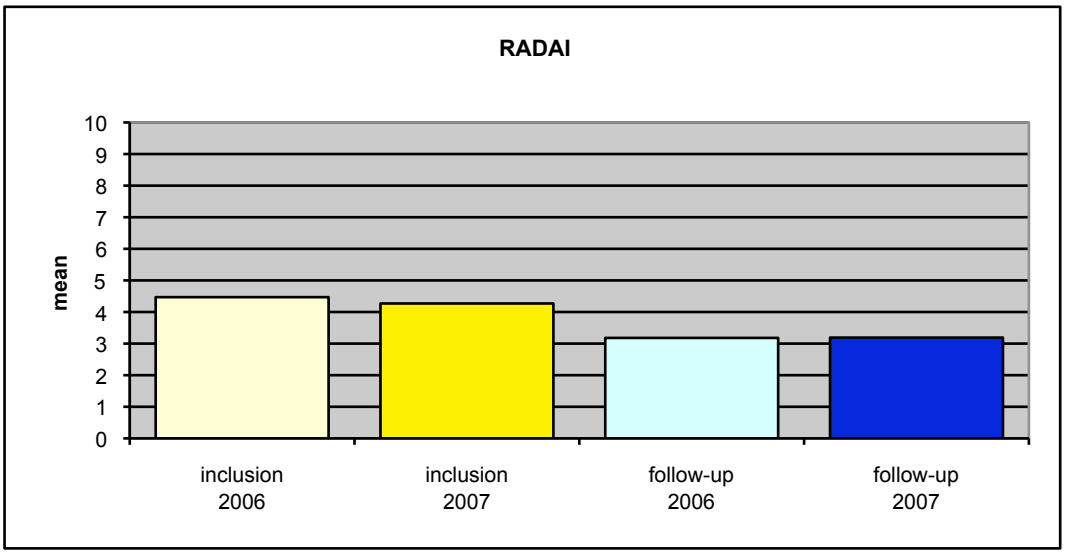


Figure 3: mean score of the DAS28 (ESR) (Disease Activity Score)

(0 = no disease activity, 10 = max. disease activity, ESR: erythorocyte sedimentation rate)

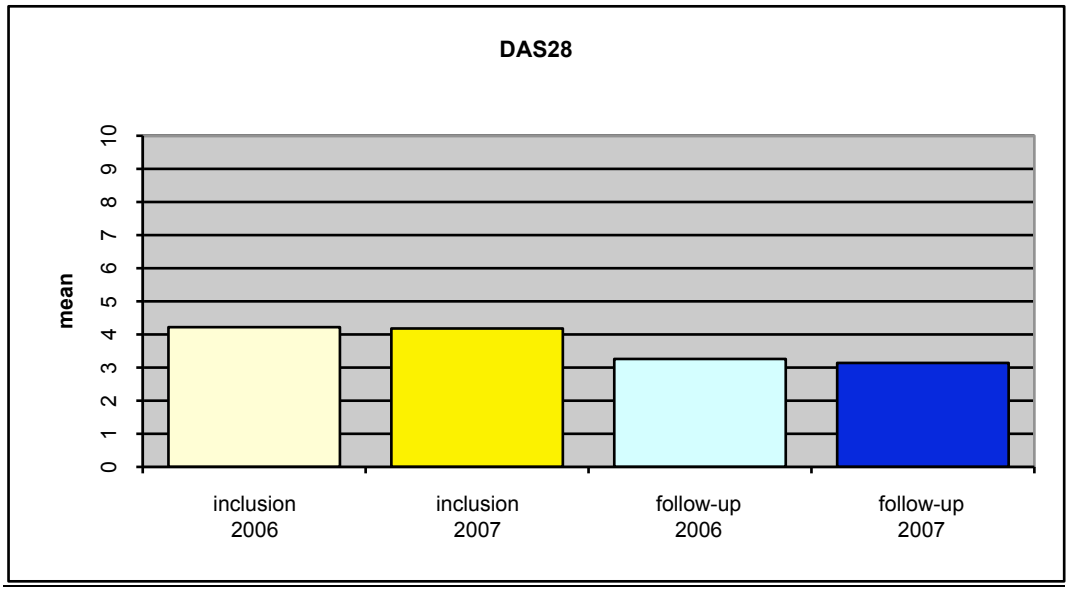
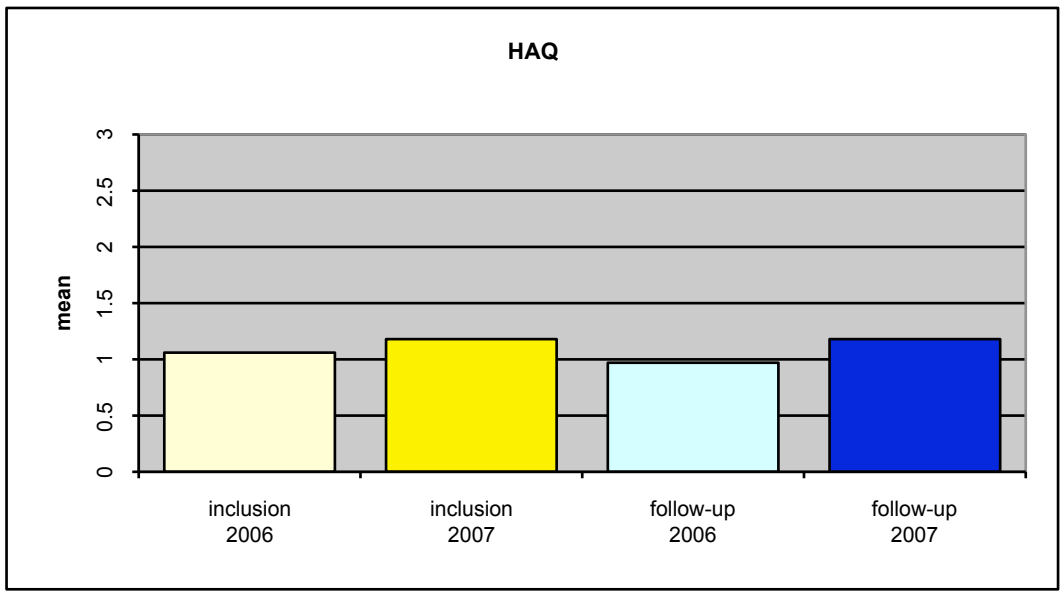


