



2016 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 \geq 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 \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.

NUMERATOR: Patients with $\geq 50\%$ 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 $\geq 50\%$ 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

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 \geq 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

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 (PROPF CAT)
- 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 feedback 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 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 (>3months). (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. (ACE7)

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