



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF’s measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 2525

Corresponding Measures:

De.2. Measure Title: Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy (Reccomended for eMeasure Trial Approval)

Co.1.1. Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY

De.3. Brief Description of Measure: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who are newly prescribed disease modifying anti-rheumatic drug (DMARD) therapy within 12 months.

1b.1. Developer Rationale: The American College of Rheumatology (ACR) guidelines recommend the use of disease-modifying antirheumatic drugs (DMARDs) in every patient with active RA at the earliest stage of disease, ideally within 3 months of disease onset. These guidelines are based on results from numerous clinical trials demonstrating that DMARDs slow the progression of RA by decreasing inflammation and reducing articular erosions. In addition, both clinical trials and observational studies demonstrate that DMARDs improve functional status and health-related quality of life. Both underuse and disparities in DMARD use have been well-documented in numerous studies.

Sources:

Singh JA, Furst DE, Bharat A, Curtis JR. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res (Hoboken)*. 2012 May;64(5):625-39.

Schmajuk G, Trivedi AN, Solomon DH, Yelin E, Trupin L, Chakravarty EF, Yazdany J. Receipt of disease-modifying antirheumatic drugs among patients with rheumatoid arthritis in Medicare managed care plans. *JAMA*. 2011 Feb 2;305(5):480-6.

Schmajuk G, Solomon DH, Yazdany J. Patterns of disease-modifying antirheumatic drug use in rheumatoid arthritis patients after 2002: a systematic review. *Arthritis Care Res (Hoboken)*. 2013 Dec;65(12):1927-35.

S.4. Numerator Statement: Patient received a DMARD

S.6. Denominator Statement: Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

S.8. Denominator Exclusions: Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

De.1. Measure Type: Process

S.17. Data Source: Electronic Health Records, Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Nov 10, 2014 **Most Recent Endorsement Date:** Oct 24, 2019

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret

results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[DMARD_Evidence_Form_Final.docx](#), [DMARD_evidence_form_2019_FINAL.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

The American College of Rheumatology (ACR) guidelines recommend the use of disease-modifying antirheumatic drugs (DMARDs) in every patient with active RA at the earliest stage of disease, ideally within 3 months of disease onset. These guidelines are based on results from numerous clinical trials demonstrating that DMARDs slow the progression of RA by decreasing inflammation and reducing articular erosions. In addition, both clinical trials and observational studies demonstrate that DMARDs improve functional status and health-related quality of life. Both underuse and disparities in DMARD use have been well-documented in numerous studies.

Sources:

Singh JA, Furst DE, Bharat A, Curtis JR. 2012 update of the 2008 American College of Rheumatology recommendations for the use of disease-modifying antirheumatic drugs and biologic agents in the treatment of rheumatoid arthritis. *Arthritis Care Res (Hoboken)*. 2012 May;64(5):625-39.

Schmajuk G, Trivedi AN, Solomon DH, Yelin E, Trupin L, Chakravarty EF, Yazdany J. Receipt of disease-modifying antirheumatic drugs among patients with rheumatoid arthritis in Medicare managed care plans. *JAMA*. 2011 Feb 2;305(5):480-6.

Schmajuk G, Solomon DH, Yazdany J. Patterns of disease-modifying antirheumatic drug use in rheumatoid arthritis patients after 2002: a systematic review. *Arthritis Care Res (Hoboken)*. 2013 Dec;65(12):1927-35.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Data source: Performance among providers and practices participating in the Rheumatology Informatics System for Effectiveness (RISE) registry during the measurement periods

Average performance over time

Dates: July 1, 2014 through June 30, 2016

Practices: 44

Providers: 223

2014 Q3: 90.87%
2014 Q4: 90.75%
2015 Q1: 93.38%
2015 Q2: 91.61%
2015 Q3: 91.51%
2015 Q4: 91.52%
2016 Q1: 91.5%
2016 Q2: 91.6%