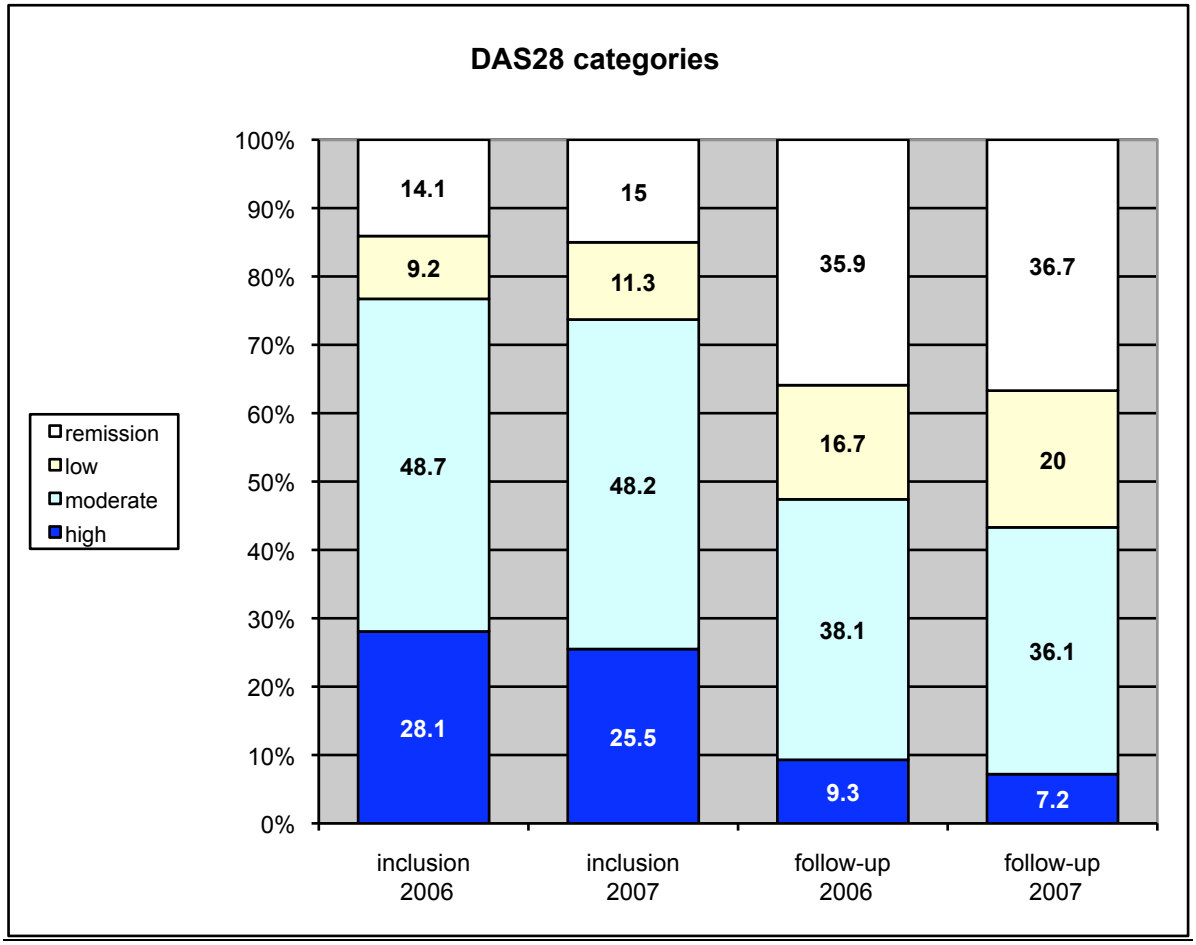
Figure 4: mean score of the HAQ (Health Assessment Questionnaire)

(0 = no functional disability, 3 = max. functional disability)



As shown in table 3 and figure 1 to 4, there is a difference between the groups of inclusion patients and follow-up patients. The RADAI and DAS28 scores show a higher disease activity for the patients when they were included in the SCQM data base. The same tendencies can be seen for the other relevant scores like the RADAI and DAS28. However, functional disability as measured by the mean HAQ score (Health Assessment Questionnaire) shows less variation, which is expected since this outcome measure is less sensitive to change.
The DAS28 is a composite measure of the underlying inflammatory disease activity. The DAS28 can be classified into disease states, such as high, moderate or low disease activity. This interpretation is based on a classification system suggested by experienced rheumatologists[6] and has shown to have predictive validity on development of joint destruction[7]. There are four categories: remission (DAS28 ≤ 2.6), low disease activity (2.6 < DAS28 ≤ 3.2), moderate disease activity (3.2 < DAS28 ≤ 5.1) and high disease activity (DAS28 > 5.1) . Figure 5 presents the percentage of the patients for the four categories. More than a quarter of patients have a high disease activity at inclusion in 2006 and 2007, whereas only about 9% of the follow-up patients belong to this category. Over a third of the follow-up patients, however, are in remission.

