



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
<p>NQF #: 2549eeee</p> <p>Corresponding Measures:</p> <p>De.2. Measure Title: Gout: Serum Urate Target (Recommended for eMeasure Trial Approval)</p> <p>Co.1.1. Measure Steward: AMERICAN COLLEGE OF RHEUMATOLOGY</p> <p>De.3. Brief Description of Measure: Percentage of patients aged 18 and older with a diagnosis of gout treated with urate-lowering therapy (ULT) for at least 12 months, whose most recent serum urate result is less than 6.8 mg/dL.</p> <p>1b.1. Developer Rationale: Patients with hyperuricemia are subject to recurrent gout flares and formation of tophi, which can lead to joint and other tissue damage. Urate lowering therapy reduces the frequency of acute gouty attacks [1,2] and reduces the rate of growth of tophi and decreases the size of tophi [5].</p> <p>For patients with indications for serum urate lowering therapy, after starting therapy, the goal of treatment is serum urate < 6 mg/dl. Lower serum urate levels are associated with fewer acute gout attacks [3] and decreased formation (and improvement) of tophi [4]. Patients on ULT that do not achieve target serum urate < 6 mg/dl are 75% more likely to flare than patients who reach target [5].</p> <p>The American College of Rheumatology (ACR) guidelines on gout recommends that if a patient with gout has been treated with urate lowering therapy for at least 12 months, then the serum urate should be checked at least once yearly and the most recent serum urate should be < 6.8 mg/dl.</p> <p>As a quality measure, the ACR quality improvement panel recommended a less stringent target and selected the solubility concentration of urate 6.8 mg/dl for a quality target.</p> <ol style="list-style-type: none"> Shoji A, Yamanaka H, Kamatani N. A retrospective study of the relationship between serum urate level and recurrent attacks of gouty arthritis: evidence for reduction of recurrent gouty arthritis with antihyperuricemic therapy. <i>Arthritis Rheum</i> 2004; 51:321-325. Perez-Ruiz F, Atxotegi J, Hernando I, Calabozo M, Nolla JM. Using serum urate levels to determine the period free of gouty symptoms after withdrawal of long-term urate-lowering therapy: a prospective study. <i>Arthritis Rheum</i> 2006; 55:786-790 Becker MA, Schumacher HR, Espinoza LR, Wells AF, Mac-Donald P, Lloyd E, et al. The urate-lowering efficacy and safety of febuxostat in the treatment of the hyperuricemia of gout: the CONFIRMS trial. <i>Arthritis Res Ther</i> 2010;12:R63. Perez-Ruiz F, Calabozo M, Pijoan JI, Herrero-Beites AM, RuiBAL A. Effect of urate-lowering therapy on the velocity of size reduction of tophi in chronic gout. <i>Arthritis Rheum</i> 2002; 47: 356–60. Sarawate CA, Patel PA, Schumacher HR, Yang W, Brewer KK, Bakst AW. Serum urate levels and gout flares: analysis from managed care data. <i>J Clin Rheumatol.</i> 2006 Apr;12(2):61-5.
<p>S.4. Numerator Statement: Patients whose most recent serum urate level is less than 6.8 mg/dL</p> <p>S.6. Denominator Statement: Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy (ULT) for at least 12 months</p> <p>S.8. Denominator Exclusions: Patients with a history of solid organ transplant</p>
<p>De.1. Measure Type: Process</p> <p>S.17. Data Source: Electronic Health Records, Other, Registry Data</p> <p>S.20. Level of Analysis: Clinician : Individual</p>
<p>IF Endorsement Maintenance – Original Endorsement Date: Nov 10, 2014 Most Recent Endorsement Date: Nov 10, 2014</p>
<p>IF this measure is included in a composite, NQF Composite#/title:</p>
<p>IF this measure is paired/grouped, NQF#/title:</p>

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

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

[Gout_Serum_Urate_Target_Evidence_Form_Final.docx](#)

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

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

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 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.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

Patients with hyperuricemia are subject to recurrent gout flares and formation of tophi, which can lead to joint and other tissue damage. Urate lowering therapy reduces the frequency of acute gouty attacks [1,2] and reduces the rate of growth of tophi and decreases the size of tophi [5].

For patients with indications for serum urate lowering therapy, after starting therapy, the goal of treatment is serum urate < 6 mg/dl. Lower serum urate levels are associated with fewer acute gout attacks [3] and decreased formation (and improvement) of tophi [4]. Patients on ULT that do not achieve target serum urate < 6 mg/dl are 75% more likely to flare than patients who reach target [5].

The American College of Rheumatology (ACR) guidelines on gout recommends that if a patient with gout has been treated with urate lowering therapy for at least 12 months, then the serum urate should be checked at least once yearly and the most recent serum urate should be < 6.8 mg/dl.

As a quality measure, the ACR quality improvement panel recommended a less stringent target and selected the solubility concentration of urate 6.8 mg/dl for a quality target.

1. Shoji A, Yamanaka H, Kamatani N. A retrospective study of the relationship between serum urate level and recurrent attacks of gouty arthritis: evidence for reduction of recurrent gouty arthritis with antihyperuricemic therapy. *Arthritis Rheum* 2004; 51:321-325.
2. Perez-Ruiz F, Atxotegi J, Hernando I, Calabozo M, Nolla JM. Using serum urate levels to determine the period free of gouty symptoms after withdrawal of long-term urate-lowering therapy: a prospective study. *Arthritis Rheum* 2006; 55:786-790
3. Becker MA, Schumacher HR, Espinoza LR, Wells AF, Mac-Donald P, Lloyd E, et al. The urate-lowering efficacy and safety of febuxostat in the treatment of the hyperuricemia of gout: the CONFIRMS trial. *Arthritis Res Ther* 2010;12:R63.
4. Perez-Ruiz F, Calabozo M, Pijoan JI, Herrero-Beites AM, Ruibal A. Effect of urate-lowering therapy on the velocity of size reduction of tophi in chronic gout. *Arthritis Rheum* 2002; 47: 356–60.
5. Sarawate CA, Patel PA, Schumacher HR, Yang W, Brewer KK, Bakst AW. Serum urate levels and gout flares: analysis from managed care data. *J Clin Rheumatol.* 2006 Apr;12(2):61-5.

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 (4b) under Usability and Use.

Performance scores for this measure are not available at this time. We are submitting this measure for consideration for time-limited endorsement and will be able to provide performance scores from testing sites after measures have been tested.

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.

There are many gaps in quality of care for patients with gout. Patients started on ULT are frequently not appropriately managed to achieve serum urate targets.

In a cohort of British patients, of 306 gout patients identified as needing urate lowering therapy, only 34% were ever prescribed such treatment and only 25% were taking treatment at time of the study. Furthermore, serum urates were not being checked regularly and dose adjustment to elevated serum urates were deemed inadequate [1]. Patient adherence and education is critical to achieving target goals. From two panels of managed care patient, over half of the 4,166 patients studied were found to be non-adherent [2].

[1] Cottrell E1, Crabtree V, Edwards JJ, Roddy E. Improvement in the management of gout is vital and overdue: an audit from a UK primary care medical practice. BMC Fam Pract. 2013 Nov 14;14:170

[2] Harrold LR1, Andrade SE, Briesacher BA, Raebel MA, Fouayzi H, Yood RA, Ockene IS. Adherence with urate-lowering therapies for the treatment of gout. Arthritis Res Ther. 2009;11(2):R46. doi: 10.1186/ar2659. Epub 2009 Mar 27.

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 (4b) under Usability and Use.

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

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

Since this is a newly proposed e-measure, no disparities data from the measure is yet available. However, a recent review highlighted that there is a higher prevalence of gout among African-Americans and poorer quality of care delivered to this group. The prevalence of gout in men is much higher than women, until post-menopausal status when rates for gout increase markedly among women.

Singh JA. Racial and gender disparities among patients with gout. Curr Rheumatol Rep. 2013 Feb;15(2):307.

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

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.)