Most recent performance
Dates: January 1, 2017 through December 31, 2017
Practices: 107
Setting: 73% group, 25% solo practitioner, 2% health system
Patients: 94,872

Mean: 90.47%
Standard Deviation: 9.62%
Min: 28.17%
Max: 100.00%
Interquartile Range: 6.42%

Deciles
10%: 84.63%
20%: 88.03%
30%: 89.38%
40%: 90.96%
50%: 93.03%
60%: 94.14%
70%: 95.12%
80%: 95.94%
90%: 97.23%
100%: 100.00%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Relevant disparities data are not routinely and uniformly collected on all patients within the RISE registry.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

o This measure is not risk-adjusted and the RISE registry has limited data on social risk factors. Furthermore, optimal clinical performance for this measure should be 100%, regardless of social risk, as this measure reflects the minimum performance standard. Nevertheless, as part of RISE's ongoing efforts to expand and improve, the American College of Rheumatology is exploring

ways to obtain better social risk data to appropriately monitor performance disparities going forward. However, we know from literature that disparities in DMARD use by race/ethnicity, socioeconomic status, age and geographic location have been reported in several well-conducted studies, some applying a similar performance measure.

The largest study examined nationwide performance data on the HEDIS DMARD quality measure in over 90,000 individuals with RA enrolled in Medicare managed care plans. According to Schmajuk, et al., blacks (-4 absolute percentage points; 95% CI, -6 to -2 points; P < .001), those with low socioeconomic status (-4 points; 95% CI, -6 to 2 points; P < .001), older individuals (-30 points; 95% confidence interval [CI], -29 to -32 points; P < .001) and those residing in certain geographic regions (in the Middle Atlantic region (-7 points; 95% CI, -13 to -2 points; P < .001) and South Atlantic regions (-11 points; 95% CI, -20 to -3 points; P < .001) as compared with the Pacific region) were significantly less likely to receive a DMARD for RA.

Several additional studies using the Medicare Current Beneficiaries Survey, nationwide data from the Medicare fee-for-service population, and clinic-based populations have also found significant disparities in DMARD use. Solomon, et al. noted, “DMARD use declined significantly at older ages (compared with <75 years: ages 75 to 84, OR 0.58, 95% CI 0.37, 0.92, and age 85 and over, OR 0.09, 95% CI 0.02, 0.31).”

Suarez-Almazor, et al. studied disparities in the median time from onset of disease to initiation of DMARD therapy. They found a significant difference in timing between White patients, 1 year, and non-White patients, 7 years (p < 0.0001).

Even when looking at patients with expanded drug coverage under Part D, Yazdany et al. discovered disparities in DMARD use. “Beneficiaries with low incomes were more likely to receive glucocorticoids alone (12.3%; 95% confidence interval [95% CI] 10.9-13.8% versus 9.4%; 95% CI 8.6-10.1%), as were those living in certain US regions.” They found it was more common for patients to only be on glucocorticoid without a DMARD in the Mid-Atlantic region (14.4%; 95% CI 12.3–16.5%) compared to the Pacific region (8.5%; 95% CI 6.7–10.2%).

Sources:

Schmajuk G, Trivedi AN, Solomon DH, Yelin E, Trupin L, Chakravarty EF, Yazdany J. Receipt of disease-modifying antirheumatic drugs among patients with rheumatoid arthritis in Medicare managed care plans. JAMA. 2011 Feb 2;305(5):480-6.

Solomon DH, Yelin E, Katz JN, Lu B, Shaykevich T, Ayanian JZ. Treatment of rheumatoid arthritis in the Medicare Current Beneficiary Survey. Arthritis Res Ther. 2013 Mar 18;15(2):R43.

Suarez-Almazor ME, Berrios-Rivera JP, Cox V, Janssen NM, Marcus DM, Sessoms S. Initiation of disease-modifying antirheumatic drug therapy in minority and disadvantaged patients with rheumatoid arthritis. J Rheumatol. 2007 Dec;34(12):2400-7.

Yazdany J, Tonner C, Schmajuk G et al. Receipt of Glucocorticoid Monotherapy Among Medicare Beneficiaries with Rheumatoid Arthritis. Arthritis Care Res (Hoboken). 2014 Oct; 66(10): 1447–1455.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):
Musculoskeletal : Rheumatoid Arthritis

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

<https://www.rheumatology.org/Portals/0/Files/DMARD-Measure.pdf>

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [DMARD_Value_Sets_Updated_2018-03-30.xls](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Current HQMF specifications were insufficient to capture all the data elements required for measurement. Also, we have practices participating in the ACR's RISE registry using more than 30 different electronic health record vendors. Based on member input, ACR made a conscious decision to provide the most flexible route to electronic health record data-based measurement and avoid forcing individual practitioners to change their workflow and documentation to satisfy requirements for HQMF specifications. Finally, as the majority of RISE participants are solo or small practices and unaffiliated with an academic or other institution, few have IT services sufficient to support modifications to their electronic health records to meet eCQM standards. For these reasons, we decided to change this from an eMeasure to a standard quality measure.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) **DO NOT** include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patient received a DMARD

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

DMARD therapy includes:

abatacept

adalimumab
Adalimumab-adbm
Adalimumab-atto
anakinra
certolizumab
etanercept
Etanercept-szsz
golimumab
infliximab
Infliximab-abda
Infliximab-dyyb
Infliximab-qbtx
Sarilumab
rituximab
tocilizumab
Tofacitinib
Non-Biologic Agents-
auranofin
azathioprine
gold
hydroxychloroquine
leflunomide
methotrexate
minocycline
penicillamine
sulfasalazine

Anti-inflammatory medications, including glucocorticoids do not meet the measure.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)
Patient age 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)
IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).
Patients 18 years and older with a diagnosis of Rheumatoid Arthritis seen for two or more encounters for Rheumatoid Arthritis during the measurement period.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)
Patients with a diagnosis of HIV; patients who are pregnant; or patients with inactive Rheumatoid Arthritis.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)
Patients who have a diagnosis of HIV, who are pregnant, or have inactive rheumatoid arthritis can be identified using the ICD-9, ICD-10, and/or SNOMED diagnosis codes included in S2b.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

CASES MEETING TARGET PROCESS/TARGET POPULATION

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

A random sample is obtained by assigning each patient a sequential number and then using a random number generator to select patients.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Electronic Health Records, Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

Data source 1: electronic health records

Instrument: RA Measure Testing Data Collection Form

Data source 2: Rheumatology Informatics System for Effectiveness (RISE) Registry

Data collection: passive abstraction from EHR

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

Available in attached appendix at A.1

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A
<p>2. Validity – See attached Measure Testing Submission Form DMARD_Measure_Testing_Form_Final.docx,DMARD_measure_testing_form_January_2019_FINAL_Updated_4.3.2019-636912729262571589.docx</p> <p>2.1 For maintenance of endorsement <i>Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.</i> Yes</p> <p>2.2 For maintenance of endorsement <i>Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.</i> Yes</p> <p>2.3 For maintenance of endorsement <i>Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.</i> No - This measure is not risk-adjusted</p>

<p>3. Feasibility</p> <p>Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.</p> <p>3a. Byproduct of Care Processes For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p> <p>3a.1. Data Elements Generated as Byproduct of Care Processes. Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims) If other:</p> <p>3b. Electronic Sources The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.</p> <p>3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for <u>maintenance of endorsement</u>. ALL data elements are in defined fields in a combination of electronic sources</p> <p>3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For <u>maintenance of endorsement</u>, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM). As noted in S.3.2., the ACR made a conscious decision to move away from an eCQM in order to provide the most flexible route to electronic health record data-based measurement and avoid forcing individual practitioners to change their workflow and</p>

documentation to satisfy requirements for HQMF specifications. The ACR will continue to monitor developments in coding and HQMF specifications to determine if the updates would provide the necessary flexibility to make this measure an eCQM.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment: [RA_Feasibility_Survey_Responses_-_Data_Element_Scores.xls](#)

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Testing did not uncover any additional issues with this measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Program: [The Rheumatology Informatics System for Effectiveness \(RISE\) registry](#)

Sponsor: [American College of Rheumatology](#)

Purpose: [To help prepare rheumatologists for the significant challenges of a rapidly changing healthcare environment, including adapting to new payment and delivery models, meeting evolving certification requirements, and using EHR data to assess quality of care.](#)

Geographic area: [United States](#)

Number of entities and patients: As of January 3, 2019, 937 rheumatology providers participated in RISE, representing 1,787,394 patients

Level of measurement: provider and practice

Setting: Solo practice, single-specialty group practice, multi-specialty group practice

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The measure as specified was part of CMS's PQRS payment program. However, they declined to carryover this measure when they transitioned to the MIPS payment program. We will be meeting with CMS and plan to discuss how to make this measure acceptable for use in MIPS.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

This measure continues to be tracked in the ACR's RISE registry. While the main purpose of the registry has been to help providers meet federal reporting requirements, the ACR is actively pursuing opportunities with private payers to track performance on a variety of quality measures, including this measure, through the RISE registry in order to identify high quality providers and determine payment reimbursement. In particular, the ACR is working to develop a value recognition program that sets high quality thresholds for each measure that providers must meet as opposed to having providers compete against their peers. Discussions around the specific program details and timeline are ongoing and contain sensitive information. However, the ACR has a vested interest in developing and implementing this additional use of the RISE registry as quickly as possible. In addition, we are actively working with CMS to ensure as many of the ACR's measures as possible are either designated as QCDR measures or as MIPS measures.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

For information on feedback from those being measured during measure development, please refer to the validity testing in section 2.

For implementation, those being measure are deeply involved in the process. Measure performance is shared with rheumatology providers via the ACR's RISE registry. Participating providers work closely with the registry technology vendor to ensure data is being extracted from their EHR correctly and portrayed accurately via the registry's analytic dashboard. Through the RISE dashboard, providers are able to see their individual overall performance on the measure, their practice's overall performance on the measure, and the average performance of all RISE users on the measure. Each provider is also able to drill down into their measure performance to see the patients who qualify for the denominator and the numerator. Furthermore, providers have direct access to the human readable measure specifications in the dashboard. If they have any questions or concerns about how the measure is being calculated or the specifications in general, they are able to contact both ACR staff and the registry technology vendor staff directly. This allows providers the ability to confirm the accuracy of their measure performance, review how their own practices impact their measure performance, and get any questions on measure interpretation answered directly by the measure owner.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

The analytic dashboard for all RISE providers is updated every month following the most recent data extraction. All providers have constant access to their analytic dashboard to review the measure specifications and their measure performance. ACR and vendor staff are available during regular business hours to answer their questions over the phone or via e-mail.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

RISE users communicate directly with the registry technology vendor and ACR staff over the phone and via e-mail.

4a2.2.2. Summarize the feedback obtained from those being measured.

When communicating with staff, they have said that this and the other measures included in the registry to be very helpful in understanding the quality of care they provide patients. When a provider first joins the RISE registry, most often they note that they expected higher performance on their measures. However, through their work with the registry technology vendor and the analytic dashboard, they are able to see an objective analysis of their data and realize that they are not providing as high of quality care as they assumed. The other most common feedback received on this measure is focused on ways to identify the various data elements in the measure. For example, a provider may use a different tool than approved for use in the measure or document a lab result in a different way than expected.