Figure 5: percentage of patients to the DAS28 categories (Disease Activity Score)



[6] Van Gestel AM, Haagsma CJ, Van Riel PLCM. Validation of rheumatoid arthritis improvement criteria that include simplified joint counts. Arthritis Rheum 1998;41:1845-50.
[7] Prevoo MLL, Van 't Hof MA, Kuper HH, Van Leeuwen MA, Van de Putte LBA, Van Riel PLCM. Modified disease activity scores that include twenty-eight-joint counts. Development and validation in a prospective longitudinal study of patients with rheumatoid arthritis. Arthritis Rheum 1995;38:44-8.

2.1.7.3 Prescription of Disease Modifying Anti-rheumatic Drugs (DMARDs)

Disease Modifying Antirheumatic Drugs (DMARDs) are an important element in the treatment of Rheumatoid Arthritis. The most prescribed DMARD in active SCQM patients remains Methotrexate, followed by Leflunomide, Sulfasalazine and the TNF-α-blocking agents (Adalimumab, Etanercept, Infliximab). Rituximab is used more and more since its official launch for RA in 2006.

2.1.7.4 Surgeries

Both in the inclusion questionnaire as well as in the yearly control questionnaire, the number and type of surgeries are registered. In the inclusion questionnaire, all surgeries prior to inclusion are recorded, whereas in the yearly control questionnaire only surgeries during the last 12 months are captured. Therefore, the inclusion and follow-up groups can not be compared directly. As shown in table 4, every fifth patient had had a surgery before inclusion. At follow-up visits, patients had on average one surgery every ten years. Type and number of surgeries is listed below (table 4). Surgeries at hands and feet were most common, followed by hip and knee surgeries. Note that in table 5, which lists the type of surgeries, the absolute numbers of operations is listed.

Table 4: frequencies of consultations and surgery

		inclusion 2006	**inclusion 2007**	**follow-up 2006**	**follow-up 2007**
consultations with rheumatologists	n	495	386	1816	1864
	mean	**5.07**	**5.66**	**5.26**	**5.19**
	SD*	5.68	6.37	5.04	5.17
surgery/patient/year[#]	n	498	398	1916	1939
	mean	**0.23**	**0.23**	**0.10**	**0.11**
	SD*	0.64	0.62	0.35	0.37

* SD = standard deviation, # yearly mean only for follow-up patients

Table 5: number of surgeries by type

	inclusion 2006	inclusion 2007	follow-up 2006	follow-up 2007
type of surgery	**number of surgery**			
hands	**32**	**18**	**38**	**38**
feet	**30**	**29**	**69**	**72**
shoulder	**8**	**7**	**12**	**8**
spine	**7**	**11**	**15**	**16**
hip	**24**	**12**	**32**	**37**
knee	**15**	**15**	**35**	**46**

The physicians are futher asked to list any adverse events, and to indicate whether these were related to the medicational therapy. In Table 6, the number and type of adverse events that the treating physician considered to be drug related (ADEs), are listed.

Table 6: Types of adverse drug related events (ADEs)

	2006	2007
type of ADE	**number of ADE**	
Allergic / immunologic	**8**	**18**
Cardiologic	**57**	**44**
Dermatologic	**9**	**32**
Gastrointestinal	**6**	**32**
General / systemic	**2**	**12**
Hematologic	**3**	**6**
Infectious	**11**	**17**
Neoplasm	**3**	**9**
Nephrological	**4**	**1**
Muscular	**3**	**6**
Neuropsychiatric	**42**	**29**
Pulmonal	**3**	**7**
Ophthalmologic	**3**	**1**
ENT	**-**	**2**

2.1.8 FUTURE OF THE REGISTER FOR RHEUMATOID ARTHRITIS

In 2007, the new RA questionnaires were introduced, and the data were migrated to a new data base. Towards the end of 2007, the cry for an online registry became more and more prominent, both from the side of the data contributers and of the SCQM office personal. We are currently in the process of developing an online data base. With this online data base, we are aiming to make the data entry process more user friendly for the contributing patients and physicians. Furthermore, online data-forms allow for direct data-clearing, which will contribute to an improved data quality. Feed-back forms will be generated real-time, which means that the physician can see the course of a patients disease activity and the overview of medicational treatment directly after the entry of the data. The existing data will be migrated to the new data base to ensure that long-term analyses remain possible. We are aiming to have an operational online data base by mid 2009.

2.2 Register of Ankylosing Spondylitis

2.2.1 BACKGROUND INFORMATION

The project on Ankylosing Spondylitis was started in 2004, supported by three members of the ASAS (**AS**sessments in **A**nkylosing **S**pondylitis) International Working Group, namely Prof. Dr. D. van der Heijde, Maastricht, president ASAS, Prof. Dr. M. Dougados, Paris, vice president ASAS, Prof. Dr. A. Boonen, Maastricht.
The aims of the study are the collection of data on disease activity and functional parameters, the effectiveness of different therapies and socioeconomic issues of the disease. The collection of data on biologics and other medication allows the analysis of their benefit on the disease and socioeconomic consequences.
Radiology represents an important element. A standardised conventional radiological instrument with four radiographs every two years are used.

