



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 subcriterion 1b).

Brief Measure Information

NQF #: 2524

De.2. Measure Title: Rheumatoid Arthritis: Functional Status Assessment

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 for whom a functional status assessment was performed at least once during the measurement period.

1b.1. Developer Rationale: Patient-reported outcome (PRO) measurement is a high priority nationally. Among chronic conditions, rheumatoid arthritis (RA) has robust scientific evidence around the validity of functional status PROs. Functional status assessments have been central outcome measures in RA clinical trials and groundbreaking efforts such as the Swedish national RA registry; they are responsive to therapy changes, are strong predictors of future disability and mortality, and can be used to feed back information to both patients and providers on RA to guide management. Functional status assessment is recommended by guidelines of the American College of Rheumatology and other nations.

S.4. Numerator Statement: Number of patients with functional status assessment documented once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.

S.7. Denominator Statement: Patients age 18 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.10. Denominator Exclusions: N/A

De.1. Measure Type: Process

S.23. Data Source: Electronic Clinical Data : Electronic Health Record

S.26. Level of Analysis: Clinician : Individual

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

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.**

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

[Functional_Status_Measure_Evidence_Form_Final.docx](#)

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., the benefits or improvements in quality envisioned by use of this measure) Patient-reported outcome (PRO) measurement is a high priority nationally. Among chronic conditions, rheumatoid arthritis (RA) has robust scientific evidence around the validity of functional status PROs. Functional status assessments have been central outcome measures in RA clinical trials and groundbreaking efforts such as the Swedish national RA registry; they are responsive to therapy changes, are strong predictors of future disability and mortality, and can be used to feed back information to both patients and providers on RA to guide management. Functional status assessment is recommended by guidelines of the American College of Rheumatology and other nations.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Number of Measured Entities: 3

Number of Patients: 223

Dates of Data: January 1, 2013 – December 31, 2013

Performance Rate Overall: 43.78%

Performance Rate Site #1: 62.86%

Performance Rate Site #2: 0.00%

Performance Rate Site #3: 92.18%

Site #2's performance rate is 0 due to data being captured in the notes field as opposed to structured fields. If Site #2 is excluded from the performance score, the results would be:

Number of Measured Entities: 2

Number of Patients: 189

Dates of Data: January 1, 2013 – December 31, 2013

Performance Rate Overall: 77.52%

Performance Rate Site #1: 62.86%

Performance Rate Site #3: 92.18%

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.

Data reported through the ACR's Rheumatology Clinical Registry (RCR) indicate the following performance rates:

CY2011: 69.6%

CY2012: 86.6%

Source:

Yazdany, Jinoos, Kazi, Salahuddin, Francisco, Melissa, Myslinski, Rachel. "Uptake of the American College of Rheumatology's Rheumatology Clinical Registry (RCR): Quality Measure Summary Data". Annual Scientific Meeting. American College of Rheumatology. Reed Convention Center, Washington, DC. 27 October 2013. Conference Presentation.

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.

Since this is a newly proposed e-measure, no disparities data from the measure as specified is yet available.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Since this is a newly proposed e-measure, no disparities data from the measure as specified is yet available. However, disparities in functional status among patients with RA have been reported. Applying a standardized functional status assessment, the Health Assessment Questionnaire (HAQ), Barton et al. found better function among whites compared to nonwhites at a university hospital,

even after controlling for a variety of disease-related and sociodemographic factors. A cross-sectional analysis of 855 African-American patients in the southeastern U.S. found that low socioeconomic status was significantly related to poorer RA disease outcomes, particularly patient-reported outcomes, including HAQ.

Barton JL, Trupin L, Schillinger D, Gansky SA, Tonner C, Margaretten M, Chernitskiy V, Graf J, Imboden J, Yelin E. Racial and ethnic disparities in disease activity and function among persons with rheumatoid arthritis from university-affiliated clinics. *Arthritis Care Res (Hoboken)*. 2011 Sep;63(9):1238-46.

Callahan LF, Cleveland RJ, Li X, et al. Current social position associated with rheumatoid arthritis severity and self-reported health outcomes in African Americans. *Arthritis Rheum*. 2011;63 Suppl 10:1545.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Patient/societal consequences of poor quality

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

The National Priorities Partnership has identified rheumatoid arthritis (RA) as one of the prioritized Top 20 high-impact Medicare conditions. RA affects an estimated 1.3 million Americans. Without appropriate treatment, 1 in 3 individuals with RA progress to permanent disability within 5 years. The societal impact of appropriate RA care is high given the tremendous disability associated with uncontrolled disease. Using functional status assessments is a standard component of guideline-based care.