4a2.2.3. Summarize the feedback obtained from other users

As far as we are aware, this measure has only been implemented in the RISE registry. As mentioned in 4a1.2., this measure was previously used by RISE participants for PQRS reporting. However, when CMS transitioned to MIPS, they did not carryover this measure. We will be meeting with CMS and plan to discuss how to make this measure acceptable for use in MIPS. Because of this, we have not yet received feedback from other entities.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

As noted, RISE providers have direct communication with the registry vendor and ACR staff. They are able to ask questions and share concerns directly with the ACR and receive prompt feedback. As needed, ACR staff are able to take questions and concerns to a team of rheumatology volunteers with expertise in quality measurement. Feedback from ACR and the quality measure experts is then used to improve the guidance on quality measure implementation for both the registry technology vendor and the provider.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

The relatively high performance over time reflects intense attention paid to DMARD treatment by rheumatology societies and evidence supporting the value of early, aggressive use of DMARDs. It may also reflect the increasing numbers of DMARDs available to the US market (enabling patients who have failed other DMARDs to try new DMARDs), as well as increased direct to consumer advertising (resulting in higher patient acceptance rates and likely greater patient-driven discussions about initiating DMARDs. Even with this improvement, the variation in results indicates continued need for monitoring and assessing performance on this measure, especially as more practices continue to join RISE.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

As noted in S.3.2, we found that many providers were documenting key aspects of the measure data elements in free text or other non-standardized formats. Only a portion of providers have laboratory data and/or prescription data integrated into their outpatient electronic health record, further complicating the ability to pull HQMF-formatted specifications.

We are unaware of any negative or unintended impacts on patients due to measurement.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

We received positive feedback from several participating providers. This included both the benefits of better understanding provider variation within practices as well as identification of higher-risk patients such as those with frequent disease flares.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

Measure Title: Rheumatoid Arthritis DMARD Therapy

Owner: NCQA

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

The current NQF-endorsed DMARD measure is specified for claims-based reporting. Our measure is specified for use with EHR data and intended for use in electronic reporting options. Also, the NCQA's DMARD measure does not include "Rheumatoid Arthritis, Inactive" as an exclusion. This exclusion has been incorporated into this submission. Furthermore, measure is built for plan-level analysis, whereas our measure focuses on provider- and practice-level performance. The ACR would be happy to work with NCQA to harmonize the measures.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

The current NQF-endorsed DMARD measure is specified for claims-based reporting. Our measure is specified for use with EHR data and intended for use in electronic reporting options. Also, the NCQA's DMARD measure does not include "Rheumatoid Arthritis, Inactive" as an exclusion. This exclusion has been incorporated into this submission. Furthermore, the NCQA's measure is built for plan-level analysis, whereas our measure focuses on provider- and practice-level performance. The ACR would be happy to work with NCQA to harmonize the measures.

Appendix
<p>A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. Attachment Attachment: Appendix.xlsx</p>
Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): AMERICAN COLLEGE OF RHEUMATOLOGY Co.2 Point of Contact: RACHEL, MYSLINSKI, RMYSLINSKI@RHEUMATOLOGY.ORG, 404-633-3777-824 Co.3 Measure Developer if different from Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY Co.4 Point of Contact: RACHEL, MYSLINSKI, RMYSLINSKI@RHEUMATOLOGY.ORG, 404-633-3777-</p>
Additional Information
<p>Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Jinoos Yazdany, MD, MPH University of California San Francisco Mark Robbins, MD Harvard Vanguard Medical Associates Sonali Parekh Desai, MD Diane V. Lacaille, MD, FRCPC, MHSc Arthritis Research Center Canada Gabby Schmajuk, MD University of California San Francisco Eric Newman, MD Geisinger Medical Center Jasvinder Singh, MD University of Alabama Birmingham Tuhina Neogi, MD Boston University</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? Ad.5 When is the next scheduled review/update for this measure?</p>
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Ad.8 Additional Information/Comments: