SCQM

Swiss Clinical
Quality Management in
Rheumatic Diseases

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SCQM Scoreboard Documentation

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1. Introduction

The Swiss Clinical Quality Management in Rheumatic Diseases (SCQM) Foundation provides a digital scoreboard to physicians and patients that offers an overview of disease-relevant measurements used in the management of rheumatic diseases.

As part of participation in the SCQM patient registry, patients complete standardized questionnaires for their medical visits to systematically document the course of the disease and to support discussions between patients and physicians. The collected data also contribute to medical research and help improve long-term care for people with rheumatic diseases.

Some scores are derived directly from patient questionnaire responses (patient-reported outcomes, PROs), others combine patient input with measurements collected during the clinical consultation (e.g., laboratory values), or are based solely on physician assessments (e.g., joint counts).

This document summarizes key information and references for the scores displayed on the SCQM Scoreboard used by physicians and in the graphical timeline under «Disease Activity» in the web application «mySCQM». It covers only scores that are part of routine clinical practice.

2. Scores Presented on the SCQM Scoreboard

2.1. Scores Associated with Clinical Visits

The following scores are collected in association with clinical visits. Depending on the score, they may be based on physician assessments, patient reported outcomes (PROs) via mySCQM, or a combination of both. Some scores may also be updated between visits when short questionnaires are completed in mySCQM.

2.1.1.   ASAS-HI

Name	Assessment of SpondyloArthritis international Society – Health Index (ASAS-HI)
Purpose	To assess overall health as conceived by the patient
Indications	axSpA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	2018 – present
References	1. Kiltz U, van der Heijde D, Boonen A, et al. Development of a health index in patients with spondyloarthritis (ASAS HI). *Ann Rheum Dis.* 2015;74(6):998–1004. https://doi.org/10.1136/annrheumdis-2013-203967 2. ASAS Health Index – Users Manual 3. ASAS Working Group. www.asas-group.org
Calculation	The ASAS-HI consists of 17 questions covering 3 domains (functioning, disability, health). Each question is scored as 0 (I do not agree) or 1 (I agree). The ASAS-HI is the sum across all questions. The range is from 0 to 17, with lower values indicating better health.
Handling of Missing Values	The ASAS-HI is calculated if at least 14 of the 17 questions were answered. In presence of missing answers, the sum score across the answered questions is weighted by 17/number of answered questions and rounded to the nearest integer.
Copyright	© Assessment of SpondyloArthritis Society (ASAS). https://www.asas-group.org/

2.1.2.   ASDAS$_{CRP}$

Name	Ankylosing Spondylitis Disease Activity Score – C-Reactive Protein (ASDAS$_{CRP}$)

Purpose	To assess disease activity
Indications	axSpA
Data Sources	PRO and laboratory values
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	1. Lukas C, Landewé R, Sieper J, et al. Development of an ASAS-endorsed disease activity score (ASDAS) in patients with ankylosing spondylitis. *Ann Rheum Dis.* 2009;68(1):18–24. https://doi.org/10.1136/ard.2008.094870 2. Machado P, Navarro-Compán V, Landewé R, et al. Calculating the Ankylosing Spondylitis Disease Activity Score if the conventional C-reactive protein level is below the limit of detection or if high-sensitivity C-reactive protein is used: an analysis in the DESIR cohort. *Arthritis Rheumatol.* 2015 Feb;67(2):408–413. https://doi.org/10.1002/art.38921 3. ASDAS – Calculator
Calculation	$ASDAS_{CRP} = 0.12 \times$ back pain[1] $+ 0.11 \times PtGA$[2] $+ 0.07 \times$ peripheral pain/swelling[3] $+ 0.06 \times$ duration of morning stiffness[4] $+ 0.58 \times \ln(CRP$[5]$+1)$, with the result rounded to one decimal place. The range is from 0.6 to 6.9, with lower values indicating less activity. [1] BASDAI Question 2 (see 2.1.3) [2] Patient global assessment of disease activity (see 2.1.19) [3] BASDAI Question 3 (see 2.1.3) [4] BASDAI Question 6 (see 2.1.3) [5] in mg/l, values reported as below the limit of detection or smaller than 2mg/l are replaced by 2mg/l
Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
Copyright	© Assessment of SpondyloArthritis Society (ASAS). https://www.asas-group.org/

2.1.3. BASDAI

Name	Bath Ankylosing Spondylitis Disease Activity Index (BASDAI)
Purpose	To assess disease activity as conceived by the patient
Indications	axSpA