1c.4. Citations for data demonstrating high priority provided in 1a.3

Helmick CG, Felson DT, Lawrence RC, et al. Estimates of the prevalence of arthritis and other rheumatic conditions in the United States. Part I. *Arthritis Rheum*. 2008 Jan;58(1):15-25.

American College of Rheumatology Subcommittee on Rheumatoid Arthritis Guidelines. Guidelines for the management of rheumatoid arthritis: 2002 Update. *Arthritis Rheum*. 2002 Feb;46(2):328-46.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

The proposed measure is a process measure relating to standardized collection of an important patient-reported outcome. Although there is ongoing research in this area in the United States, most notably a study funded by the Patient-Centered Outcomes Research Institute (PCORI), there are important examples of PRO measurement in rheumatoid arthritis in other countries. A notable example is the Swedish rheumatoid arthritis registry, which has been collecting PRO data for over a decade. Information is fed back to patients, forwarded to providers and also accessible to population health researchers. PROs from the registry have been found to be valuable by patients and have been used to enable a number of important patient empowerment innovations. For example, visual displays of PROs help patients understand their progress, aids in shared decision-making, and helps patients prepare for physician consultations. PROs also allow “N of 1” trials to test hypotheses about response to treatments. PROs are also used to help patients manage clinical follow-up. Ovretveit et al. summarizes these innovations and the value that they provide to patients.

Ovretveit J, Keller C, Hvitfeldt Forsberg H, Essén A, Lindblad S, Brommels M. Continuous innovation: developing and using a clinical database with new technology for patient-centred care--the case of the Swedish quality register for arthritis. *Int J Qual Health Care*. 2013 Apr;25(2):118-24.

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 subcriteria 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. Cross Cutting Areas (check all the areas that apply):

Functional Status

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.)

N/A

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the 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)

Attachment Attachment: [Functional_Status_Assessment_Updated_Human_Readable-635291745679791340.docx](#)

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: [Functional_Status_Assessment_Updated_Value_Sets.xls](#)

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

N/A

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)

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

Number of patients with functional status assessment documented once during the measurement period. Functional status can be assessed using one of a number of valid and reliable instruments available from the medical literature.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

12 months

S.6. 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, 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.

Functional status can be assessed by using one of a number of instruments, including several instruments originally developed and validated for screening purposes. Examples include, but are not limited to:

- Health Assessment Questionnaire-II (HAQ-II)
- Multi-Dimensional Health Assessment Questionnaire (MDHAQ)
- PROMIS Physical Function 10-item (PROPF10)
- PROMIS Physical Function 20-item (PROPF20)
- PROMIS Physical Function Computerized Adaptive Tests (PROPCAT)

Use of a standardized tool or instrument to assess functional status other than those listed will meet numerator performance.

S.7. Denominator Statement *(Brief, narrative description of the target population being measured)*

Patients age 18 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. Target Population Category *(Check all the populations for which the measure is specified and tested if any):*

S.9. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, 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)*

SEE ATTACHMENT IN S2B

S.10. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

N/A

S.11. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, 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)*

N/A

S.12. Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)*

N/A

S.13. Risk Adjustment Type *(Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)*

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*

N/A

S.15. Detailed risk model specifications *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications *(if not provided in excel or csv file at S.2b)*

N/A

S.16. Type of score:

Rate/proportion

If other:

S.17. 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.18. Calculation Algorithm/Measure Logic *(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; aggregating data; risk adjustment; etc.)*

CASES MEETING TARGET PROCESS / TARGET POPULATION

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)
No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)
If a PRO-PM, identify whether (and how) proxy responses are allowed.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)
If a PRO-PM, specify calculation of response rates to be reported with performance measure results.
N/A

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)
Required for Composites and PRO-PMs.
Lack of clinical documentation in extractable or structured fields may lead to missing data in performance measures derived from the electronic medical record. A variety of clinicians with expertise in both performance measurement and those primarily engaged in clinical care reviewed these instances. The consensus was that because both disease activity and functional status have a reasonable benchmark (more than 50% of visits for disease activity and once per year for functional status), and missing data were infrequent, missing data were unlikely to significantly influence provider performance. Statistical analysis of our testing sites found no instance in which such missing data influenced a provider's performance on a measure.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).
If other, please describe in S.24.
Electronic Clinical Data : Electronic Health Record

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)
If a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
Data source: electronic health records
Instrument: RA MEASURE TESTING DATA COLLECTION FORM

S.25. 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.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)
Clinician : Individual

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)
Ambulatory Care : Clinician Office/Clinic
If other:

S.28. 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

2a. Reliability – See attached Measure Testing Submission Form
2b. Validity – See attached Measure Testing Submission Form
Functional_Status_Measure_Testing_Form_Final.docx

3. Feasibility

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.