2.2.2 POPULATION

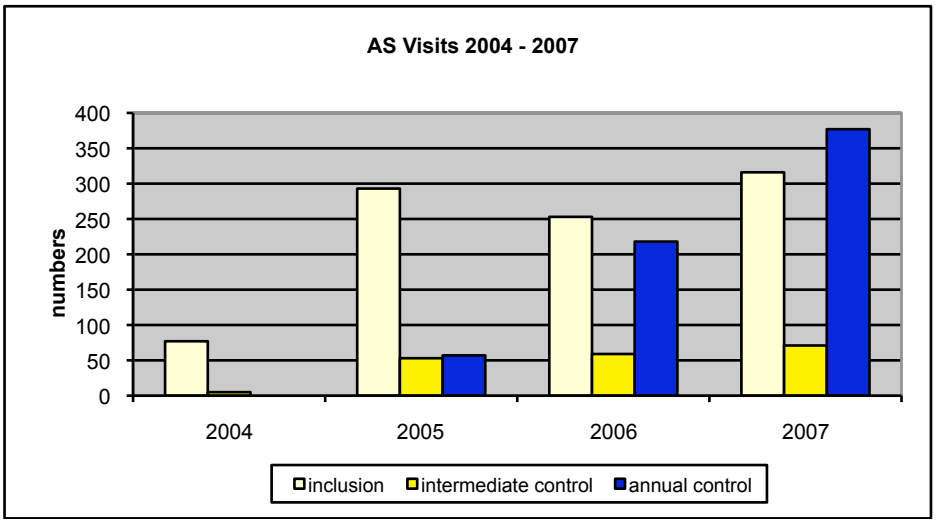
All patients in Switzerland with Ankylosing Spondylitis, independent of age, disease duration, severity and type of therapy can participate. It is *not* a biologics registry, but a prospective observational cohort study. All Swiss rheumatologists are encouraged to cooperate. Currently, the number of active patients in the AS cohort, with at least one entry in the SCQM between the 1st of January 2006 and the 31st of December 2007, is 832.

2.2.3 DATA COLLECTION

The questionnaires consist of an inclusion and a yearly control set. If relevant changes of disease activity or therapy occur, a questionnaire for an intermediate control should be filled in. All questionnaires are available in German and in French. Beside the use of internationally validated instruments, data on laboratory tests and four standardised radiographs every two years are collected.

2.2.4 STATE OF THE PROJECT AND SOME FIRST RESULTS

Since 2005, the number of new inclusions in the AS registry have remained constant at around 300 per year. In 2007, we received 317 inclusion, 71 intermediate controls and 379 yearly control visit questionnaires in the data base.



2.2.4.1 Patient Characteristics

As already mentioned, the four radiographs of pelvic, lateral-cervical spine and lateral and AP-lumbar spine are crucial to the AS registry. Patients with a radiographically confirmed diagnosis of AS can be used for further scientific analyses. Classification according to the pelvic radiograph is in process and will be integrated into the AS data base. For the analyses presented below, *all* active patients in the AS cohort were analysed. This is a very heterogeneous group of patients, of which only a part will be classified as AS after the radiograhic scoring.

About two thirds of the AS patients in the registry are men (see Table 7) and patients are on average about 43 years old. Between diagnosis and entry to the SCQM, a median of 3.3 and 2.25 years passed in 2006 and 2007 respectively. The range of the time passing between diagnosis and entry into the SCQM is very broad (between four months and ten years).

Table 7: Patient characteristics of AS patients

		2006	2007
number	n	**492**	**715**
male	%	**67.07**	**66.01**
age (in years)	mean	**43.56**	**42.15**
	SD*	12.15	11.96
time interval: **first symptoms to entry SCQM** (in months)	n	256	313
	median	**40**	**27**
	IQR*	4 - 128	2 - 118

Variables of Disease Activity

The following table represents several disease activity and disability variables of the active patients in the AS registry.

Table 8: Variables of disease activity

		inclusion 2006	inclusion 2007	follow-up 2006	follow-up 2007
global health assessment by patient 0 = bad /10 = excellent	n	247	310	208	378
	mean	**6.00**	**6.03**	**6.85**	**7.04**
	SD*	2.13	2.14	2.05	2.02
global health assessment by physician 0 = bad /10 = excellent	n	251	306	213	333
	mean	**6.23**	**6.26**	**7.85**	**7.76**
	SD*	2.13	2.12	1.74	1.72
BASDAI 0 = no disease activity 10 = max. disease activity	n	249	315	216	380
	mean	**4.83**	**4.76**	**3.81**	**3.63**
	SD*	2.17	2.27	2.34	2.33
BASFI 0 = no disease activity 10 = max. disease activity	n	245	315	213	380
	mean	**3.40**	**3.40**	**2.96**	**2.59**
	SD*	2.45	2.51	2.52	2.53
BASMI 0 = no functional disability 3 = max. functional disability	n	240	304	207	371
	mean	**2.24**	**2.26**	**2.46**	**2.46**
	SD*	2.02	2.07	2.11	2.23

2.2.4.2 Prescription of Disease Modifying Antirheumatic Drugs (DMARDs)

TNF-inhibitors are efficacious in the symptomatic treatment AS[8]. The evidence for a reduction of structural progression by treatment with TNF-inhibitors, is, however, limited AS[9] [10]. In the

[8] Zochling J *et al.*. ASAS/EULAR recommendations for the management of ankylosing spondylitis Ann Rheum Dis 2006; 65(4):Epub 2005 Aug. 26.

[9] Baraliakos X *et al.*. Radiographic progression in patients with ankylosing spondylitis after 4 yrs of treatment with the anti-TNF-alpha antibody infliximab. Rheumatology 2007; 46(9): 1450 – 1553.

SCQM registry, less than 50% of patients are under anti-TNF treatment. Of the 720 patients for whom an entry or follow-up questionnaire was available for 2007, 135 were treated with infliximab, 126 with etanercept and 102 with adalimumab.

2.2.5 FUTURE OF THE REGISTER FOR ANKYLOSING SPONDYLITIS

Towards the end of 2007, the X-ray data base of the AS registry was moved to the Balgrist University Hospital in Zuerich. Here, Prof. Kissling and Dr. Weber are setting up a digital X-ray data base, supported by IT-expert Dr. Schwaerzler. The images in the digital data base are being scored according to the modified New-York criteria in a consensus procedure by two independent readers. The results will allow a classification of the participating patients according to the modified NY criteria. Once these modified New-York criteria are merged with the SCQM questionnaire data, the way is paved for scientific analyses of the AS cohort. As for the rheumatoid arthritis data base, the biggest upcoming challenge for the AS registry is the development of the online data base and migration of the data into this data base.

[10] Van der Heijde D *et al.*. Radiopgraphic progression of ankylosing spondylitis after two years of treatment with etanercept. Arthritis Rheum 2008; 58 (5): 1324 – 1331.

2.3 REGISTER OF PSORIATIC ARTHRITIS

2.3.1 BACKGROUND INFORMATION

The project on Psoriatic Arthritis (PsA) was started at the end of 2004, mainly developed by Dr. Adrian Forster, at this time with the University Hospital Zurich, now Thurgauer Klinik St. Katharinental, Diessenhofen.
In 2005 the PsA Commission was established. PD Dr. Burkhard Möller, Inselspital Bern, agreed to be the chair of the commission. In order to improve the cooperation with the dermatologists, a representative of them is a member of the commission.
The aims of the register are the collection of data on disease activity and functional parameters, the effectiveness of different therapies and socioeconomic issues of the disease. Important aspects like involvement of the skin and osteoporosis are also considered. Unlike the other two registries radiographic information is not yet collected.

2.3.2 POPULATION

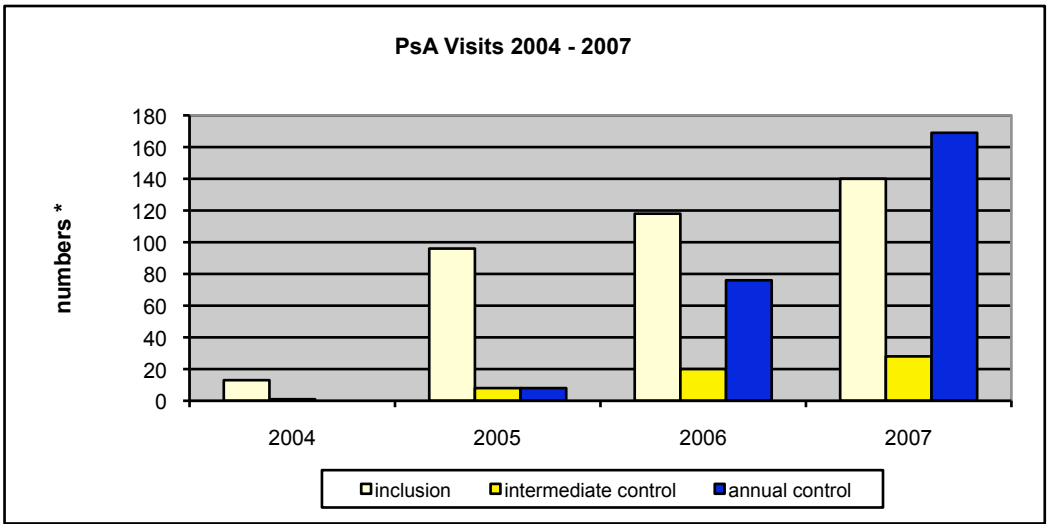
All patients with Psoriatic Arthritis in Switzerland, independent of age, disease duration, severity and type of therapy can participate. It is a population based prospective conservational study. All Swiss rheumatologists are encouraged to cooperate.

2.3.3 DATA COLLECTION

A clinical examination and the collection of blood samples are included during initial, intermediate control and annual control visits. Patients are also asked to complete a questionnaire. All collected data (physician and patient) is communicated to the SCQM Office for evaluation. The questionnaires are available in German and French.

2.3.4 STATE OF THE PROJECT

90 patients were included in the first year after starting the PsA register. The number of inclusions and follow-up entries in the SCQM has grown steadily since 2005. Approximately half of the PsA patients are under treatment with a biologic. Since there is no electronic data base for PsA yet, analyses on the collected data are not yet realisable.



2.3.5 FUTURE OF THE REGISTER FOR PSORIATIC ARTHRITIS

In summer 2007 the PsA questionnaires have been revised by the PsA Commission and the SCQM team. These revised forms are the basis for the PsA questionnaires in the online data base.

Entry of the data of the psoriatic arthritis questionnaires will be performed into the new online data base, and is planned for the first quarter of 2009. Radiographic images are still not collected centrally by the SCQM. The treating physicians are, however, strongly encouraged to perform the radiographic images of hands and feet, as is common practice, and store and archive them decentrally.

