



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 #: 2523

Corresponding Measures:

De.2. Measure Title: Rheumatoid Arthritis: Assessment of Disease Activity

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 and $\geq 50\%$ of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

1b.1. Developer Rationale: Disease activity is a key outcome in RA. American College of Rheumatology (ACR) guidelines recommend routine disease activity measurement in clinical practice to target low disease activity or remission in all patients. Clinical trials indicate that using validated assessments to set treatment goals and target therapy results in improved patient outcomes, including better functional and radiographic outcomes.

S.4. Numerator Statement: # of patients with $\geq 50\%$ of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.

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

S.8. Denominator Exclusions: 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:** 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?

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

[Disease_Activity_Measure_Evidence_Form_Final-635294352077200854.docx, RA_DAS_evidence_form_2019_FINAL.docx](#)

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

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

No

1b. Performance Gap

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

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

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

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

Disease activity is a key outcome in RA. American College of Rheumatology (ACR) guidelines recommend routine disease activity measurement in clinical practice to target low disease activity or remission in all patients. Clinical trials indicate that using validated assessments to set treatment goals and target therapy results in improved patient outcomes, including better functional and radiographic outcomes.

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

Performance over time

Dates: July 1, 2014 through June 30, 2016

Practices: 44

Providers: 223

2014 Q3: 44.6%

2014 Q4: 42.42%

2015 Q1: 53.05%

2015 Q2: 54.96%

2015 Q3: 55.65%

2015 Q4: 58.63%

2016 Q1: 61.07%

2016 Q2: 62.97%

Most recent performance

Dates: January 1, 2017 through December 31, 2017

Practices: 107

Setting: 73% group, 25% solo practitioner, 2% health system

Patients: 94,872

Mean: 43.91%

Standard Deviation: 37.46%

Min: 0.00%

Max: 100.00%

Interquartile Range: 80.08%

Deciles

10%: 0.00%

20%: 0.00%

30%: 4.98%

40%: 26.78%

50%: 42.96%

60%: 55.57%

70%: 73.69%

80%: 84.41%

90%: 97.09%
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. However, observational studies of patients with RA suggest significant disparities in disease activity and clinical outcomes across racial and ethnic groups. For example, data from a large US registry using the Clinical Disease Activity Index (CDAI), one of the recommended measures for disease activity assessment, found important differences in mean disease activity level across racial and ethnic groups, with African-Americans being less likely to achieve clinical remission and having higher disease activity overall. Standardized collection of disease activity assessments such as CDAI therefore has significant potential to unveil such differences and provide critical data for reducing disparities in RA outcomes.

Greenberg JD1, Spruill TM, Shan Y, Reed G, Kremer JM, Potter J, Yazici Y, Ogedegbe G, Harrold LR. Racial and ethnic disparities in disease activity in patients with rheumatoid arthritis. Am J Med. 2013 Dec;126(12):1089-98

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Musculoskeletal : Rheumatoid Arthritis

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

Health and Functional Status : Change

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/RA-Disease-Activity-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: [Disease_Activity_Updated_Value_Sets_2018-03-30.xls](#)

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

Attachment Attachment: [RA_Disease_Activity_Measures_ACR_Recommendations_for_Use_in_Clinical_Practice_Paper.pdf](#)

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.

[Clinician](#)

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 \(S.14\).](#)

[# of patients with >=50% of total number of outpatient RA encounters in the measurement year with assessment of disease activity using a standardized measure.](#)

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 \(S.14\).](#)

[For purposes of this measure, "Rheumatoid Arthritis Disease Activity Measurement Tools" include the following instruments:](#)

[-Clinical Disease Activity Index \(CDAI\)](#)

[-Disease Activity Score with 28-joint counts \(erythrocyte sedimentation rate or C-reactive protein\) \(DAS-28\)](#)

[-Patient Activity Scale \(PAS\)](#)

[-Patient Activity Score-II \(PAS-II\)](#)

[-Routine Assessment of Patient Index Data with 3 measures \(RAPID 3\)](#)

[-Simplified Disease Activity Index \(SDAI\)](#)

[A result of any kind qualifies for meeting numerator performance.](#)

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

Patients 18 years and older with a diagnosis of rheumatoid arthritis seen for two or more face-to-face encounters for RA with the same clinician during the measurement period.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

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

One of the requirements for a patient to be included in the Initial Patient Population is that the patient has a minimum of 2 RA encounters with the same provider, all occurring during the measurement period.

If the patient qualifies for the Initial Patient Population, then every encounter for RA should be evaluated to determine whether disease activity using a standardized measurement tool was assessed. The logic represented in this measure will determine if the patient had a disease activity assessment performed at each visit during the measurement period (ie, Occurrence A of Encounter, Performed). The measure requires all of the eligible encounters to be analyzed in order to determine if the patient's disease activity was assessed at $\geq 50\%$ of encounters for RA. Once it has been determined if the patient meets $\geq 50\%$ threshold, all patient data across a single physician should be aggregated to determine the performance rate.

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 the 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.)

2. Validity – See attached Measure Testing Submission Form

Disease_Activity_Measure_Testing_Form_Final.docx, RA_DAS_measure_testing_form_January_2019_FINAL_4.3.2019_Update-636912728895407605.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-635291967610444146.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.

Measurement of RA disease activity using a standardized, validated instrument requires significant changes to current clinical workflow for many practices. A range of options were provided in the measure since 1) there is good scientific evidence suggesting comparable validity of several measures, which are endorsed by the ACR as recommended measures, and 2) feasibility of using different measures depends greatly on the U.S. practice setting. Rheumatologists practice in a great variety of settings, including solo clinical offices, single and multi-specialty group practices, and academic and large group settings. Resources available for disease activity measures vary between practices, and the consensus process for this measure took this into account. For example, academic medical centers may have same-day laboratory information available, allowing calculation of a Disease Activity Score 28 (DAS 28) or Simplified Disease Activity Index (SDAI). Small or rural practices often do not have access to same day laboratory results

and may not have adequate support staff to implement the more complex workflow required for composite measures such as the Clinical Disease Activity Assessment (CDAA). In these settings, the Routine Assessment of Patient Index Data (RAPID3) or Patient Activity Scores (PAS) are both valid and feasible to implement. There is a large body of research spanning many decades regarding these outcome measures in RA. In a large, national effort that involved many stakeholders, the ACR has summarized information on use of these measures in clinical practice. This manuscript includes information on time to collect each measure and feasibility based on practice setting. It is important to note that the recommended measures all have cut-offs for remission and low, moderate and high disease activity.

Anderson J, Caplan L, Yazdany J, Robbins ML, Neogi T, Michaud K, Saag KG, O'Dell JR, Kazi S. Rheumatoid arthritis disease activity measures: American College of Rheumatology recommendations for use in clinical practice. *Arthritis Care Res (Hoboken)*. 2012 May;64(5):640-7.

Yazici Y, Bergman M, Pincus T. Time to score quantitative rheumatoid arthritis measures: 28-Joint Count, Disease Activity Score, Health Assessment Questionnaire (HAQ), Multidimensional HAQ (MDHAQ), and Routine Assessment of Patient Index Data (RAPID) scores. *J Rheumatol*. 2008 Apr;35(4):603-9.

Anderson JK, Zimmerman L, Caplan L, Michaud K. Measures of rheumatoid arthritis disease activity: Patient (PtGA) and Provider (PrGA) Global Assessment of Disease Activity, Disease Activity Score (DAS) and Disease Activity Score with 28-Joint Counts (DAS28), Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), Patient Activity Score (PAS) and Patient Activity Score-II (PASII), Routine Assessment of Patient Index Data (RAPID), Rheumatoid Arthritis Disease Activity Index (RADAI) and Rheumatoid Arthritis Disease Activity Index-5 (RADAI-5), Chronic Arthritis Systemic Index (CASI), Patient-Based Disease Activity Score With ESR (PDAS1) and Patient-Based Disease Activity Score without ESR (PDAS2), and Mean Overall Index for Rheumatoid Arthritis (MOI-RA). *Arthritis Care Res (Hoboken)*. 2011 Nov; 63 Suppl 11:S14-36.

Anderson J, Caplan L, Yazdany J, Robbins ML, Neogi T, Michaud K, Saag KG, O'Dell JR, Kazi S. Rheumatoid arthritis disease activity measures: American College of Rheumatology recommendations for use in clinical practice. *Arthritis Care Res (Hoboken)*. 2012 May;64(5):640-7.

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
Regulatory and Accreditation Programs	MIPS https://qpp.cms.gov/mips/overview
Professional Certification or Recognition Program	Quality Improvement (external benchmarking to organizations) The RISE Registry

www.riseregistry.org
 Quality Improvement (Internal to the specific organization)
 The RISE Registry
www.riseregistry.org

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 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 less stringent QPP measure. We have since updated the QPP measure for the 2019 reporting year to conform to the more stringent 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 between 2016 Q2 and the end of 2017 reflects persistent low performance of routinely collecting and documenting disease activity among US rheumatologists. 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

disease activity, and they were receiving quarterly results allowing them to implement improvements. The over doubling of the number of practices in RISE between the two time periods (44 to 107), many in response to the MACRA legislation, probably reflects a more generalizable group of US rheumatology practices. Furthermore, during this time, CMS shifted from providers reporting on this measure to a less stringent version which only required assessment of disease activity once a year. The current measure, as specified, is only now being implemented in MIPS for the 2019 reporting year. The variation in results indicates continued need for assessing performance on this measure, especially as more practices continue to join RISE and providers are once again held to this higher standard as supported by RA treatment guidelines.

4b2. Unintended Consequences

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

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

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

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

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

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

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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-635294351903102622.xlsx](#)

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

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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.

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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?

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Ad.8 Additional Information/Comments: