



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 #: 1932

Corresponding Measures:

De.2. Measure Title: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

1b.1. Developer Rationale: As patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases, screening for diabetes will allow for proper diagnosis and treatment, if warranted.

S.4. Numerator Statement: Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

S.6. Denominator Statement: Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

S.8. Denominator Exclusions: Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Health Plan, Integrated Delivery System, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Nov 02, 2012 **Most Recent Endorsement Date:** Oct 26, 2018

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? Not applicable.

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

[1932_SSD_MEF_7.1.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.

Yes

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.

As patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases, screening for diabetes will allow for proper diagnosis and treatment, if warranted.

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.*

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th, 50th, 75th, and 90th percentile. Data are stratified by year and product line (i.e. Medicaid).

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications– Medicaid Rate (HMO and PPO Combined)

MEASUREMENT YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range

2015 | 79.8% | 0.1 | 72.7% | 75.7% | 80.1% | 83.8% | 87.0% | 8.1

2016 | 80.4% | 0.1 | 72.3% | 77.4% | 80.7% | 84.0% | 87.2% | 6.6

2017 | 80.7% | 0.1 | 74.0% | 77.5% | 81.0% | 84.2% | 87.4% | 6.7

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2016, HEDIS measures covered 47 million Medicaid health plan beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications– Medicaid
YEAR | N Plans | Median Denominator Size per plan

2015 | 143 | 437

2016 | 185 | 804

2017 | 202 | 1,018

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.

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. The HEDIS Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

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

A number of research studies, including several meta-analyses, demonstrate that individuals with serious mental illness have an increased risk for diabetes as well as disparities in their care.

One review article estimated the prevalence of diabetes among individuals with SMI is approximately 12% (Holt and Mitchell, 2015), while the prevalence in the general population is approximately 9% aged ≥18 (CDC, 2017). Additionally, there is a known link between SMI treatments such as mood stabilizers, anticonvulsants and antipsychotic medications to adverse metabolic risks in patients, such as diabetes (Vancampfort, 2016).

A systematic review article assessed 118 cross-sectional, retrospective and prospective studies, and population versus non-population based studies comparing SMI individuals with non-serious mental illness control groups. Based on this evidence review, authors conclude that diabetes is more common among patients with SMI with a relative risk of 2.04 in patients with schizophrenia or related psychotic disorders and 1.89 in patients with bipolar disorder compared to the general population (Vancampfort, 2016).

Evidence suggests that individuals with SMI, specifically those with schizophrenia and bipolar disorder, are at increased risk of developing diabetes due to a higher prevalence of risk factors including tobacco use, poor nutrition and obesity and weight gain from the use of antipsychotics (Mangurian, 2016). Furthermore, these risk factors result in increased morbidity, such as hospitalizations and complications from diabetes, and mortality in the SMI population (Mai et al., 2011; CDC, 2010).

Despite these risks, people with SMI are less likely to have annual A1c testing or glucose screening (Banta 2009; Mai, 2011; Mangurian et al., 2016). A literature review found that up to 70% of individuals on antipsychotics do not receive screening or treatment for diabetes (Mangurian et al., 2016). In another study, only 47.3% of Medicaid psychiatric patients received annual HbA1c testing. Further, researchers in this study found that second-generation antipsychotic medications, used for schizophrenic and bipolar patients, were associated with higher diabetes risk and a reduced likelihood of HbA1c testing. (Banta, 2009)

Another study found that only 37.2% of mental health patients, compared to 42.9% of non-mental health patients, received a recommended HbA1c annual test. In general, patients with mental illness received less ongoing diabetes monitoring and had higher risk for diabetes complications and diabetes-related mortality compared to non-mental health patients (Mai, 2011).

References

Banta JE, Morrato EH, Lee SW, et al. (2009) Retrospective Analysis of Diabetes Care in California Medicaid Patients with Mental Illness. *J Gen Intern Med.* 24:802-8.

Centers for Disease Control and Prevention (CDC). (2010) Diagnosed and undiagnosed diabetes in the United States, all ages, 2010. Retrieved from: <http://www.cdc.gov/diabetes/pubs/estimates11.htm>. Accessed on June 19, 2014.

Centers for Disease Control and Prevention (CDC). National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017.

Holt R.I., Mitchell A.J. (2015). Diabetes mellitus and severe mental illness: mechanisms and clinical implications. *Nat Rev Endocrinol*. 2015 Feb;11(2):79-89. doi: 10.1038/nrendo.2014.203.

Mai Q, Holman CD, Sanfilippo FM, et al. (2011) Mental illness related disparities in diabetes prevalence, quality of care and outcomes: a population-based longitudinal study. *BMC Medicine*. 9:118.

Mangurian, C., Newcomer, J.W., Modlin, C. et al. Diabetes and Cardiovascular Care Among People with Severe Mental Illness: A Literature Review. *J GEN INTERN MED* (2016) 31: 1083. <https://doi.org/10.1007/s11606-016-3712-4>

Mangurian C, Newcomer JW, Vittinghoff E, Creasman JM, Knapp P, Fuentes-Afflick E, Schillinger D. Diabetes Screening Among Underserved Adults With Severe Mental Illness Who Take Antipsychotic Medications. *JAMA Intern Med*. 2015;175(12):1977–1979. doi:10.1001/jamainternmed.2015.6098

Vancampfort D, Correll CU, Galling B, et al. Diabetes mellitus in people with schizophrenia, bipolar disorder and major depressive disorder: a systematic review and large scale meta-analysis. *World Psychiatry*. 2016;15(2):166-174. doi:10.1002/wps.20309.

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):

Behavioral Health, Endocrine : Diabetes

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

Primary Prevention

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Populations at Risk

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.)

Not Applicable

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: 1932_SSD_Value_Sets.xlsx

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

No, this is not an instrument-based measure Attachment:

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

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

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.

No important changes since the last update.

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).

Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

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).

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.

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

Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

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).

Follow the steps below to identify the eligible population.

Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
 - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
 - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
 - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.
 - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
 - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.
 - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:

- BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
- ED Value Set with Schizophrenia Value Set.
- BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:
 - BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
 - BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.
 - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
 - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.
 - ED Value Set with Bipolar Disorder Value Set.
 - ED Value Set with Other Bipolar Disorder Value Set.
 - BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.
 - BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.
 - BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.
 - BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.
 - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.
 - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

(See corresponding Excel document for the above value sets)

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

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

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.)*

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).

Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlintide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin degludec, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin human inhaled

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set).
- Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.

ANTIPSYCHOTIC MEDICATIONS:

(Antipsychotic Medications List)

Miscellaneous antipsychotic agents:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone

Phenothiazine antipsychotics:

Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine

Thioxanthenes:

Thiothixene

Long-acting injections:

Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

(Antipsychotic Combination Medications List)

Psychotherapeutic combinations:

Fluoxetine-olanzapine, Perphenazine-amitriptyline

See corresponding Excel document for the value sets referenced above.

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.)

None.

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.)

Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.
- Patients with diabetes during the measurement year or the year prior to the measurement year.
- Patients who had no antipsychotic medications dispensed during the measurement year.

Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year.

Step 4. Calculate the rate.

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.

Not applicable.

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.

Claims

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database,

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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.

This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

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)*

No data collection instrument provided

S.20. Level of Analysis *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*

Health Plan, Integrated Delivery System, Population : Regional and State

S.21. Care Setting *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*

Other:Any outpatient setting represented with Medicaid claims data, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications *(Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)*

N/A

2. Validity – See attached Measure Testing Submission Form

[1932_-_SSD_-_Testing_Form_v7.1_FINAL.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 electronic claims

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).

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:

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.

NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

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).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

NCQA STATE OF HEALTH CARE QUALITY REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. In 2017, the report included results from calendar year 2016 for health plans covering over 171 million people.

NCQA HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings, which are reported in Consumer Reports and on the NCQA website. These rankings are based on performance on HEDIS measures among other factors. In 2016, a total of 472 Medicare Advantage health plans, 413 commercial health plans and 270 Medicaid health plans across 50 states were included in the rankings.

MEDICAID ADULT CORE SET: The Affordable Care Act (Section 1139B) requires the Secretary of HHS to identify and publish a core set of health care quality measures for adult Medicaid enrollees. The law requires that measures designated for the core set be currently in use. CMS annually releases information on state progress in reporting the Adult Core Set measures and assesses state-specific performance for measures that are reported by at least 25 states and which met internal standards of data quality.

NCQA QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting health plans, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the

ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

NCQA HEALTH PLAN ACCREDITATION: This measure is used to calculate health plan ratings, which are reported on the NCQA website. These ratings are based on a plan's performance on their HEDIS, CAHPS and accreditation standards scores. In 2017, a total of 521 Medicare Advantage health plans, 614 commercial health plans and 294 Medicaid health plans across 50 states, D.C., Guam, Puerto Rico, and the Virgin Islands were included in the Ratings.

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?)

N/A

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.)

N/A

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.

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

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.

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

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.

NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. Summarize the feedback obtained from those being measured.

In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the specifications, such as benefit requirements to report the measure and approved medications to identify the eligible population. NCQA responded to all questions to ensure consistent implementation of the specifications.

4a2.2.3. Summarize the feedback obtained from other users

This measure has been deemed a priority measure by NCQA and other entities, like the Medicaid Adult Core Set.

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.

Feedback has not required modification to this measure.

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.

From 2015 to 2017, performance rates for this measure have been generally stable or shown slight improvement. In 2017, Medicaid plans had an average performance rate of 81 percent. There continues to be significant variation between the 10th and 90th percentiles, suggesting room for improvement. In 2017, Medicaid plans in the 10th percentile had a rate of 74 percent, compared to 87 percent among plans in the 90th percentile.

This measure was first introduced in HEDIS 2013. Rates for Medicaid were 78.0 percent. In the last 5 years, we have seen improvement of three percent.

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.

There were no identified unintended consequences for this measure during testing or since implementation.

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

There were no identified unintended consequences for this measure during testing or since implementation.

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.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

1933 : Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)

1934 : Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

N/A

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?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

N/A

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.)

N/A

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.

No appendix Attachment:

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Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

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Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

Co.4 Point of Contact: Kristen, Swift, Swift@ncqa.org, 202-955-5174-

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.

The Technical Advisory Group advised Mathematica Policy Research, Inc. and the National Committee for Quality Assurance during measure development. The TAG was responsible for providing feedback on measure concepts, specifications, results from field and data testing. The TAG consisted of a multistakeholder group of experts with knowledge in behavioral health and quality measurement.

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#1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), Last Updated: Oct 26, 2018

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 John Straus, MD, Massachusetts Behavioral Health Partnership-A Beacon Health Options Company

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2012

Ad.3 Month and Year of most recent revision: 04, 2018

Ad.4 What is your frequency for review/update of this measure? Every 3-5 years.

Ad.5 When is the next scheduled review/update for this measure? 12, 2019

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