3 Patrons, Sponsors and Contacts

Patrons

Sponsors

- Fondation Jean & Linette Warnery

Contacts

- Schweizerische Vereinigung Morbus Bechterew
- Schweizerische Polyarthritiker Vereinigung

4 Annual Acounts

4.1 Balance

SCQM Foundation, Zürich

Bilanz per 31. Dezember	**Anmerkung**	**2007**	**2006**
		CHF	CHF
AKTIVEN			
Umlaufvermögen			
Flüssige Mittel		235,971.65	280,210.13
Andere Forderungen		16,953.95	9,735.90
Aktive Rechnungsabgrenzung		9,364.90	0.00
		262,290.50	289,946.03
Anlagevermögen			
Sachanlagen			
- EDV	2	14,721.25	31,228.55
- Datenbank	2	24,344.93	63,507.93
		39,066.18	94,736.48
		301,356.68	384,682.51
PASSIVEN			
Fremdkapital			
Verbindlichkeiten gegenüber Dritten		84,077.81	75,597.90
Übrige kurzfristige Verbindlichkeiten		38,642.35	129,470.60
Transitorische Passiven		0.00	2,070.00
Darlehen Klinik Balgrist	3	40,000.00	50,000.00
		162,720.16	257,138.50
Stiftungskapital			
Stiftungskapital		80,000.00	80,000.00
Bilanzsaldo			
Gewinn- / Verlustvortrag		47,544.01	-936.53
Jahresgewinn		11,092.51	48,480.54
		138,636.52	127,544.01
		301,356.68	384,682.51

4.2 Income Statement

SCQM Foundation, Zürich

Erfolgsrechnung	**Anmerkung**	**2007**	**2006**
		CHF	CHF
ERTRAG			
Erlös aus Sponsoring	4	630,000.00	417,754.02
Erlös aus zus. Dienstleistungen		500.00	16,000.00
Spenden	5	5,000.00	187,000.00
übriger Ertrag		2,070.00	0.00
		637,570.00	620,754.02
AUFWAND			
Personalaufwand		-422,977.70	-368,646.71
Raumaufwand		-25,611.23	-29,132.08
Verwaltungs- und Informatikaufwand		-110,621.71	-81,424.03
Übriger Aufwand		-9,816.00	-11,738.49
Abschreibungen		-57,338.35	-81,187.32
Ergebnis vor Zinsen		11,205.01	48,625.39
Finanzertrag		274.60	241.05
Finanzaufwand		-387.10	-385.90
Jahresgewinn		11,092.51	48,480.54

4.3 Balance Annexe

SCQM Foundation, Zürich

Anhang der Jahresrechnung 2007

1 Gründung und Stiftungszweck

Die SCQM Foundation (Swiss Clinical Quality Management in Rheumatoid Arthritis) mit Sitz in Zürich, wurde gemäss der Stiftungsurkunde per 1. Oktober 2003 notariell beurkundet und per 12. Februar 2004 ins Handelsregister eingetragen.
Zweck der Stiftung ist:
Die Stiftung will im Bereich der Rheumatologie eine unabhängige, von lokalen, regionalen und persönlichen Interessen freie Forschungsplattform errichten und betreiben. Sie verfolgt weder Erwerbs- noch Selbsthilfezwecke. Die Stiftung bezweckt insbesondere die kontinuierliche Verbesserung der Qualität der Behandlung der rheumatoiden Arthritis mittels eines Feedback-gestützten Messsystems.

2 Brandversicherungswert	2007 CHF	2006 CHF
Feuer / Elementar / Erweiterte Deckung	100,000	100,000

3 Darlehen der Klinik Balgrist

Das Darlehen der Klinik Balgrist im Betrag von CHF 40,000 (Vorjahr CHF 50,000) ist unbefristet. Es ist beidseitig mit einer Kündigungsfrist von sechs Monaten jeweils auf Ende eines Kalenderjahres kündbar.
Per Ende Geschäftsjahr 2007 wurde eine Teilrückzahlung von CHF 10,000 an die Klinik Balgrist beschlossen.

4 Beitritt Patron Bristol-Myers Squibb

Im Geschäftsjahr 2007 wurde mit Bristol-Myers Squibb ein Vertrag abgeschlossen, welcher der Firma nach Eingang einer Zahlung von CHF 90,000 rückwirkend Zugang zu den 2006 erhobenen Daten gewährt. Die Zahlung ist in der Betriebsrechnung 2007 verbucht. Im Geschäftsjahr 2007 hat der Sponsor zusätzlich den ordentlichen Beitrag von CHF 90,000 für 2007 bezahlt.

5 Spenden

Im Geschäftsjahr 2006 erfolgte im Betrag von CHF 180,000 eine einmalige Spende von Seiten der Vontobel Stiftung, Zürich, im Zusammenhang mit der Umstellung des Datenbanksystems.

4.4 Auditor's Report

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Audit
Badenerstrasse 172
CH-8004 Zürich

Postfach
CH-8026 Zürich

Telefon +41 44 249 31 31
Telefax +41 44 249 23 19
Internet www.kpmg.ch

Bericht der Revisionsstelle an den Stiftungsrat der

SCQM Foundation, Zürich

Als Revisionsstelle haben wir die Buchführung und die Jahresrechnung (Bilanz, Erfolgsrechnung und Anhang) der SCQM Foundation für das am 31. Dezember 2007 abgeschlossene Geschäftsjahr geprüft.

Für die Jahresrechnung ist der Stiftungsrat verantwortlich, während unsere Aufgabe darin besteht, diese zu prüfen und zu beurteilen. Wir bestätigen, dass wir die Anforderungen hinsichtlich Befähigung und Unabhängigkeit erfüllen.

Unsere Prüfung erfolgte nach den Grundsätzen des schweizerischen Berufsstandes, wonach eine Prüfung so zu planen und durchzuführen ist, dass wesentliche Fehlaussagen in der Jahresrechnung mit angemessener Sicherheit erkannt werden. Wir prüften die Posten und Angaben der Jahresrechnung mittels Analysen und Erhebungen auf der Basis von Stichproben. Ferner beurteilten wir die Anwendung der massgebenden Rechnungslegungsgrundsätze, die wesentlichen Bewertungsentscheide sowie die Darstellung der Jahresrechnung als Ganzes. Wir sind der Auffassung, dass unsere Prüfung eine ausreichende Grundlage für unser Urteil bildet.

Gemäss unserer Beurteilung entsprechen die Buchführung und die Jahresrechnung dem schweizerischen Gesetz, der Stiftungsurkunde und dem Reglement.

Wir empfehlen, die vorliegende Jahresrechnung zu genehmigen.

KPMG AG

Hans Knobel
Leitender Revisor

Martin Hemmi

Zürich, 9. April 2008

Beilage:
- Jahresrechnung (Bilanz, Erfolgsrechnung und Anhang)

5 The SCQM Foundation

5.1 Background Information

DEVELOPMENT OF THE SWISS CLINICAL QUALITY MANAGEMENT

First attempts to initiate the start up of a data base for Rheumatoid Arthritis were undertaken back in 1995. The subsequent collection of regular patient follow-up data was started in 1996. The project started at the University Hospital of Zurich, supported by Dutch colleagues. The idea was to put a comprehensive quality management into clinical practice. Prof. Dr. Gerold Stucki together with Dr. Thomas Langenegger, Dr. Adrian Forster and Prof. Dr. Beat Michel were the initiatiors of the project.
The project expanded more and more in the past years. The need for a better organisational and political framework arised. In summer 2003 the Swiss Clinical Quality Management FOUNDATION was established under the umbrella of the Swiss Society for Rheumatology (Schweizerische Gesellschaft für Rheumatologie, SGR). The founders of this non-profit organisation comprise 23 rheumatological clinics and two societies. The list of the founding hospitals is shown in section 5.6.

5.2 The SCQM Board

The overall authority of SCQM is the FOUNDATION Board. It is composed of five to seven members including a president and a vice-president. At least two members of the Board have to be active members of the SGR Board of directors.
In 2005 the SCQM Board agreed that patrons (the main sponsors of SCQM) will have a temporary seat for one year in rotation on the Board. In 2007 the patrons were represented by Ms Lucia Sutter of the company Essex.
The members of the SCQM Board are listed under title 5.2 (as of December 2007).

- Dr. Hans A. Schwarz (President), Bethesda Spital, Basel
- Prof. Dr. Cem Gabay (Vice-President), Hôpitaux Universitaires de Genève, Geneva
- Dr. Anne-Marie Chamot, medical specialist FMH, Morges
- Dr. Adrian Forster, Thurgauer Klinik St. Katharinental, Diessenhofen
- Prof. Dr. Paul Hasler, Kantonsspital Aarau, Aarau
- Prof. Dr. Rudolph Kissling, Universitätsklinik Balgrist, Zurich
- Ms Gisela Dalvit, Executive Secretary

5.3 The Executive Committee

In 2006 an Executive Committee was set up, this group was elected out of the members of the SCQM Board. The aim of the establishment was to reduce the workload and to prepare decisions for the Board members.

- Dr. Hans A. Schwarz (President), Bethesda Spital, Basel

- Ms Gisela Dalvit, Executive Secretary
- Dr. Adrian Forster, Thurgauer Klinik St. Katharinental, Diessenhofen
- Prof. Dr. Rudolph Kissling, Universitätsklinik Balgrist, Zurich
- Dr. Silvia Dehler, MPH, project manager
- Sabine von Känel, Executive Secretary (since 01.11.2007)

5.4 The Scientific Commissions

For concentrating more effecient on strategic issues the SCQM Board decided to establish a scientific commission for each register. Since the commissions will mainly deal with the professional aspects of the register, their members should be experts in the field of the respective register. It is recommended that at least one member of the commission should be a private practitioner in order to bring in the relevant inputs of a private practice. The chairmen of the commissions also participate in the SCQM Board meetings to assure a link between strategic and operational level of the SCQM FOUNDATION.

RA Commission
- Dr. Axel Finckh (Chairman), Hôpitaux Universitaires de Genève, Geneva
- Dr. Jean Dudler, Centre Hospitalier Universitaire Vaudois, Lausanne
- PD Dr. Diego Kyburz, Universitätsspital Zurich
- Dr. Ines von Mühlenen, medical specialist FMH, Basel

AS Commission
- Dr. Ulrich Weber (Chairman), Universitätsklinik Balgrist, Zurich
- Dr. Jürg Bernhard, Bürgerspital Solothurn
- Brigitte Beyeler, member of the SVMB Board, Zurich
- Dr. Adrian Ciurea, Universitätsspital Zurich
- Dr. Jean Dudler, Centre Hospitalier Universitaire Vaudois, Lausanne
- Dr. Pascale Exer, Bethesda Spital, Basel

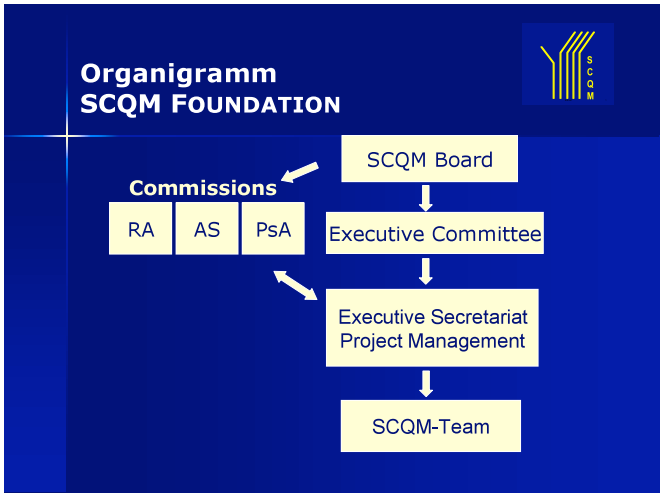
PsA Commission
- PD Dr. Burkhard Möller (Chairman), Inselspital, Bern
- Dr. Jean Dudler, Centre Hospitalier Universitaire Vaudois, Lausanne
- Dr. Bettina Weiss, Bethesda Spital, Basel
- Prof. Dr. Nikhil Yawakhar (Dermatologist), Inselspital, Bern

5.5 The SCQM Office

- Dr. Silvia Dehler, MPH, project manager (until 12.2007)
- Sabine von Känel, executive Secretary (since 11.2007)

- Cláudia Cutler, assistant for Administration, Communication and PsA
- Jacqueline Hirt, assistant for AS
- Rowena Laue, data management and statistics
- Marion Täsch Furger, assistant RA X-rays scoring
- Heinz Wyrsch, assistant for RA
- Marco Wyrsch, X-ray digitalising (temporary for six month)

5.6 The SCQM Organigram



5.7 List of SCQM Founders

- aarReha, Schinznach Bad
- Abteilung für Rheumatologie und Rehabilitation, Kantonsspital St. Gallen
- Abteilung für Rheumatologie/Rehabilitation, Kantonsspital Schaffhausen
- Hôpitaux Universitaires de Genève, Div. de Rhumatologie, Genève
- Hôpital cantonal de Fribourg, Service de Rhumatologie, Fribourg
- Klinik Adelheid AG, Unterägeri
- Klinik für Rheumatologie und Klinische Immunologie/Allergologie, Inselspital Bern
- Klinik für Rheumatologie und Rehabilitation des Bewegungsapparates, Klinik Valens
- Klinik für Rheumatologie und Rehabilitation, Bethesda Spital, Basel
- Klinik für Rheumatologie und Rehabilitation, Stadtspital Triemli, Zürich
- Klinik Schloss Mammern AG
- Rehabilitationszentrum Leukerbad AG
- Rehabilitationszentrum Bürgerspital Solothurn
- RehaClinic Zurzach
- Rehaklinik Rheinfelden
- Rheumaklinik Kantonsspital Luzern
- Rheumaklinik Kantonsspital Winterthur
- Rheumaklinik & Institut f. Physikalische Medizin & Rehabilitation, Kantonssspital Aarau
- Rheumaklinik und Institut für Physikalische Medizin, Universitätsspital Zürich
- Rheumatologische Universitätsklinik, Felix Platter-Spital, Basel

- Service de Rhumatologie, Médicine Physique et Réadaptation, Centre Hospitalier Universitaire Vaudois, Lausanne
- Thurgauer Klinik St. Katharinental, Diessenhofen
- Universitätsklinik Balgrist, Abteilung für Rheumatologie, Zürich
- Rheumaliga Schweiz, RLS
- Schweizerische Gesellschaft für Rheumatologie, SGR

6 Publications

6.1 Scientific Publications 2007

Finckh A , Dehler S, Costenbader K, Gabay C, on behalf of the SCQM-RA.
Cigarette smoking and radiographic progression in rheumatoid arthritis.
Annals of the Rheumatic Diseases 2007; 66; 1066-1071.

Finckh A, Ciurea A, Brulhart L, Revaz S, Möller B, Dehler S, Kyburz D, Dudler J, Gabay C, on behalf of the SCQM-RA.
Rituximab may be more effective than switching to an alternative anti-TNF agent in RA patients with inadequate response to anti-TNF agents.
Arthritis and Rheumatism 2007; May 2007; 56(5), 1417-23.

Genevay S*, Finckh A*, Ciurea A, Chamot AM, Kyburz D, Gabay C, for the physician of the SCQM-RA (* Authors have equally contributed).
Tolerance and effectiveness of anti-TNF-a therapies in elderly patients with rheumatoid arthritis. A population based cohort study.
Arthritis and Rheumatism (AC&R) 2007 Apr 30; 57(4):679-685.

6.2 Scientific Publications 2006

Finckh A, Simard J, Gabay C, Guerne PA, for the physician of the SCQM-RA.
Evidence for differential acquired drug resistance to anti-TNF agents in rheumatoid arthritis.
Annals of Rheumatic Diseases 2006 Jun; 65(6):746-52. [IF: 6.95]

Finckh A, Simard JF, Huang J, Duryea J, Liang M, Daneel S, Forster A, Gabay C, Guerne PA.
The effectiveness of anti-TNF therapy in preventing progressive radiographic joint damage in rheumatoid arthritis. A population based study.
Arthritis and Rheumatism, 2006 Jan; 54(1):54-9.
Pfizer Price 2006 for medical research: Clinical rheumatology and immunology.

Genta MS, Kardes H, Gabay C.
Clinical evaluation of a cohort of patients with rheumatoid arthritis treated with anti-TNF-α in the community.
Joint Bone Spine, 2006 Jan; 73(1):51-6.

CONTACT INFORMATION

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