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 an eMeasure Attachment: [2549_GOUTSerumUrateTarget_Artifacts-635336942431044983-636580034344748366.zip](#)

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: [Gout_Serum_Urate_Target_Value_Sets_Updated_2018-03-30.xls](#)

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.

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.

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) 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).

[Patients whose most recent serum urate level is less than 6.8 mg/dL](#)

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).

[Patients whose most recent serum urate level is less than 6.8 mg/dL](#)

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

[Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy \(ULT\) for at least 12 months](#)

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).

[Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy \(ULT\) for at least 12 months](#)

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

[Patients with a history of solid organ transplant](#)

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.)

N/A

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.)

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

If other:

S.12. Type of score:

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)

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.)

S.15. 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.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.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

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, Other, 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 is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

[The ACR plan for measure testing includes testing data from at least 3 different types of EHRs, from at least 3 different sites, using a standardized data collection form.](#)

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)

[No data collection instrument provided](#)

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

[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.)

2. Validity – See attached Measure Testing Submission Form

2.1 For maintenance of endorsement

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. (Do not remove prior testing information – include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

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) Update this field for **maintenance of endorsement**.

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. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (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: [Gout_Measures_Feasibility_Assessment_Summary_for_NQF_Submission-635336921173048660.xlsx](#)

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 a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

This measure is being submitted for time-limited endorsement and has not been tested. Plans are in place for a 2014 testing project. These measures will also be implemented in the ACR’s registry.

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)
Public Reporting	
Payment Program	

Quality Improvement (Internal to the specific organization)	
Not in use	

4a.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

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?)

Measure is still being tested. We are submitting this measure for time-limited endorsement because the ACR believes it is important to have measures related to gout that can be used for public reporting and accountability applications in the future. The ACR plans to test this measure in the next 12 months.

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.)

Specifications for this measure will be finalized and full field testing will be completed in the next 12 months, at which time the ACR will seek full NQF endorsement. In addition, the ACR will implement these measures into its EHR-enabled registry this year, at which time they will be part of the registry's plan for public reporting.

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. 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 ACR is seeking time-limited endorsement for this measure because testing is not yet completed; therefore, this does not apply.

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

The ACR is seeking time-limited endorsement for this measure because testing is not yet completed; therefore, this does not apply.

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

4d1.1. 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.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

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 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?

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.

No appendix Attachment:

Contact Information

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, 404-633-3777-824

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.

John Fitzgerald, MD, Univ of California, Los Angeles (UCLA) (workgroup/panel chair)

Puja Khanna, MD, MPH, University of Michigan (workgroup member)

Ted Mikuls, MD, MSPH, University of Nebraska (workgroup member)

Tuhina Neogi, MD, PhD, Boston University (workgroup member)

Mark Robbins, MD, Harvard Vanguard Medical Associates (workgroup member)

Jasvinder Singh, MD, MPH, Univ of Alabama at Birmingham (UAB) (workgroup member)

Lisa Suter, MD, Yale University (workgroup member)

Neil Wenger, MD, UCLA (panel moderator)

Martin Bergman, MD, private practice-Ridley Park, PA (panel member)

Harjinder Chowdhary, MD, William W Backus Hospital (panel member)

Fiona Donald, MD, Health Plan of San Mateo (panel member)

Jerome Epplin, MD, Litchfield Family Practice Center (panel member)

Danielle Jones, MD, Emory University School of Medicine (panel member)

Dinesh Khanna, MD, MSc, University of Michigan (panel member)

Michael Lazarus, MD, UCLA (panel member)

Gerald Levy, MD, MBA, Kaiser Permanente (panel member)

Tom Mattimore, MD, UCLA (panel member)

David Mount, MD, Brigham and Women's Hospital (panel member)

Ed Sims, Patient (panel member)

John Sundy, MD, Duke University Medical Center (panel member)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2014

Ad.3 Month and Year of most recent revision: 02, 2014

Ad.4 What is your frequency for review/update of this measure? Annually, once the measure is fully tested and finalized

Ad.5 When is the next scheduled review/update for this measure? 03, 2014

Ad.6 Copyright statement: N/A - measure is still being tested

Ad.7 Disclaimers:
Ad.8 Additional Information/Comments: