**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 2525

**Measure Title**: Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 4/1/2019

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Disease modifying anti-rheumatic drug (DMARD) prescription for patients with rheumatoid arthritis

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

This measure is used to assess the percentage of patients with rheumatoid arthritis dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD).

DMARD prescription 🡪 DMARD use 🡪 decreased disease activity and erosions 🡪 decreased disability, decreased pain, improved functional status, improved health-related quality of life

Disease modifying anti-rheumatic drugs (DMARDs) improve the disease course of rheumatoid arthritis (RA) through attenuation of progression of bony erosions, reduction of inflammation and long-term structural damage. The utilization of DMARDs also improves functional status in individuals with RA. Evidence supports using a “treat to target” approach, where DMARDs are escalated, added and/or replaced to achieve the target of disease remission or low disease activity. This approach has been shown to improve clinical and radiographic outcomes (*Schipper LG et al. A tight control treatment strategy aiming for remission in early rheumatoid arthritis is more effective than usual care treatment in daily clinical practice: a study of two cohorts in the Dutch Rheumatoid Arthritis Monitoring registry. Ann Rheum Dis. 2012 Jun;71(6):845-50; Smolen JS et al. Treating rheumatoid arthritis to target: recommendations of an international task force. Ann Rheum Dis. 2010 Apr;69(4):631-7; Grigor C et al. Effect of a treatment strategy of tight control for rheumatoid arthritis (the TICORA study): a single-blind randomized controlled trial. Lancet 2004;364:263–9.).*

RA is a chronic autoimmune disorder often characterized by progressive joint destruction and multisystem involvement. It affects approximately 1.3 million Americans and affects women disproportionately (*Helmick CG et al., Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. Part I. Am J Public Health. 2012 Mar;102(3):426-33*). There is no cure; consequently, the goal of treatment is to slow the progression of the disease and thereby delay or prevent joint destruction, relieve pain, and maintain functional capacity.

Evidence-based guidelines, summarized below, support early initiation of DMARD therapy in patients diagnosed with RA. All patients with RA are candidates for DMARD therapy, and the majority of newly diagnosed individuals should be started on DMARD therapy within three months of diagnosis.

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

☐ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | * 2015 American College of Rheumatology * Guideline for the Treatment of Rheumatoid Arthritis * Singh J et al. * 2016 Dec * Arthritis Rheumatol.;68(1):1-26 * [**https://onlinelibrary.wiley.com/doi/epdf/10.1002/art.39480**](https://onlinelibrary.wiley.com/doi/epdf/10.1002/art.39480) |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | **Figure 1. Recommendations for patients with symptomatic early RA.**  Figure 1. Recommendations for patients with symptomatic early RA. Summary of 2015 American College of Rheumatology recommendations for the treatment of Early and Established rheumatoid arthritis (RA). Green and bolded = strong recommendation. A strong recommendation means that the panel was confident that the desirable effects of following the recommendation outweigh the undesirable effects (or vice versa), so the course of action would apply to most patients, and only a small proportion would not want to follow the recommendation. Yellow and italicized = conditional recommendation: The desirable effects of following the recommendation probably outweigh the undesirable effects, so the course of action would apply to the majority of the patients, but some may not want to follow the recommendation. |
|  | **Figure 2. Recommendations for patients with established RA.**  Figure 2. Recommendations for patients with established RA. Summary of 2015 American College of Rheumatology recommendations for the treatment of Early and Established rheumatoid arthritis (RA). Green and bolded = strong recommendation. A strong recommendation means that the panel was confident that the desirable effects of following the recommendation outweigh the undesirable effects (or vice versa), so the course of action would apply to most patients, and only a small proportion would not want to follow the recommendation. Yellow and italicized = conditional recommendation: The desirable effects of following the recommendation probably outweigh the undesirable effects, so the course of action would apply to the majority of the patients, but some may not want to follow the recommendation. |
|  | Summary of 2015 American College of Rheumatology recommendations for the treatment of Early and Established rheumatoid arthritis (RA). Green and bolded = strong recommendation. A strong recommendation means that the panel was confident that the desirable effects of following the recommendation outweigh the undesirable effects (or vice versa), so the course of action would apply to most patients, and only a small proportion would not want to follow the recommendation. Yellow and italicized = conditional recommendation: The desirable effects of following the recommendation probably outweigh the undesirable effects, so the course of action would apply to the majority of the patients, but some may not want to follow the recommendation. Because of this, conditional recommendations are preference sensitive and always warrant a shared decision‐making approach. A treatment recommendation favoring one medication over another means that the preferred medication would be the recommended first option and the nonpreferred medication may be the second option. Favoring one medication over the other does not imply that the nonfavored medication is contraindicated for use; it is still an option. Therapies are listed alphabetically; azathioprine, gold, and cyclosporine were considered but not included. Disease‐modifying antirheumatic drugs (DMARDs) include hydroxychloroquine, leflunomide, methotrexate (MTX), and sulfasalazine. PICO = population, intervention, comparator, and outcomes; TNFi = tumor necrosis factor inhibitor. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | See above for grade; below for grade explanation |
| Provide all other grades and definitions from the evidence grading system | **Figure 3. Implications of strong and conditional GRADE (Grading of Recommendations Assessment, Development, and Evaluation) methodology recommendations.**  Figure 3. Implications of strong and conditional GRADE (Grading of Recommendations Assessment, Development, and Evaluation) methodology recommendations. The GRADE method distinguishes 4 levels of quality of evidence based on the degree of confidence that the pooled effect estimate lies close to the true effect. Thus, the quality of evidence for each outcome could be rated as high, moderate, low, or very low. The overall evidence quality grade was the lowest quality rating among the individual outcomes deemed critical for the comparison between interventions. In the absence of any data, the level of evidence was rated as very low, because it was based on clinical experience only.  ∗ = majority means >50% of the people.  The GRADE method distinguishes 4 levels of quality of evidence based on the degree of confidence that the pooled effect estimate lies close to the true effect. Thus, the quality of evidence for each outcome could be rated as high, moderate, low, or very low. The overall evidence quality grade was the lowest quality rating among the individual outcomes deemed critical for the comparison between interventions. In the absence of any data, the level of evidence was rated as very low, because it was based on clinical experience only.  We developed this guideline following the recently revised ACR guideline development process (<http://www.rheumatology.org/Practice-Quality/Clinical-Support/Clinical-Practice-Guidelines> ). This process includes the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) methodology (available at [www.gradeworkinggroup.org](http://www.gradeworkinggroup.org))  Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008;336:924–6.  Andrews J, Guyatt G, Oxman AD, Alderson P, Dahm P, Falck-  Ytter Y, et al. GRADE guidelines: 14. Going from evidence to  recommendations: the significance and presentation of recom-  mendations. J Clin Epidemiol 2013;66:719–25.  Andrews JC, Schunemann HJ, Oxman AD, Pottie K, Meerpohl  JJ, Coello PA, et al. GRADE guidelines: 15. Going from evi-  dence to recommendation: determinants of a recommendation’s  direction and strength. J Clin Epidemiol 2013;66:726–35. |
| Grade assigned to the **recommendation** with definition of the grade | See above |
| Provide all other grades and definitions from the recommendation grading system | See above |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | See above |
| Estimates of benefit and consistency across studies | N/A |
| What harms were identified? | N/A |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | N/A |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**