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).

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:

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.

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)

ALL data elements are in defined fields in a combination of electronic sources

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.

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.

Attachment [Attachment: RA_Feasibility_Survey_Responses_-_Data_Element_Scores-635291968195904640.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. Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

Measurement of functional status patient-reported outcomes (PRO) in routine clinical practice requires workflow changes for many practices. A range of valid PROs for this purpose are available. , The ACR's RA Quality Measures workgroup formally surveyed clinical experts in functional status PRO measurement to determine which measures were felt to be most feasible in routine clinical practice. Information was compiled and presented to an expert panel, members of which formally rated the validity of the proposed PROs. Several PROs assessing functional status (HAQ II, PROMIS physical function – 10, 20 or CAT, and MDHAQ) were supported by rigorous scientific evidence, feasible for implementation in clinical practice, and rated highly by our expert panels. Our testing sites had implemented different measures in routine care, including the HAQ II, PROMIS physical function, and MDHAQ, allowing us to collect data on each of these measurement approaches. Sites provided feedback regarding how these chose specific measures. A variety of factors were considered, including health literacy of the population, time to complete forms, availability in languages other than English, and ease of scoring. For example, one site with a racial/ethnically and socioeconomically diverse patient population and limited staff resources chose the PROMIS physical function 10 form since it takes less than one minute for patients to complete and only a few seconds to score, is short, allowing staff to read items to patients with low health literacy, and is available in multiple languages, including Spanish.

Maska L, Anderson J, Michaud K. Measures of functional status and quality of life in rheumatoid arthritis: Health Assessment Questionnaire Disability Index (HAQ), Modified Health Assessment Questionnaire (MHAQ), Multidimensional Health Assessment Questionnaire (MDHAQ), Health Assessment Questionnaire II (HAQ-II), Improved Health Assessment Questionnaire (Improved HAQ), and Rheumatoid Arthritis Quality of Life (RAQoL). Arthritis Care Res (Hoboken). 2011 Nov;63 Suppl 11:S4-13.

Fries JF, Cella D, Rose M, Krishnan E, Bruce B. Progress in assessing physical function in arthritis: PROMIS short forms and

computerized adaptive testing. *J Rheumatol.* 2009 Sep;36(9):2061-6.

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.

Planned	Current Use (for current use provide URL)
Public Reporting	
Payment Program	
Regulatory and Accreditation Programs	
Professional Certification or Recognition Program	
Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	
Quality Improvement (Internal to the specific organization)	

4a.1. For each CURRENT use, checked above, provide:

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

N/A

4a.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?)

A measure analogous to the proposed e-measure is currently used in the PQRS program, "Patients for whom a functional status assessment was performed at least once within twelve months." The newly proposed measure adds specificity to this older measure by recommending options for PRO assessment to those that have been found to be valid and feasible through the measure development process, which included systematic literature reviews, expert input and formal consensus methodology.

4a.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.)

In recent deliberations, the Measure Applications Partnership has reviewed the proposed measure concept for RA functional status assessment and found it to be a high priority for inclusion in upcoming programs pending availability of measure testing. The American College of Rheumatology has recently launched a national EHR-enabled RA registry and is seeking certification as a qualified clinical data registry and this measure will be incorporated into the registry. The measure is not currently publicly reported, but is likely to be publicly reported in the future as the registry data becomes more robust. The registry will provide benchmarking and performance feedback to practices using a federated EHR system.

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

N/A

4b.2. 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.

N/A

4c. 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).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

N/A

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.

No

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.

5a. Harmonization

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 completely harmonized?

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

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.)

Appendix

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-635291746895982932.xlsx](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [AMERICAN COLLEGE OF RHEUMATOLOGY](#)

Co.2 Point of Contact: [RACHEL, MYSLINSKI, \[RMYSLINSKI@RHEUMATOLOGY.ORG\]\(mailto:RMYSLINSKI@RHEUMATOLOGY.ORG\), 404-633-3777-824](#)

Co.3 Measure Developer if different from Measure Steward: [AMERICAN COLLEGE OF RHEUMATOLOGY](#)

Co.4 Point of Contact: [RACHEL, MYSLINSKI, \[RMYSLINSKI@RHEUMATOLOGY.ORG\]\(mailto:RMYSLINSKI@RHEUMATOLOGY.ORG\), 404-633-3777-](#)

Additional Information

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](#)

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?

Ad.6 Copyright statement: Copyright (c) 2013, American College of Rheumatology

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Ad.8 Additional Information/Comments: