Non-PQRS Measure Descriptions

ACR 1: Disease Activity Measurement for Patients with Rheumatoid Arthritis (RA)

Measure Type: Process

NQS Domain: Clinical Process/Effectiveness

Description:
Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis whose disease activity is assessed using a standardized measurement tool at 50% or more encounters for RA with the same clinician during the measurement period.

Denominator:
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

Denominator Criteria (Eligible Cases):
Patients aged >= 18 years on date of encounter

AND
Diagnosis for Rheumatoid Arthritis (RA)

AND
2 or more patient encounters for RA with the same clinician during the measurement period

Instructions:
One of the requirements for a patient to be included in the denominator 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 denominator, 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 reporting period. The measure requires all of the eligible encounters to be analyzed in order to determine if the patient’s disease activity was assessed at >=50% of encounters for RA. Once it has been determined if the patient meets >=50% threshold, all patient data across a single physician should be aggregated to determine the performance rate.
**Numerator:**
Patients with >= 50% of total number of outpatient RA encounters in the reporting period with assessment of disease activity using a standardized measurement tool.

**Definition:**
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 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.

**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.

**Clinical Recommendation Statement:**
In 2008, the American Medical Association’s Physician Consortium for Performance Improvement (AMA PCPI), the National Committee for Quality Assurance (NCQA) and the American College of Rheumatology (ACR) collaborated to develop a rheumatoid arthritis (RA) quality measure set for the Physical Quality Reporting System (PQRS), including a measure related to disease activity assessment. The measure assessed whether disease activity was assessed at least once per year and categorized as remission, low, moderate or high. The ACR subsequently developed a national registry platform, the Rheumatology Clinical Registry (RCR), to aid rheumatologists in reporting this PQRS measure. In 2012, performance on the measure was 54% among participating rheumatologists. Feedback from the rheumatology community and experts suggested potential ways to improve the measure (Desai S and Yazdany J. Arthritis Rheum. 2011 Dec;63(12):3649-60). The current e-measure builds on the experience of the last 6 years to add specificity and greater validity to disease activity assessment in RA (only validated and feasible measures are listed as acceptable, and the requirement for performing assessments has been increased to ≥50% or more of all RA encounters). These changes more closely align with ACR guidelines for measuring disease activity and “treating to target” in RA (Singh J, Arthritis Care Res. 2012 May;64(5):625-39) and Anderson J, Arthritis Care Res (Hoboken). 2012 May; 64(5):640-7).
ACR 2: Functional Status Assessment for Patients with Rheumatoid Arthritis (RA)

**Measure Type:** Process

**NQS Domain:** Clinical Process/Effectiveness

**Description:**
Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis whose functional status is assessed using a standardized measurement tool at least once during the measurement period.

**Denominator:**
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.

**Denominator Criteria (Eligible Cases):**
- Patients aged >= 18 years on date of encounter
- Diagnosis for Rheumatoid Arthritis (RA)
- 2 or more patient encounters for RA with the same clinician during the measurement period

**Numerator:**
Patients with functional status assessment documented once during the measurement period.

**Definition:**
Functional status can be assessed by using one of a number of instruments, including several instruments originally developed and validated for screening purposes. Examples include, but are not limited to:
- Health Assessment Questionnaire (HAQ)
- Health Assessment Questionnaire-II (HAQ-II)
- Multi-Dimensional Health Assessment Questionnaire (MDHAQ)
- PROMIS Physical Function 10-item (PROPF10)
- PROMIS Physical Function 20-item (PROPF20)
- PROMIS Physical Function Computerized Adaptive Tests (PROPFCAT)
- Short Form 36-item Physical Functioning (SF-36 PF)

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

**Clinical Recommendation Statement:**
In 2008, the American Medical Association’s Physician Consortium for Performance Improvement (AMA PCPI), the National Committee for Quality Assurance (NCQA) and the American College of Rheumatology (ACR) collaborated to develop a rheumatoid arthritis (RA) quality measure set for the Physical Quality Reporting System (PQRS), including a measure related to functional status assessment. The measure assessed whether functional status was evaluated at least once per year using any method. The ACR developed a national registry platform, the Rheumatology Clinical Registry (RCR), to aid rheumatologists in reporting this PQRS measure. In 2012, performance on the measure was 87% among participating rheumatologists. Over the last six years, feedback from the rheumatology community and experts suggested potential ways to improve the measure (Desai S and Yazdany J. Arthritis Rheum. 2011 Dec;63(12):3649-60). The current e-measure builds on the experience of the earlier versions of the measure. It adds specificity to the measure by listing specific tools recommended for valid and reliable functional status assessment in RA.
ACR 3: Disease-Modifying Anti-Rheumatic Drug (DMARD) Therapy for Active Rheumatoid Arthritis (RA)

Measure Type: Process

NQS Domain: Clinical Process/Effectiveness

Description:
Percentage of patients 18 years and older with active rheumatoid arthritis who are treated with a disease-modifying anti-rheumatic drug (DMARD) during the measurement period

Denominator:
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

Denominator Criteria (Eligible Cases):
- Patients aged >= 18 years on date of encounter
- Diagnosis for Rheumatoid Arthritis (RA)
- 2 or more patient encounters for RA with the same clinician during the measurement period

Denominator Exclusions:
Patients with a diagnosis of HIV, pregnancy or inactive RA

Denominator Exclusion Criteria:
- Diagnosis of HIV
- Diagnosis of pregnancy
- Diagnosis of inactive RA

Numerator:
Patients who received a DMARD during the measurement period

Definition:
DMARD therapy includes:

Biologic Agents:
• abatacept
• adalimumab
• anakinra
• certolizumab
• etanercept
• golimumab
• infliximab
• rituximab
• tocilizumab

Non-Biologic Agents:
• azathioprine
• cyclophosphamide
• cyclosporine
• gold
• hydroxychloroquine
• leflunomide
• methotrexate
• minocycline
• penicillamine
• sulfasalazine
• tofacitinib

Anti-inflammatory medications, including glucocorticoids do not meet the measure.

Rationale:

The American College of Rheumatology (ACR) guidelines recommend the use of disease-modifying antirheumatic drugs (DMARDs) in every patient with active RA at the earliest stage of disease, ideally within 3 months of disease onset. These guidelines are based on results from numerous clinical trials demonstrating that DMARDs slow the progression of RA by decreasing inflammation and reducing articular erosions. In addition, both clinical trials and observational studies demonstrate that DMARDs improve functional status and health-related quality of life. Both underuse and disparities in DMARD use have been well-documented in numerous studies.

Clinical Recommendation Statement:

Early RA (disease duration >= 6 months): In patients with early RA, the panel recommends the use of DMARD monotherapy both for low disease activity and for moderate or high disease activity with the absence of poor prognostic features (Figure 1; level of evidence A–C) (2012 RA guideline, page 631)

Established RA (disease duration >= 6 months or meeting the 1987 ACR RA classification criteria):

Initiating and switching among DMARDs
If after 3 months of DMARD monotherapy (in patients without poor prognostic features), a patient deteriorates from low to moderate/high disease activity, then methotrexate, hydroxychloroquine, or leflunomide should be added (rectangle A of Figure 2; level of evidence A and B). If after 3 months of methotrexate or methotrexate/DMARD combination, a patient still has moderate or high disease activity, then add another non-methotrexate DMARD or switch to a different non-methotrexate DMARD (rectangle B of Figure 2; level of evidence B and C). (2012 RA guideline, page 631-632)
ACR 4: Tuberculosis Test Prior to First Course Biologic Therapy

**Measure Type:** Process

**NQS Domain:** Patient Safety

**Description:**

Percentage of patients 18 years and older with a diagnosis of rheumatoid arthritis that are newly prescribed a biologic therapy during the measurement period and whose medical record indicates tuberculosis testing in the 12 months preceding the biologic prescription.

**Denominator:**

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

**Denominator Criteria (Eligible Cases):**

- Patients aged >= 18 years on date of encounter
- Diagnosis for Rheumatoid Arthritis (RA)
- At least one face-to-face encounter for RA
- Biologic therapy, newly started

**Definition:**

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.

**Numerator:**

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 prescription

**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.

**Clinical Recommendation Statement:**

The panel recommends screening to identify LTBI in all RA patients being considered for therapy with biologic agents, regardless of the presence of risk factors for LTBI (diamond A of Figure 3) (14). It recommends that clinicians assess the patient’s medical history to identify risk factors for TB (specified by the DC) (Table 2).

The panel recommends the tuberculin skin test (TST) or interferon-release assays (IGRAs) as the initial test in all RA patients starting biologic agents, regardless of risk factors for LTBI (diamond A of Figure 3). It recommends the use of the IGRA over the TST in patients who had previously received a BCG vaccination, due to the high false positive test rates for TST (Figure 3).

The panel recommends that RA patients with a positive initial or repeat TST or IGRA should have a chest radiograph and, if suggestive of active TB, a subsequent sputum examination to check for the presence of active TB (diamonds B and C of Figure 3). RA patients with a negative screening TST or IGRA may not need further evaluation in the absence of risk factors and/or clinical suspicion for TB. Since patients with RA may have false-negative TST or IGRA results due to immunosuppression, a negative TST or IGRA should not be interpreted as excluding the possibility that a patient has LTBI. Accordingly, in immunosuppressed RA patients with risk factors for LTBI and negative initial screening tests, the panel recommends that a repeat TST or IGRA could be considered 1–3 weeks after the initial negative screening (diamond A of Figure 3).

If the RA patient has active or latent TB based on the test results, the panel recommends appropriate antitubercular treatment and consideration of referral to a specialist. Treatment with biologic agents can be initiated or resumed after 1 month of latent TB treatment with antitubercular medications and after completion of the treatment of active TB, as applicable (Figure 3).

The panel recommends annual testing in RA patients who live, travel, or work in situations where TB exposure is likely while they continue treatment with biologic agents (diamond D of Figure 3). Patients who test positive for TST or IGRA at baseline can remain positive for these tests even after successful treatment of TB. These patients need monitoring for clinical signs and symptoms of recurrent TB, since repeating tests will not help in the diagnosis of recurrent TB.
ACR 5: Glucocorticosteroids and Other Secondary Causes

**Measure Type:** Process

**NQS Domain:** Clinical Process/Effectiveness

**Description:**
Percentage of patients 18 years and older with one of the following conditions or therapies: receiving oral glucocorticosteroid therapy for greater than 3 months OR hypogonadism OR fracture history OR transplant history OR obesity surgery OR malabsorption disease OR receiving aromatase therapy for breast cancer who had a central DXA ordered or performed or pharmacologic therapy prescribed within 12 months.

**Denominator:**
All patients aged 18 years and older with one of the following conditions or therapies:

- receiving oral glucocorticosteroid therapy for greater than 3 months
  OR
- hypogonadism
  OR
- fracture history (radius, vertebral bodies, hip, or humerus)
  OR
- transplant history
  OR
- obesity surgery
  OR
- malabsorption disease
  OR
- aromatase therapy for breast cancer

**Denominator Exceptions:**
Documentation of medical reason(s) for not ordering or performing central DXA measurement or not prescribing pharmacologic therapy

Documentation of patient reason(s) for not ordering performing central DXA or ordering or not prescribing pharmacologic therapy

Documentation of system reason(s) for not ordering or performing central DXA or not prescribing pharmacologic therapy

**Numerator:**
Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed within 12 months

**Rationale:**
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and support the rationale:
• DXA scans should be done in patients with the GI disorders reviewed earlier who have experienced a vertebral fracture, are postmenopausal, or have been on chronic corticosteroid therapy (>3 months). (AGA)

• Physicians should obtain a baseline BMD measurement at the lumbar spine and/or hip when initiating long-term (i.e., >6 months) glucocorticoid therapy. (ACR7)

• The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

• The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

• Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

• Cyclic etidronate, alendronate, and risedronate have been shown to increase BMD at the spine and hip in a dose-dependent manner. They consistently reduce the risk of vertebral fractures by 30 to 50 percent. Alendronate and risedronate reduce the risk of subsequent nonvertebral fractures in women with osteoporosis and adults with glucocorticoid-induced osteoporosis. (NIH)

• Because hypogonadism frequently results in low bone density and increased fracture risk, baseline hip and spine bone densitometry studies should be performed to assess the initial situation and all future interventions to be based on any deterioration in bone density that may occur over time. (AACE7)

Clinical Recommendation Statement:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and support the rationale:

• DXA scans should be done in patients with the GI disorders reviewed earlier who have experienced a vertebral fracture, are postmenopausal, or have been on chronic corticosteroid therapy (>3 months). (AGA)

• Physicians should obtain a baseline BMD measurement at the lumbar spine and/or hip when initiating long-term (i.e., >6 months) glucocorticoid therapy. (ACR7)

• The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)
• The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

• Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

• Cyclic etidronate, alendronate, and risedronate have been shown to increase BMD at the spine and hip in a dose-dependent manner. They consistently reduce the risk of vertebral fractures by 30 to 50 percent. Alendronate and risedronate reduce the risk of subsequent nonvertebral fractures in women with osteoporosis and adults with glucocorticoid-induced osteoporosis. (NIH)

• Because hypogonadism frequently results in low bone density and increased fracture risk, baseline hip and spine bone densitometry studies should be performed to assess the initial situation and all future interventions to be based on any deterioration in bone density that may occur over time. (AACE7)
ACR 6: Gout: Serum Urate Monitoring

Measure Type: Process

NQS Domain: Clinical Process/Effectiveness

Description:
Percentage of patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period, and who had their serum urate level measured within 6 months.

Denominator:
Adult patients aged 18 and older with a diagnosis of gout who were either started on urate lowering therapy (ULT) or whose dose of ULT was changed in the year prior to the measurement period

Denominator Exceptions:
None

Numerator:
Patients whose serum urate level was measured within six months after initiating ULT or after changing the dose of ULT

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].

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 gouty 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.


**Clinical Recommendation Statement:**

The 2012 American College of Rheumatology Guidelines for Management of Gout. Part 1: Systematic Nonpharmacologic and Pharmacologic Therapeutic Approaches to Hyperuricemia recommend that all gout patients with indications for ULT should have their serum urate lowered to 6 mg/dl. Serum urate is the hemoglobin A1C of gout. Lower levels of serum urate are associated with less frequent gout attacks and reduction of tophaceous deposits. Based on feedback from public comment and expert panel, the less stringent level of 6.8 mg/dl cut-off was used to evaluate quality of care. 6.8 mg/dl is the solubility concentration of urate crystals. Serum urate responds to changes in urate lowering therapy within 14-days. The Guidelines recommends dose titration every 2-5 weeks. Twelve months was selected as sufficient time to achieve serum urate target, evidence Level C.

ACR 7: Gout: Serum Urate Target

**Measure Type:** Process

**NQS Domain:** Clinical Process/Effectiveness

**Description:**
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.

**Denominator:**
Adult patients aged 18 and older with a diagnosis of gout treated with urate lowering therapy (ULT) for at least 12 months.

**Denominator Exclusions:**
Patients with a history of solid organ transplant

**Denominator Exceptions:**
Documentation of medical reason(s) for not expecting a serum urate target level of < 6.8 mg/dL (ie, any eGFR level < 30 mL/min or Stage 3 or greater chronic kidney disease in the measurement year or year prior)

**Numerator:**
Patients whose most recent serum urate level is less than 6.8 mg/dL

**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].

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.


**Clinical Recommendation Statement:**

The 2012 American College of Rheumatology Guidelines for Management of Gout. Part 1: Systematic Nonpharmacologic and Pharmacologic Therapeutic Approaches to Hyperuricemia recommend that all gout patients with indications for ULT should have their serum urate lowered to 6 mg/dl. Serum urate is the hemoglobin A1C of gout. Lower levels of serum urate are associated with less frequent gout attacks and reduction of tophaceous deposits. Based on feedback from public comment and expert panel, the less stringent level of 6.8 mg/dl cut-off was used to evaluate quality of care. 6.8 mg/dl is the solubility concentration of urate crystals. Serum urate responds to changes in urate lowering therapy within 14-days. The Guidelines recommends dose titration every 2-5 weeks. Twelve months was selected as sufficient time to achieve serum urate target, evidence Level C.

ACR 8: Gout: ULT Therapy

**Measure Type:** Process

**NQS Domain:** Clinical Process/Effectiveness

**Description:**
Percentage of patients aged 18 and older with a diagnosis of gout and either tophus/tophi or at least two gout flares (attacks) in the past year who have a serum urate level > 6.0 mg/dL, who are prescribed urate lowering therapy (ULT)

**Denominator:**
Adult patients aged 18 and older with a diagnosis of gout and a serum urate level > 6.0 mg/dL who have at least one of the following: presence of tophus/tophi or two or more gout flares (attacks) in the past year

**Denominator Exclusions:**
None

**Denominator Exceptions:**
None

**Numerator:**
Patients who are prescribed urate lowering therapy (ULT)

**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].

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.


Clinical Recommendation Statement:

The 2012 American College of Rheumatology Guidelines for Management of Gout. Part 1: Systematic Nonpharmacologic and Pharmacologic Therapeutic Approaches to Hyperuricemia recommend that all gout patients with indications for ULT should have their serum urate lowered to 6 mg/dl. Serum urate is the hemoglobin A1C of gout. Lower levels of serum urate are associated with less frequent gout attacks and reduction of tophaceous deposits. Based on feedback from public comment and expert panel, the less stringent level of 6.8 mg/dl cut-off was used to evaluate quality of care. 6.8 mg/dl is the solubility concentration of urate crystals. Serum urate responds to changes in urate lowering therapy within 14-days. The Guidelines recommends dose titration every 2-5 weeks. Twelve months was selected as sufficient time to achieve serum urate target, evidence Level C.