Data Sources	PRO
Frequency of Assessment	Annual and interim visits, optionally between visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	≤ 2009 – present
References	1. Garrett SL, Jenkinson T, Kennedy LG, et al. A new approach to defining disease status in ankylosing spondylitis: the Bath Ankylosing Spondylitis Disease Activity Index. *J Rheumatol.* 1994;21(12):2286–2291. https://pubmed.ncbi.nlm.nih.gov/7699630 2. Ramiro S, van Tubergen A, van der Heijde D, et al. How to deal with missing items in BASDAI and BASFI. *Rheumatology* (Oxford). 2014;53(2):374–376. https://doi.org/10.1093/rheumatology/ket396
Calculation	BASDAI = (Q1 + Q2 + Q3 + Q4 + (Q5 + Q6)/2)/5 where Q1 to Q6 are the answers on a 0-10 numeric rating scale (NRS) (0 = none, 10 = very severe) for questions on fatigue (Q1), spinal pain (Q2), peripheral joint pain/swelling (Q3), enthesitis (Q4), morning stiffness severity (Q5), and morning stiffness duration (Q6). The range is from 0 to 10, with lower values indicating less activity.
Handling of Missing Values	The BASDAI is calculated if at least 5 of the 6 questions are answered. If the missing question is either Q5 or Q6, the BASDAI is calculated as the average of Q1–Q4 and the available question from Q5 or Q6. If one of Q1–Q4 is missing, the BASDAI is calculated as the average of the four available components, one of which is the mean of (Q5 + Q6)/2, rounded to one decimal place.
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2.1.4. BASFI

Name	Bath Ankylosing Spondylitis Functional Index (BASFI)
Purpose	To assess functional ability as conceived by the patient
Indications	axSpA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits

Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	≤ 2009 – present
References	1. Calin A, Garrett S, Whitelock H, et al. A new approach to defining functional ability in ankylosing spondylitis: the Bath Ankylosing Spondylitis Functional Index. *J Rheumatol. 1994;21(12):2281–2285.* https://pubmed.ncbi.nlm.nih.gov/7699629 2. Ramiro S, van Tubergen A, van der Heijde D, et al. How to deal with missing items in BASDAI and BASFI. *Rheumatology* (Oxford). 2014;53(2):374–376. https://doi.org/10.1093/rheumatology/ket396
Calculation	BASFI = (Q1 + Q2 + … + Q10)/10 where Q1 to Q10 are the answers on a 0-10 NRS (0 = easy, 10 = impossible) for 10 questions regarding functional ability. The range is from 0 to 10, with lower values indicating less functional impairment.
Handling of Missing Values	The BASFI is calculated if at least 7 of the 10 questions are answered. In presence of missing answers, the BASFI is the mean across the available components, rounded to one decimal place.
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2.1.5. mBASMI

Name	modified Bath Ankylosing Spondylitis Metrology Index (mBASMI)
Purpose	To assess spinal mobility
Indications	axSpA, PsA
Data Sources	Physician-assessed (measurements)
Frequency of Assessment	Annual visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA: ≤ 2009 – present PsA: 2021 – present
References	1. Jenkinson TR, Mallorie PA, Whitelock HC, et al. Defining spinal mobility in ankylosing spondylitis (AS): The Bath AS Metrology Index (BASMI). *J Rheumatol.* 1994;21(9):1694–1698. https://pubmed.ncbi.nlm.nih.gov/7799351

	2. Macrae IF, Wright V, et al. Measurement of back movement. *Ann Rheum Dis.* 1969;28(6):584–589. https://pubmed.ncbi.nlm.nih.gov/5363241
	3. Heuft-Dorenbosch L, Vosse D, Landewé R, et al. Measurement of spinal mobility in ankylosing spondylitis: comparison of occiput-to-wall and tragus-to-wall distance. *J Rheumatol.* 2004;31(9):1779–1784. https://pubmed.ncbi.nlm.nih.gov/15338500
Calculation	mBASMI is the sum score with respect to severity of limitation in 5 different movements. These are: cervical rotation (mean of left and right measurement), occiput-to-wall distance[1], lateral spinal flexion (mean of left and right measurement), modified Schober's test (modification by MacRae and Wright), and intermalleolar distance. Severity of limitation for each movement is scored from 0 (normal) to 2 (severe). The range is from 0 to 10 with lower values indicating less limitation. [1] This measure differs from the official tragus-to-wall distance. Its conversion to the 0-2 severity scale is based on expert opinion, as no validated threshold values exist. 0: <3cm 1: >=3cm and <=18cm 2: >18cm
Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
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2.1.6. DAPSA Score

Name	Disease Activity in Psoriatic Arthritis (DAPSA) Score
Purpose	To assess disease activity
Indications	PsA, UA
Data Sources	PRO, physician-assessed (physical examination and laboratory values)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	PsA, UA: December 2025 – present
References	1. Schoels M, Aletaha D, Funovits J, et al. Application of the DAREA/DAPSA score for assessment of disease activity in

psoriatic arthritis. Ann Rheum Dis. 2010;69(8):1441–1447. https://doi.org/10.1136/ard.2009.122259

2. Proft F, Schally J, Brandt HC, et al. Evaluation of the Disease Activity index for PSoriatic Arthritis (DAPSA) with a quick quantitative C reactive protein assay (Q-DAPSA) in patients with psoriatic arthritis: a prospective multicentre cross-sectional study. RMD Open. 2022;8(2):e002626. https://doi.org/10.1136/rmdopen-2022-002626

3. Schoels MM, Aletaha D, Alasti F, et al. Disease activity in psoriatic arthritis (PsA): defining remission and treatment success using the DAPSA score. *Ann Rheum Dis.* 2016;75(5):811–818. https://doi.org/10.1136/annrheumdis-2015-207507

Calculation	The DAPSA score is calculated as the sum of SJC 66 (see 2.1.24), TJC 68 (see 2.1.29), the PtGA (see 2.1.19), patient-assessed joint pain on a 0–10 NRS (0 = no pain, 10 = worst imaginable pain), and CRP[1]. The range is from 0 to 184, with lower values indicating less activity. [1] in mg/dl and rounded to one decimal, values reported as below the limit of detection are replaced by 0 mg/dl.
Handling of Missing Values	If any component value is missing, the DAPSA Score is not calculated and is not displayed on the scoreboard.
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2.1.7. cDAPSA Score

Name	clinical Disease Activity in Psoriatic Arthritis (cDAPSA) Score
Purpose	To assess disease activity
Indications	PsA, UA
Data Sources	PRO, physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	PsA, UA: December 2025 – present
References	1. Schoels M, Aletaha D, Funovits J, et al. Application of the DAREA/DAPSA score for assessment of disease activity in psoriatic arthritis. Ann Rheum Dis. 2010;69(8):1441–1447. https://doi.org/10.1136/ard.2009.122259

	2. Proft F, Schally J, Brandt HC, et al. Evaluation of the Disease Activity index for PSoriatic Arthritis (DAPSA) with a quick quantitative C reactive protein assay (Q-DAPSA) in patients with psoriatic arthritis: a prospective multicentre cross-sectional study. RMD Open. 2022;8(2):e002626. https://doi.org/10.1136/rmdopen-2022-002626
	3. Schoels MM, Aletaha D, Alasti F, et al. Disease activity in psoriatic arthritis (PsA): defining remission and treatment success using the DAPSA score. *Ann Rheum Dis.* 2016;75(5):811–818. https://doi.org/10.1136/annrheumdis-2015-207507
Calculation	The cDAPSA score is calculated as the sum of SJC 66 (see 2.1.24), TJC 68 (see 2.1.29), the PtGA (see 2.1.19) and patient-assessed joint pain on a 0–10 NRS (0 = no pain, 10 = worst imaginable pain),
	Compared to the DAPSA score, it omits CRP and is therefore readily available in the clinical setting.
	The range is from 0 to 154, with lower values indicating less activity.
Handling of Missing Values	If any component value is missing, the cDAPSA is not calculated and is not displayed on the scoreboard.
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2.1.8. DAS28(3)-CRP

Name	Disease Activity Score using 28 joint counts and C-reactive protein (DAS28(3)-CRP); version with 3 components
Purpose	To assess disease activity
Indications	PsA, RA, UA
Data Sources	Physician-assessed (physical examination and laboratory values)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	1. Prevoo MLL, van 't Hof MA, Kuper HH, et al. 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(1):44–48. https://doi.org/10.1002/art.1780380107

	2. Fransen J, Welsing PMJ, de Keijzer RMH, van Riel PLCM, et al. Development and validation of the DAS28 using CRP. Ann Rheum Dis. 2003;62(Suppl 1):151. 3. DAS28 – Calculator
Calculation	DAS28(3)-CRP = [0.56 × $\sqrt{(TJC28^1)}$ + 0.28 × $\sqrt{(SJC28^2)}$ + 0.36 × $\ln(CRP^3+1)$] × 1.10 + 1.15, with the result rounded to one decimal place. The range is from 1.2 to 8.3, with lower values indicating less activity. [1] Tender Joint Count 28 joints (see 2.1.27) [2] Swollen Joint Count 28 joints (see 2.1.22) [3] in mg/l, values reported as below the limit of detection are replaced by the limit of detection
Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
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2.1.9. DAS28(4)-CRP

Name	Disease Activity Score using 28 joint counts and C-reactive protein (DAS28(4)-CRP); version with 4 components
Purpose	To assess disease activity
Indications	PsA, RA, UA
Data Sources	PRO, physician-assessed (physical examination and laboratory values)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	Beginning of November 2025 – present
References	1. Prevoo MLL, van 't Hof MA, Kuper HH, et al. 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(1):44–48. https://doi.org/10.1002/art.1780380107 2. Fransen J, Welsing PMJ, de Keijzer RMH, van Riel PLCM, et al. Development and validation of the DAS28 using CRP. *Ann Rheum Dis.* 2003;62(Suppl 1):151. 3. DAS28 – Calculator
Calculation	DAS28(4)-CRP = 0.56 × $\sqrt{(TJC28^1)}$ + 0.28 × $\sqrt{(SJC28^2)}$ + 0.36 × $\ln(CRP^3+1)$ + 0.014 × 10 x PtGA^4 + 0.96, with the result rounded to one decimal place.

	The range is from 1.0 to 8.9 with lower values indicating less activity.
	[1] Tender Joint Count 28 joints (see 2.1.27)
	[2] Swollen Joint Count 28 joints (see 2.1.22)
	[3] in mg/l, values reported as below the limit of detection are replaced by the limit of detection
	[4] Patient global assessment of disease activity (see 2.1.19)
Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
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Remarks	Since the PtGA (see 2.1.19) has only been collected from January 2021 onwards for PsA, RA and UA, the score cannot be calculated for earlier visits.

2.1.10. DAS28(3)-ESR

Name	Disease Activity Score using 28 joint counts and Erythrocyte Sedimentation Rate (DAS28(3)-ESR); version with 3 components
Purpose	To assess disease activity
Indications	RA, UA
Data Sources	Physician-assessed (physical examination and laboratory values)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	1. Prevoo MLL, van 't Hof MA, Kuper HH, et al. 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(1):44–48. https://doi.org/10.1002/art.1780380107 2. DAS28 – Calculator
Calculation	DAS28(3)-ESR = [0.56 × $\sqrt{(\text{TJC28}[1])}$ + 0.28 × $\sqrt{(\text{SJC28}[2])}$ + 0.70 × ln(ESR[3])] × 1.08 + 0.16, with the result rounded to one decimal place. The range is from 0.7 to 8.7 with lower values indicating less activity. [1] Tender Joint Count 28 joints (see 2.1.27) [2] Swollen Joint Count 28 joints (see 2.1.22) [3] in mm/first hour, 0 =< value < 2 is replaced by 2 mm/first hour

Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
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2.1.11. DAS28(4)-ESR

Name	Disease Activity Score using 28 joint counts and Erythrocyte Sedimentation Rate (DAS28(4)-ESR); version with 4 components
Purpose	To assess disease activity
Indications	RA, UA
Data Sources	PRO, physician-assessed (physical examination and laboratory values)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	Beginning of November 2025 – present
References	1. Prevoo MLL, van 't Hof MA, Kuper HH, et al. 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(1):44–48. https://doi.org/10.1002/art.1780380107 2. DAS28 – Calculator
Calculation	DAS28(4)-ESR = $0.56 \times \sqrt{(TJC28^1)} + 0.28 \times \sqrt{(SJC28^2)} + 0.70 \times \ln(ESR^3) + 0.014 \times 10 \times PtGA^4$, with the result rounded to one decimal place. The range is from 0.5 to 9.4 with lower values indicating less activity. [1] Tender Joint Count 28 joints (see 2.1.27) [2] Swollen Joint Count 28 joints (see 2.1.22) [3] in mm/first hour, 0 =< value < 2 is replaced by 2 mm/first hour [4] Patient global assessment of disease activity (see 2.1.19)
Handling of Missing Values	If any component value is missing, the score is not calculated and is not displayed on the scoreboard.
Copyright	© Piet Van Riel, 1995. Licensor: Mapi Research Trust. https://eprovide.mapi-trust.org/
Remarks	Since the PtGA (see 2.1.19) has only been collected from January 2021 onwards for PsA, RA and UA, the score cannot be calculated for earlier visits.

2.1.12. DLQI

Name	Dermatology Life Quality Index (DLQI)
Purpose	To assess a patient's perceived impact of their skin disease on quality of life
Indications	PsA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	≤ 2009 – present
References	1. Finlay AY, Khan GK. Dermatology Life Quality Index (DLQI): a simple practical measure for routine clinical use. *Clin Exp Dermatol.* 1994;19(3):210–216. https://pub-med.ncbi.nlm.nih.gov/8033378 2. Cardiff University – DLQI
Calculation	The DLQI questionnaire consists of 10 questions covering 6 domains (symptoms and feelings, daily activities, leisure, work and school, personal relationships, and treatment). Each answer is scored from 0 (not at all) to 3 (very much). The DLQI is the sum across all scored questions. The range is from 0 to 30, with lower values indicating smaller impact.
Handling of Missing Values	The DLQI is calculated if at least 9 of the 10 questions were answered. The one missing answer is allocated a score of 0.
Copyright	© AY Finlay, GK Khan, April 1992. www.dermatology.org.uk Licensor: Cardiff University
Remarks	From mid-January 2021 to the end of October 2025, the DLQI questionnaire was not presented to patients who answered «no involvement» to the question «How do you rate the current extent of your skin involvement?». As a result, no DLQI could be calculated for these cases.

2.1.13. Enthesitis Count

Name	Enthesitis Count
Purpose	To assess the extent of enthesitis
Indications	axSpA, PsA

Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA: ≤ 2009 – present PsA: 2014 – present
References	1. Heuft-Dorenbosch L, Spoorenberg A, van Tubergen A, et al. Assessment of enthesitis in ankylosing spondylitis. Ann *Rheum Dis.* 2003;62(2):127–132. https://doi.org/10.1136/ard.62.2.127
Calculation	The enthesitis count is the number of entheseal sites with enthesitis out of a set of 15 sites[1]. The range is from 0 to 15, with lower values indicating a smaller extent. [1] Sites assessed in the Maastricht Ankylosing Spondylitis Enthesitis Score (MASES) plus the right and left plantar fascia.
Handling of Missing Values	When individual enthesitis is recorded using the 15-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The enthesitis count equals the number of affected sites. If no sites are marked as affected, the count is set to 0 only if all 15 sites are marked «not affected»; otherwise, it remains missing.
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2.1.14. EQ-5D-3L

Name	EuroQol 5-Dimension 3-Level instrument (EQ-5D-3L)
Purpose	To assess health-related quality of life
Indications	axSpA, GCA, PMR, PsA, RA, UA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA, PsA, RA, UA: ≤ 2009 – present GCA, PMR: Beginning of 2025 – present
References	1. EuroQol Group. EuroQol—a new facility for the measurement of health-related quality of life. *Health Policy.*

	1990;16(3):199–208. https://doi.org/10.1016/0168-8510(90)90421-9
	2. Greiner W, Weijnen T, Nieuwenhuizen M, et al. A single European currency for EQ-5D health states. *Eur J Health Econ.* 2003;4(3):222–231. https://doi.org/10.1007/s10198-003-0182-5
	3. EQ-5D-3L User Guide
	4. EuroQol Group. https://euroqol.org/
Calculation	The EQ-5D-3L covers 5 dimensions (mobility, self-care, usual activities, pain/discomfort, anxiety/depression). Each dimension is scored at 3 levels (1 = no problems, 2 = some problems, 3 = unable to do). A health utility index is then calculated using the European value set according to EQ-5D-3L European valuation instructions (Greiner et al., 2003). The range is from -0.074 (indicating a state worse than death) to 1 (best health).
Handling of Missing Values	If any dimension value is missing, the score is not calculated and is not displayed on the scoreboard.
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2.1.15. GPAQ Score

Name	Global Physical Activity Questionnaire (GPAQ) Score
Purpose	To assess levels of physical activity as conceived by the patient
Indications	axSpA, PsA, RA, UA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	2021 – present
References	1. Armstrong T, Bull F. Development of the World Health Organization Global Physical Activity Questionnaire (GPAQ). *J Public Health.* 2006;14(2):66–70. https://doi.org/10.1007/s10389-006-0024-x 2. GPAQ – Analysis Guide 3. World Health Organization. https://www.who.int/ 4. Wanner M, Hartmann C, Pestoni G, et al. Validation of the Global Physical Activity Questionnaire for self-administration in a European context. *BMJ Open Sport & Exercise*

	Medicine. 2017;3:e000206. https://doi.org/10.1136/bmjsem-2016-000206
Calculation	The GPAQ assesses physical activity during work, transport, and recreation. The total time spent with vigorous and moderate activities in a typical week is then converted into MET-minutes/week using WHO guidelines. The range is from 0 to 188'160, with lower values indicating less activity. However, physiologically plausible values are typically much lower.
Handling of Missing Values	The score is calculated if at least one of the activity domains (vigorous work, moderate work, travel, vigorous recreational activity, or moderate recreational activity) is reported, and none are answered inconsistently (e.g., reporting no vigorous work but indicating more than 0 days of vigorous work). In addition, none of the reported time values for these activities may exceed 16 hours per day.
Copyright	© World Health Organization. https://www.who.int/
Remarks	On the graphical scoreboard, the GPAQ score is displayed as the value divided by 600.

2.1.16. HAQ-DI

Name	Health Assessment Questionnaire Disability Index (HAQ-DI)
Purpose	To assess physical functional disability
Indications	PsA, RA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	Beginning of November 2025 – present
References	1. Bruce B, Fries JF. The Health Assessment Questionnaire (HAQ). *Clin Exp Rheumatol.* 2005;23(5 Suppl 39):S14–S18. https://pubmed.ncbi.nlm.nih.gov/16273794 2. Instructions for score calculation obtained from the Developer (James F. Fries)
Calculation	The HAQ-DI consists of 20 questions covering everyday activities in 8 domains: dressing/grooming, arising, eating, walking, hygiene, reach, grip, and activities. Each answer is scored from 0 (no difficulty) to 3 (unable to do). A domain's score is the highest score reported for its questions. Use of assistive devices or help

	required from others increases a domain's score of 0 or 1 to 2. The HAQ-DI is the mean across all 8 domain scores and reported with two decimal places. The range is from 0 to 3, with lower values indicating less disability.
Handling of Missing Values	The score is calculated if at least 6 of the 8 domains have been answered, meaning that at least one question within each of those domains has a response. If one or more domain scores are missing, the HAQ-DI is calculated as the mean of the available domain scores.
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2.1.17. mHAQ-DI

Name	modified Health Assessment Questionnaire Disability Index (mHAQ-DI); *see 2.1.16 HAQ-DI*
Display	Graphical scoreboard, mySCQM
Data Collection Period	≤ 2009 – end of October 2025
Calculation	Until the end of October 2025, the questionnaire presented to patients did not include the following aids or devices: • *Eating domain*: built up or special utensils (e.g., for eating and cooking) • *Walking domain*: walker • *Hygiene domain*: long-handled appliances in bathroom (e.g. a bath brush), bathtub bar
Remarks	In addition to the missing aids or devices, no specific timeframe was provided for patients to base their answers on. Due to the omission of some aids or devices the mHAQ-DI tends to underestimate the level of disability compared to the standard HAQ-DI. The mHAQ-DI remains available to preserve previously entered patient data and to ensure that past results remain accessible for review and longitudinal comparison within the same score.

2.1.18. PhGA

Name	Physician Global assessment of disease Activity (PhGA)
Purpose	To assess the physician's overall impression of the patient's current disease activity
Indications	axSpA, PsA, RA, UA

Data Sources	Physician-reported
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	1. Boers M, Tugwell P, Felson DT, et al. World Health Organization and International League of Associations for Rheumatology core endpoints for symptom modifying antirheumatic drugs in rheumatoid arthritis clinical trials. *J Rheumatol.* 1994;41(Suppl 41):86–89. https://pubmed.ncbi.nlm.nih.gov/7799394/
Details	The physician selects a value on a 0-10 NRS based on their overall clinical impression (wording: «Global assessment of the patient's disease activity by the physician»).
Calculation	NA
Handling of Missing Values	NA
Copyright	Public domain

2.1.19. PtGA

Name	Patient Global assessment of disease Activity (PtGA)
Purpose	To assess the patient's overall perception of their disease activity
Indications	axSpA, GCA, PMR, PsA, RA, UA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits, optionally between visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	axSpA: ≤ 2009 – present PsA, RA, UA: 2021 – present GCA, PMR: Beginning of November 2025 – present
References	1. Boers M, Tugwell P, Felson DT, et al. World Health Organization and International League of Associations for Rheumatology core endpoints for symptom modifying antirheumatic drugs in rheumatoid arthritis clinical trials. *J*

	Rheumatol. 1994;41(Suppl 41):86–89. https://pub-med.ncbi.nlm.nih.gov/7799394/
Details	The patient selects a value on a 0-10 NRS (0 = completely inactive, 10 = extremely active) based on their perception of overall disease activity (wording: «How active was your rheumatic disease over the past 7 days?»).
Calculation	NA
Handling of Missing Values	NA
Copyright	Public domain
Remarks	Until the end of October 2025, patients were asked to rate their *current* disease activity. From that point onward, the question was rephrased to refer to disease activity during the *past week*.

2.1.20. RADAI-5

Name	Rheumatoid Arthritis Disease Activity Index – 5 (RADAI-5)
Purpose	To assess disease activity as conceived by the patient
Indications	RA
Data Sources	PRO
Frequency of Assessment	Annual and interim visits, optionally between visits
Display	Tabular and graphical scoreboard, mySCQM
Data Collection Period	Beginning of November 2025 – present
References	1. Leeb BF, Haindl PM, Maktari A, et al. Patient-centered rheumatoid arthritis disease activity assessment by a modified RADAI (RADAI-5). *J Rheumatol.* 2008;35(7):1294–1299. https://www.jrheum.org/content/35/7/1294
Calculation	The RADAI-5 consists of 5 questions assessing disease activity over the past 6 months, joint tenderness/swelling, pain, duration of morning stiffness, and general health each answered on a 0-10 NRS (0 = none, 10 = extreme). The RADAI-5 is the mean across all 5 questions. The range is from 0 to 10, with lower values indicating lower disease activity.
Handling of Missing Values	The RADAI-5 is calculated if at least 4 of the 5 questions are answered. When answers are missing, the RADAI-5 is computed as the mean of the available items, rounded to one decimal place.

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2.1.21. mRADAI-5

Name	modified Rheumatoid Arthritis Disease Activity Index – 5 (mRA-DAI-5); *see 2.1.20 RADAI-5*
Display	Graphical scoreboard, mySCQM
Data Collection Period	≤ 2009 – end of October 2025
References	1. Houssien DA, Stucki G, Scott DL, et al. A patient-derived disease activity score can substitute for a physician-derived disease activity score in clinical research. *Rheumatology (Oxford)*. 1999;38(1):48–52. https://doi.org/10.1093/rheumatology/38.1.48
Calculation	Until the end of October 2025, the questionnaire presented to patients included a question on the duration of morning stiffness based on the original RADAI questionnaire. This item was assessed using an ordinal scale with 7 categories that were valuated with 0-6 for the calculation of RADAI. For the RADAI-5, these values were transformed to the 0–10 range (value / 6 × 10) prior to averaging across components.
Remarks	The transformation of the RADAI question about morning stiffness is questionable. mRADAI-5 should not be compared directly with RADAI-5. The mRADAI-5 remains available to preserve previously entered patient data and to ensure that past results remain accessible for review and longitudinal comparison within the same score.

2.1.22. SJC 28

Name	Swollen Joint Count – 28 (SJC 28)
Purpose	To assess the extent of articular swelling
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present

References	1. Fuchs HA, Brooks RH, Callahan LF, et al. A simplified twenty-eight–joint quantitative articular index in rheumatoid arthritis. *Arthritis & Rheumatism: Official Journal of the American College of Rheumatology.* 1989;32(5):531–537. https://doi.org/10.1002/anr.1780320504
Calculation	The SJC 28 is the number of joints with swelling out of a set of 28 joints (shoulders, elbows, wrists, hand MCPs 1–5, hand PIP joints 2–5, IP joints, and knees). The range is from 0 to 28, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint swelling is recorded using the 28-, 44-, or 66-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The SJC 28 equals the number of affected sites among the 28 joints. If no sites are marked as affected, the count is set to 0 only if all 28 sites are marked «not affected»; otherwise, it remains missing.
Copyright	Public domain

2.1.23. SJC 44

Name	Swollen Joint Count – 44 (SJC 44)
Purpose	To assess the extent of articular swelling
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	NA
Calculation	The SJC 44 is the number of joints with swelling out of a set of 44 joints (28 joint set, see 2.1.22, plus sternoclavicular joints, acromioclavicular joints, and foot PIP joints 1–5). The range is from 0 to 44, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint swelling is recorded using the 44-, or 66-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The SJC 44 equals the number of affected sites among the 44 joints. If no sites are marked as

	affected, the count is set to 0 only if all 44 sites are marked «not affected»; otherwise, it remains missing.
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2.1.24. SJC 66

Name	Swollen Joint Count – 66 (SJC 66)
Purpose	To assess the extent of articular swelling
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	≤ 2009 – present
References	1. Smythe HA, Helewa A, Baker S, et al. A seven-day variability study of 499 patients with peripheral rheumatoid arthritis. Arthritis Rheum. 1964;7:500–506. https://pubmed.ncbi.nlm.nih.gov/14280261
Calculation	The SJC 66 is the number of joints with swelling out of a set of 66 joints (44 joint set, see 2.1.23, plus temporomandibular joints, hand DIP joints 2–5, MTP joints 1–5, and subtalar joints). The range is from 0 to 66, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint swelling is recorded using the 66-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The SJC 66 equals the number of affected sites among the 66 joints. If no sites are marked as affected, the count is set to 0 only if all 66 sites are marked «not affected»; otherwise, it remains missing.
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Remarks	The hip joints are not included in the SJC 66 (unlike for TJC 68, see 2.1.29, because they are difficult to palpate reliably during a physical examination.

2.1.25. B-mode Score (SONAR)

Name	Grayscale (B) mode Score

Purpose	To assess the burden of synovitis (structural changes)
Indications	RA
Data Sources	Physician-assessed (ultrasound)
Frequency of Assessment	Annual and interim visits
Display	Tabular scoreboard
Data Collection Period	≤ 2009 – present
References	1. Zufferey P, Tamborrini G, Gabay C, et al. Recommendations for the use of ultrasound in rheumatoid arthritis: literature review and SONAR score experience. *Swiss Med Wkly.* 2013;143:w13861. https://doi.org/10.4414/smw.2013.13861
Calculation	The B-mode score is the sum across 22 joints (elbows, wrists, hand MCPs 2–5, hand PIP joints 2–5, and knees) assessed for signs of synovitis (0 = normal, 1 = mild, 2 = moderate, 3 = severe). The range is from 0 to 66, with lower values indicating a smaller burden of synovitis.
Handling of Missing Values	Missing sites are interpreted as «normal» if at least one site is marked as «normal», «mild», «moderate» or «severe»; otherwise, it remains missing.
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2.1.26. PD Dorsal Score (SONAR)

Name	Power Doppler (PD) Dorsal Score
Purpose	To assess the burden of synovitis (active inflammation)
Indications	RA
Data Sources	Physician-assessed (ultrasound)
Frequency of Assessment	Annual and interim visits
Display	Tabular scoreboard
Data Collection Period	≤ 2009 – present
References	1. Zufferey P, Tamborrini G, Gabay C, et al. Recommendations for the use of ultrasound in rheumatoid arthritis:

	literature review and SONAR score experience. *Swiss Med Wkly.* 2013;143:w13861. https://doi.org/10.4414/smw.2013.13861
Calculation	The PD dorsal score is the sum across 22 joints (elbows, wrists, hand MCPs 2–5, hand PIP joints 2–5, and knees) assessed for signs of synovitis (0 = normal, 1 = mild, 2 = moderate, 3 = severe). The range is from 0 to 66, with lower values indicating a smaller burden of synovitis.
Handling of Missing Values	Missing sites are interpreted as «normal» if at least one site is marked as «normal», «mild», «moderate» or «severe»; otherwise, it remains missing.
Copyright	Public domain

2.1.27. TJC 28

Name	Tender Joint Count – 28 (TJC 28)
Purpose	To assess the extent of articular tenderness
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA: 2021 – present PsA, RA, UA: ≤ 2009 – present
References	1. Fuchs HA, Brooks RH, Callahan LF, et al. A simplified twenty-eight–joint quantitative articular index in rheumatoid arthritis. *Arthritis & Rheumatism: Official Journal of the American College of Rheumatology.* 1989;32(5):531–537. https://doi.org/10.1002/anr.1780320504
Calculation	The TJC 28 is the number of tender joints out of a set of 28 joints (shoulders, elbows, wrists, hand MCPs 1–5, hand PIP joints 2–5, IP joints, and knees). The range is from 0 to 28, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint tenderness is recorded using the 28-, 44-, or 68-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The TJC 28 equals the number of affected sites among the 28 joints. If no sites are marked as affected, the count is set to 0 only if all 28 sites are marked «not affected»; otherwise, it remains missing.

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2.1.28. TJC 44

Name	Tender Joint Count – 44 (TJC 44)
Purpose	To assess the extent of articular tenderness
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)
Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA: 2021 – present PsA, RA, UA: ≤ 2009 – present
References	NA
Calculation	The TJC 44 is the number of tender joints out of a set of 44 joints (28 joint set, see 2.1.27, plus sternoclavicular joints, acromiocla-vicular joints, and foot PIP joints 1–5). The range is from 0 to 44, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint tenderness is recorded using the 44-, or 68-pup-pet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The TJC 44 equals the number of af-fected sites among the 44 joints. If no sites are marked as af-fected, the count is set to 0 only if all 44 sites are marked «not af-fected»; otherwise, it remains missing.
Copyright	Public domain

2.1.29. TJC 68

Name	Tender Joint Count – 68 (SJC 68)
Purpose	To assess the extent of articular tenderness
Indications	axSpA, PsA, RA, UA
Data Sources	Physician-assessed (physical examination)

Frequency of Assessment	Annual and interim visits
Display	Tabular and graphical scoreboard
Data Collection Period	axSpA: 2021 – present PsA, RA, UA: ≤ 2009 – present
References	1. Smythe HA, Helewa A, Baker S, et al. A seven-day variability study of 499 patients with peripheral rheumatoid arthritis. Arthritis Rheum. 1964;7:500–506. https://pub-med.ncbi.nlm.nih.gov/14280261
Calculation	The TJC 68 is the number of tender joints out of a set of 68 joints (44 joint set, see 2.1.28, plus temporomandibular joints, hand DIP joints 2–5, MTP joints 1–5, subtalar joints, and hip joints). The range is from 0 to 68, with lower values indicating a smaller extent.
Handling of Missing Values	If individual joint tenderness is recorded using the 68-puppet, missing sites are interpreted as «not affected» if at least one site is marked as «affected». The TJC 68 equals the number of affected sites among the 68 joints. If no sites are marked as affected, the count is set to 0 only if all 68 sites are marked «not affected»; otherwise, it remains missing.
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2.2. Scores Assessed Between Clinical Visits

The following scores are derived exclusively from data entered by patients through mySCQM between clinical visits using short questionnaires. They do not appear in the tabular view of the physician's scoreboard, but they are displayed in the graphical scoreboard for both patients and physicians.

2.2.1. ASAS NSAID intake / Dougados Score

Name	Assessment of SpondyloArthritis international Society (ASAS) Non-Steroidal Anti-Inflammatory Drugs (NSAID) intake / Dougados Score
Purpose	To quantify NSAID intake
Indications	axSpA, GCA, PMR, PsA, RA, UA
Data Sources	PRO
Frequency of Assessment	Between clinical visits
Display	Graphical scoreboard, mySCQM
Data Collection Period	axSpA, PsA, RA, UA: 2016 – present GCA, PMR: 2021 – present
References	1. Dougados M, Simon P, Braun J, et al. NSAID intake score in evaluating the treatment effect of NSAIDs in ankylosing spondylitis: the ASAS NSAID score. *Ann Rheum Dis.* 2011;70(1):143–146. https://doi.org/10.1136/ard.2010.133488 2. ASAS NSAID intake score – Calculator
Calculation	The score represents the average daily NSAID dose taken over the past seven days, expressed as a percentage of 150 mg of diclofenac. For example, a score of 100 indicates that the average daily NSAID dose was equivalent to 150 mg of diclofenac. The range is from 0 to 100 and more, rounded to one decimal place, with lower values indicating less NSAID intake.
Handling of Missing Values	The score is calculated provided that complete information on all NSAIDs taken is recorded and the dose equivalent to 150 mg of diclofenac is known for each reported NSAID.
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