NATIONAL QUALITY FORUM

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 #: 2522
Corresponding Measures:
De.2. Measure Title: Rheumatoid Arthritis: Tuberculosis Screening (Recommended for eMeasure Trial Approval)
Co.1.1. Measure Steward: American College of Rheumtology
De.3. Brief Description of Measure: Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis who have documentation of a tuberculosis (TB) screening performed within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD).
1b.1. Developer Rationale: It is well-documented that biologic disease-modifying drugs (DMARDs) increase the risk of reactivation of latent tuberculosis (TB) infection. Data regarding the risk of TB from biologic DMARDs has accumulated for the last 20 years from clinical trials, post-marketing surveillance, and large registries. TB testing in RA patients receiving biologic DMARDs is an important patient safety measure and recommended as standard of care by the American College of Rheumatology. Because latent tuberculosis is treatable, while TB reactivation can lead to death or significant morbidity, universal screening is a cornerstone of safe, high quality care in RA.

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.

S.4. Numerator Statement: Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.
S.6. Denominator Statement: Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy during the measurement period.
S.8. Denominator Exclusions: N/A

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
TB_Evidence_Form_Final.docx,TB_Evidence_Form_2019_FINAL.docx
1a.1 <u>For Maintenance of Endorsement</u>: 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)*
<u>If a COMPOSITE</u> (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.
It is well-documented that biologic disease-modifying drugs (DMARDs) increase the risk of reactivation of latent tuberculosis (TB) infection. Data regarding the risk of TB from biologic DMARDs has accumulated for the last 20 years from clinical trials, post-marketing surveillance, and large registries. TB testing in RA patients receiving biologic DMARDs is an important patient safety measure and recommended as standard of care by the American College of Rheumatology. Because latent tuberculosis is treatable, while TB reactivation can lead to death or significant morbidity, universal screening is a cornerstone of safe, high quality care in RA.

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.

1b.2. Provide performance scores on the measure as specified (<u>current and over time</u>) at the specified level of analysis. *(<u>This is required for maintenance of endorsement</u>. 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: 49

2015 Q1: 47.56%
2015 Q2: 51.48%
2015 Q3: 61.23%
2015 Q4: 63.23%
2016 Q1: 66.17%
2016 Q2: 67.68%
2016 Q3: 69.58%
2016 Q4: 70.99%

Most recent performance
Dates: January 1, 2017 through December 31, 2017
Practices: 105
Setting: 73% group, 25% solo practitioner, 2% health system
Patients: 9,943

Mean: 58.85%
Standard Deviation: 26.34%
Min: 0.00%
Max: 100.00%
Interquartile Range: 34.40%
Deciles
10%: 16.09%
20%: 37.21%
30%: 48.66%
40%: 57.69%
50%: 65.06%
60%: 68.97%
70%: 76.18%
80%: 82.67%
90%: 88.47%
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
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. While no studies have examined differences in TB testing by sociodemographic characteristics (race/ethnicity, sex, gender, disability status, socioeconomic status), available data suggest gaps in TB testing among patients with RA initiating biologic DMARDs, and studies demonstrate that African-Americans and immigrant populations in the United States are disproportionately affected by tuberculosis. Therefore, improvement in performance on this measure potentially has the greatest health impact on at-risk populations.

Jose A. Serpa, Larry D. Teeter, James M. Musser, and Edward A. Tuberculosis Disparity between US-born Blacks and Whites, Houston, Texas. Emerg Infect Dis. 2009 June; 15(6): 899–904.
  Nahid P, Horne D, Jarlsberg LG et al. Racial Differences in Tuberculosis Infection in United States Communities: The Coronary Artery Risk Development in Young Adults Study. Clin Infect Dis. 2011 August 1; 53(3): 291–294.
  Buskin SE, Gale JL, Weiss N, Nolan CM. Tuberculosis risk factors in adults in King County, Washington, 1988 through 1990. Am J Public Health. 1994 November; 84(11): 1750–1756.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, 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):*
Safety : Medication

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/TB-Screening-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:** TB_Screen_Value_Sets_Updated_2018-03-30-636579260604748366.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).
Any record of TB testing documented or performed (PPD, IFN-gamma release assays, or other appropriate method) in the medical record in the 12 months preceding the biologic DMARD prescription.

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).*
Acceptable TB tests include tuberculin skin test or laboratory tests for TB-specific peptide antigens, during the 12 month measurement period. A list of biologic DMARDs is provided below. Available procedure and drug codes that can be used identify both TB tests and biologic DMARDs are included in S.2b.
Biologic DMARDs:
- Adalimumab (Humira)
- Etanercept (Enbrel)
- Infliximab (Remicade)
- Abatacept (Orencia)
- Anakinra (Kineret)
- Rituximab (Rituxan)
- Certolizumab pegol (Cimzia)
- Tocilizumab (Actemra)
- Golimumab (Simponi)
- Tofacitinib (Xeljanz)
- Sarilumab (Kevzara)
- Infliximab-dyyb (Inflectra)
- Infliximab-abda (Renflexis)
- Infliximab-qbtx (Ixifi)
- Etanercept-szzs (Erelzi)
- Adalimumab-atto (Amjevita)
- Adalimumab-adbm (Cyltezo)

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Patients 18 years and older with a diagnosis of rheumatoid arthritis who are seen for at least one face-to-face encounter for RA who are newly started on biologic therapy 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).*
For the purposes of this measure, patients who are 'newly started on biologic therapy' are those who have been prescribed DMARD biologic therapy during the measurement period and who were not prescribed DMARD biologic therapy in the 12 months preceding the encounter where DMARD biologic therapy was newly started.

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

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.)
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

2. Validity – See attached Measure Testing Submission Form
TB_Measure_Testing_Form_Final.docx,TB_measure_testing_form_January_2019_FINAL_Updated_4.3.2019-636912728579779370.docx

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. 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.
Yes

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. 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.
Yes

2.3 For maintenance of endorsement
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.
No - This measure is not risk-adjusted

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).

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 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-635291966727341423.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.

TB testing data is sometimes not systematically collected in electronic health records as structured data. For example, TB testing results may reside in a scanned form sent from an outside facility, or may be recorded as free text in a clinical note, often based on patient self-report. Integrated health systems may have structured fields for immunizations and therefore easily accessible information on PPD testing. Interferon-release assays appearing as laboratory results in the electronic record are retrievable, but scanned outside laboratories may not be. As evidenced in our electronic measure testing, sites committed to patient safety have developed workflows to systematically incorporate this information in a structured field in the electronic health record. Implementation of this e-measure may require workflow changes for practices that do not record this information in a consistent way.

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: Merit-based Incentive Payment System
Sponsor: Centers for Medicare and Medicaid Services
Purpose: MIPS was designed to tie payments to quality and cost-efficient care, drive improvement in care processes and health outcomes, increase the use of healthcare information, and reduce the cost of care.
Geographic area: United States
Number and percentage of entities and patients: Per the most recent numbers provided by CMS*, approximately 3,550 rheumatologists across the country (and 100% of their patients) are eligible for MIPS reporting
Level of measurement: provider or practice, depending on whether they report as an individual or group
Setting: Non-hospital-based rheumatology practices enrolled in Medicare the exceed the low-volume threshold
* Page 374: https://www.govinfo.gov/content/pkg/FR-2017-11-16/pdf/2017-24067.pdf

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?*)

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.*)

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 as specified has only been implemented in the RISE registry until recently. This measure was previously used by RISE participants for PQRS reporting. However, when CMS transitioned to MIPS, they denied inclusion of this measure as a QCDR measure because they said it was too similar to a QPP measure. We have since updated the QPP measure for the 2019 reporting year to conform to the requirements of this measure. Because of this, we have not received feedback from other entities. However, we will have the opportunity to begin doing so in 2020.

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 decrease in performance over time reflects persistent low performance of routine Tb screening. The prior increasing performance likely reflected an early adopter phenomenon, where early RISE adopters were more likely to have systems in place to collect a range of data elements, including Tb screening and had the benefit of quarterly measure results reporting to help that initial group improve performance over time. The over doubling of the number of practices in RISE between the two time periods (50 to 105), many in response to the MACRA legislation, probably reflects a more generalizable group of US rheumatology practices. The variation in results indicates continued need for 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 <u>and</u> 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.
Attachment **Attachment:** Appendix-635291751849315969.xlsx

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American College of Rheumtology
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 Rheumtology
Co.4 Point of Contact: Rachel, Myslinski, rmyslinski@rheumatology.org, 404-633--

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
Ad.7 Disclaimers: All materials are subject to copyrights owned by the College. The College hereby provides limited permission for the user to reproduce, retransmit or reprint for such user´s own personal use (and for such personal use only) part or all of any document as long as the copyright notice and permission notice contained in such document or portion thereof is included in such reproduction, retransmission or reprinting. All other reproduction, retransmission, or reprinting of all or part of any document is expressly prohibited, unless the College has expressly granted its prior written consent to so reproduce, retransmit, or reprint the material. All other rights reserved.

CPT(R) contained in the Measure specifications is copyright 2004-2013 American Medical Association.
LOINC(R) copyright 2004-2012 Regenstrief Institute, Inc.

Ad.8 Additional Information/Comments: