



Case study: Improving access to DXA for high-risk fracture patients - KPI 5 DXA within 90 days

Oxfordshire Fracture Prevention Service

L Bershini, DXA Radiographer

MK Javaid, Rheumatology

Background

With NICE TA791 recommending romosozumab for postmenopausal people with a fracture of the hip, humerus, wrist or spine AND severe osteoporosis (as defined by a lowest T score of ≤ -3.5 or ≤ -2.5 with vertebral fractures or very high fracture risk on FRAX (NOGG/ ROS 2022)), there was a recognition that a population of FLS patients who we previously would have commenced on anti-resorptive treatments without DXA would now need a DXA. This would increase the demand on DXA services and for urgent DXAs with no increase in DXA capacity. Already our KPI 5 of DXA within 12 weeks achievement had dipped to 52.6%.

Aim

To ensure 80% patients who were identified at very high fracture risk and need a DXA can get a DXA within 12 weeks.

Process

We set up an improvement team made up of the FLS lead, consultant, FLS nurse, DXA radiographers and 2 patients.

We discussed this priority in our 6 weekly multidisciplinary governance meeting to identify the key causes of delays in DXA and potential solutions.

We audited who was currently having a DXA and if there was any DXA backlog. The audit checked if the DXA was their first or repeat DXA, if this was on or off anti-osteoporosis treatment and if FRAX was used prior to referral.

We then met regularly online to understand the possible options for prioritising DXA scans for high fracture risk patients in a sustainable way.

Interventions:

- 1) BACKLOG: To clear any patients in a backlog, write back to the referrer to use FRAX alone to guide treatment.
- 2) REPEAT DXA: We identified over 40% of DXA were for repeat scans and there was no rule for how short this interval should be. We created a general minimum interval for repeat DXA to reduce potentially low value impact DXA scans based on the published literature:
Not on any medication=3 years; Oral agents=5 years, Zoledronate= 4 or 7 years as per NOGG; Denosumab= only DXA if major fracture on treatment and potential eligible for anabolics; Anabolics= not recommended, just sequence. There are exceptions for patients with a fracture on treatment or other risks for very rapid bone loss.
- 3) Referrals from FLS for DXA that include romo are fast tracked and can access lunchtime DXA slots
- 4) For primary fracture prevention: need to FRAX first.



Outcomes

The new guideline was successfully integrated into the DXA triage pathway by the radiographers. This included writing back to referrers when the referral was rejected with a copy of the DXA monitoring guide. We now manage to DXA all high-risk patients within 12 weeks. Overall KPI 5 has improved to between 70 to 80%. Although we were concerned that some high-risk patients would decline a DXA so soon after their fracture, when they knew why this was being done, most turned up.

Summary

It is important to measure and understand the current pathway in more detail. As an FLS we had no idea how many DXA scans were repeat scans or there was no guideline for when to do a repeat scan. Meeting with the DXA team was very important as well as with patients as they gave us good feedback that while patient would like a repeat DXA, patients would not want this if it meant another patient would not get to start their treatment on time.

1. Audit your DXA scans - who is getting scanned, first time or second time, what is the benefit. Local current data is key.
2. Clear the backlog using a 'treat according to FRAX' letter if it is unrealistic to expect the backlog to be cleared in the next 3 months.
3. Create a local guideline based on the evidence and value of a repeat scan with all the stakeholders and communicate to primary care and patients.