

eMeasure Title	Functional Status Assessments and Goal Setting for Chronic Pain Due to Osteoarthritis		
eMeasure Identifier (Measure Authoring Tool)	336	eMeasure Version number	0
NQF Number	NA	GUID	1118968d-77a0-4249-9a3f-3dae72833578
Measurement Period	January 1, 20xx through December 31, 20xx		
Measure Steward	Centers for Medicare & Medicaid Services		
Measure Developer	Mathematica Policy Research		
Measure Developer	National Committee for Quality Assurance		
Endorsed By	None		
Description	Percentage of patients 18 years of age and older with a diagnosis of hip or knee osteoarthritis for whom a score from one of a select list of validated pain interference assessment tools was recorded at least twice during the measurement period and for whom a care goal was documented and linked to the initial assessment.		
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Measure Scoring	Proportion		
Measure Type	Process		
Stratification	None		
Risk Adjustment	None		
Rate Aggregation	None		
Rationale	Osteoarthritis is among the most common diseases in the United States, with approximately 27 million adults living with the condition (National Arthritis Data Workgroup 2008). Population aging and high obesity rates—the factors generally most associated with osteoarthritis—are expected to persist in the future; this will continue to		

	<p>drive increasing prevalence of the disease and its overall burden (Arthritis Foundation and Centers for Disease Control and Prevention [CDC] 2010).</p> <p>This measure is expected to increase practitioners' use of patient-reported pain interference assessments, which clinical guidelines indicate are a necessary precursor to setting appropriate goals and designing individualized care plans to manage chronic pain (Hooten et al. 2013). Pain assessments help to engage patients in setting their own outcome objectives, foster appropriate treatment expectations, and guide appropriate and coordinated pain management (National Pharmaceutical Council and the Joint Commission 2001). By better understanding how patients' pain affects their physical, mental, and social functioning, the care team can better deliver patient-centered pain management care. Moreover, there is some evidence that goal setting itself—at least as one component of a self-management program—may improve patient outcomes (Allen et al. 2010).</p>
Clinical Recommendation Statement	<p>"In people with hip or knee OA, initial assessments should use a biopsychosocial approach including (Fernandes et al. 2013):</p> <ul style="list-style-type: none"> • Physical status (including pain; fatigue; sleep quality; lower limb joint status (foot, knee, hip); mobility; strength; joint alignment; proprioception and posture; comorbidities; weight) • Activities of daily living • Participation (work/education, leisure, social roles) • Mood • Health education needs, health beliefs and motivation to self-manage" <p>"Treatment of hip and/or knee OA should be individualised according to the wishes and expectations of the individual." (Fernandes et al. 2013)</p> <p>"All people with knee/hip OA should receive an individualised management plan (a package of care) that includes the core non-pharmacological approaches." (Fernandes et al. 2013)</p> <p>"When lifestyle changes are recommended, people with hip or knee OA should receive an individually tailored programme, including long-term and short-term goals, intervention or action plans, and regular evaluation and follow-up with possibilities for adjustment of the programme." (Fernandes et al. 2013)</p>
Improvement Notation	A higher rate indicates better quality
Reference	Allen K., E. Oddone, C. Coffman, S. Datta, K. Juntilla, J. Lindquist, T. Walker, M. Weinberger, and H. Bosworth. "Telephone-Based Self-Management of Osteoarthritis: A Randomized Trial." <i>Annals of Internal Medicine</i> , vol. 153, no. 9, 2010, pp. 570–579.
Reference	Hooten W., R. Timming, M. Belgrade, J. Gaul, M. Goertz, B. Haake, C. Myers, M. Noonan, J. Owens, L. Saeger, K. Schweim, G. Shteyman, N. Walker, et al. "Assessment and Management of Chronic Pain." Institute of Clinical Systems Improvement, 2013. Available at https://www.icsi.org/_asset/bw798b/ChronicPain.pdf . https://www.icsi.org/_asset/bw798b/ChronicPain.pdf . Accessed February 24, 2014.
Reference	National Pharmaceutical Council and the Joint Commission. "Pain: Current Understanding of Assessment, Management, and Treatments." 2001. Available at http://www.npcnow.org/App_Themes/Public/pdf/Issues/pub_related_research/pub_quality_care/Pain-Current-Understanding-of-Assessment-Management-and-Treatments.pdf . Accessed December 18, 2013.
Reference	Fernandes, L., K.B. Hagen, J.W. Bijlsma, et al. EULAR Recommendations for the Non-Pharmacological Core Management of Hip and Knee Osteoarthritis." <i>Annals of the Rheumatic Diseases</i> . 2013; doi:10.1136/annrheumdis-2012-202745.
Reference	National Arthritis Data Workgroup. "Estimates of the Prevalence of Arthritis and Other Rheumatic Conditions in the United States, Part II." <i>Arthritis & Rheumatism</i> , vol.58, no. 1, 2008, pp. 26-35.
Reference	Arthritis Foundation and Centers for Disease Control and Prevention. "A National Public

	Health Agenda for Osteoarthritis. 2010." 2010. Available at http://www.cdc.gov/arthritis/docs/oaagenda.pdf . Accessed May 5, 2014.
Definition	<p>Pain assessment: Assessment of pain using a multi-dimensional tool is recommended for patients with chronic pain and osteoarthritis to evaluate the impact that pain has on function, quality of life, occupation, mood, relationships, and social activity, among other aspects of daily living.</p> <p>Index Pain Assessment Score: The first pain interference assessment score recorded in the patient record during the measurement period. The index pain score can either be recorded as (1) the cumulative score of the individually scored components or (2) an aggregate of all individual scores of the components included in the functional status assessment tool. The index pain score does not need to occur during an in-person encounter to be considered valid.</p>
Guidance	<ul style="list-style-type: none"> — Patients must have completed a pain assessment from one of the following: Brief Pain Inventory (BPI) Short Form Pain Interference Subscale, PROMIS Pain Interference Short Form 8a, the HOOS Hip Survey, or the KOOS Knee Survey. — The pain assessment score documented in the electronic health record can be either the total score or a total score summed from all the item-level scores. For the HOOS/KOOS, two subscale total scores ("Function, daily living" and "Function, sports, and recreational activities") may be reported in place of a total tool score. — The Index Pain Assessment Score must be linked to an encounter (the FSA visit). Completion of the pain assessment can occur during the encounter or within 7 days prior to it. — A quantitative goal based on the pain assessment (either total or item-level score) must be set and documented during or up to 72 hours following the initial pain assessment-related encounter. — Patients must also complete a second pain assessment using the same tool as the index pain assessment at least 15 days after the index pain assessment.
Transmission Format	TBD
Initial Patient Population	Patients 18 years of age and older with a diagnosis of hip or knee osteoarthritis and an encounter during the measurement period
Denominator	Patients in the Initial Patient Population who have their first encounter within the first 335 days of the measurement period
Denominator Exclusions	None
Numerator	Patients for whom a score from one of a select list of pain interference assessment tools was recorded at least twice during the measurement period and for whom a care goal was documented and linked to the initial assessment
Numerator Exclusions	Not Applicable
Denominator Exceptions	None
Measure Population	Not Applicable
Measure Observations	Not Applicable
Supplemental Data Elements	For every patient evaluated by this measure also identify payer, race, ethnicity and sex.