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 #: 0055
Corresponding Measures:
De.2. **Measure Title:** Comprehensive Diabetes Care: Eye Exam (retinal) performed
Co.1.1. **Measure Steward:** National Committee for Quality Assurance
De.3. **Brief Description of Measure:** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who had an eye exam (retinal) performed.
1b.1. **Developer Rationale:** This measure promotes regular eye examinations in diabetic adults (ages 18-75). Diabetic retinopathy and vision loss are complications from diabetes. Adults with diabetes that do not receive regular retinal examinations are at a higher risk for developing these vision complications. Vision screenings are part of high quality care for patients with diabetes.

S.4. **Numerator Statement:** Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:
-a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year
–a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.
S.6. **Denominator Statement:** Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.
S.8. **Denominator Exclusions:** Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):
-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
-Exclude patients 65 and older with an advanced illness condition and frailty

De.1. **Measure Type:** Process
S.17. **Data Source:** Claims, Electronic Health Data, Paper Medical Records
S.20. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Aug 10, 2009 **Most Recent Endorsement Date:** Oct 25, 2018

IF this measure is included in a composite, NQF Composite#/title:
0731:Comprehensive Diabetes Care

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?** N/A

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
nqf_evidence_0055_Eye_Exam_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.
This measure promotes regular eye examinations in diabetic adults (ages 18-75). Diabetic retinopathy and vision loss are complications from diabetes. Adults with diabetes that do not receive regular retinal examinations are at a higher risk for developing these vision complications. Vision screenings are part of high quality care for patients with diabetes.

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 reporting for this measure. Performance data is summarized at the health plan level and summarized by number of plans reporting, mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data is stratified by year and product line (i.e. commercial, Medicare, and Medicaid).

Comprehensive Diabetes Care: Eye Exam (Retinal) Performed
*Higher score= better performance
N= Number of plans reporting

Commercial Rate

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2016	411	50.5%	12.6%	19.8%	35.7%	41.6%	49.8%	55.0%	68.0%	87.8%
2015	418	50.4%	12.6%	14.3%	34.5%	41.6%	48.9%	58.4%	69.0%	86.5%
2014	391	52.6%	12.3%	25.1%	37.5%	44.5%	50.9%	60.6%	70.4%	86.3%

Medicaid Rate

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2016	271	54.9%	11.7%	15.3%	39.6%	47.6%	55.2%	63.5%	68.2%	87.8%
2015	261	52.8%	12.6%	14.9%	36.6%	44.5%	53.7%	61.5%	68.1%	88.7%
2014	220	54.4%	11.6%	23.2%	38.8%	47.1%	54.8%	63.3%	67.8%	87.3%

Medicare Rate

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2016	473	70.2%	11.0%	25.8%	56.2%	64.2%	71.0%	77.7%	83.1%	96.6%
2015	460	68.7%	11.2%	19.0%	54.3%	62.0%	69.0%	76.9%	82.4%	93.3%
2014	475	68.5%	11.5%	14.1%	55.0%	61.3%	69.2%	76.6%	82.0%	97.1%

This measure is used NCQA's Diabetes Recognition Program (DRP) that assesses clinician performance on key quality measures that are based on national evidence based guidelines in diabetes care (see full description of program in 4a1.1).

Diabetes Recognition Program -

YEAR	N	MEAN	ST DEV	MIN	10TH	25TH	50TH	75TH	90TH	MAX
2017	3771	62.8%	21.3%	0.00%	28.0%	48.0%	68.0%	82.0%	88.0%	100.00%
2016	4704	60.2%	22.8%	0.00%	28.0%	48.0%	64.0%	77.3%	85.3%	100.00%
2015	4989	61.4%	24.3%	0.00%	25.7%	44.0%	64.0%	80.0%	88.6%	100.00%

PQRS

The following PQRS performance data includes claims, registry, measures group, GPRO Web Interface/ACO, QCDR data for services performed from in 2015.

Mean: 78.1%
St dev: 28.3%

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 cross-sectional study aimed to observe the impact of racial disparities and other influencing factors such as age, gender, education, and insurance on eye examination rates among adults 18-64 years of age with diabetes. The study used data from the Medical Expenditure Panel Survey (MEPS) Household Component including the Diabetes Care Survey between 2002-2009. Eye examination rates were compared each year between non-Hispanic whites and minorities which included, but not limited to, black, American Indian/Alaska native, Asian, native Hawaiian/Pacific Islander). Between 2002-2009 there were approximately a weighted 60 percent of non-Hispanic whites compared to a 40 percent of minorities. The study found that across all years of the study, minorities had consistently lower unadjusted eye examination rates compared to non-Hispanic whites. Between 2002-2009, the unadjusted rate for eye examinations for minorities dropped from 56 percent to 49 percent while rates for non-Hispanic whites increased from 56 percent to 59 percent. When assessing associations between other influencing factors such as age, the study found that adults 45 years and older were more likely to receive an eye examination compared to adults between 18-45 years of age. The study also found that for all years except 2007, having health insurance was associated with an increased rate of eye examinations. Overall, the study found that racial disparities and other influencing factors has an impact on rates of eye examinations among patients with diabetes and there needs to be more efforts to improve screening and testing of diabetic retinopathy among minorities (Shi et al., 2014).

Another cross-sectional study also analyzed MEPS data from 2013 to assess racial and ethnic disparities in diabetes quality of care among adults with type II diabetes. The study controlled for health insurance status, poverty, and education and observed the difference in adherence to five diabetes quality of care recommendations (HbA1c twice yearly, yearly foot exam, dilated eye exam, blood cholesterol test, and flu vaccination. Among 65 percent of patients who received an eye exam, Hispanics, blacks, and Asians had lower rates compared to whites. Overall, the study noted that improvement in quality if diabetes care will help reduce diabetes complications and mortality (Canedo et al., 2018).

Shi Q, Zhao Y, Fonseca V, Krousel-Wood M, & Shi L. Racial Disparity of Eye Examinations Among the U.S. Working-Age Population With Diabetes: 2002-2009. 2014. Diabetes Care;37:1321-1328, doi: 10.2337/dc13-1038.

Canedo JR, Miller ST, Schlundt D, Fadden MK, Sanderson M. Racial/Ethnic Disparities in Diabetes Quality of Care: the Role of Healthcare Access and Socioeconomic Status. 2018. Journal of Racial Ethnic Health Disparities;5(1):7-14. doi: 10.1007/s40615-016-0335-8.

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):*
Endocrine, Endocrine : Diabetes

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

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.)*
NA

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:** 0055_CDC_Eye_Exam_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.
Yes

S.3.2. **For maintenance of endorsement,** please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.
-An additional route for numerator compliance was added to the measure which includes: Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year. This was added because these patients do not have retina's to examine
-Added another optional exclusion which is to exclude patients 65 and older with an advanced illness condition and frailty. This was added because quality measures that were intended for the general population may not be clinically appropriate or priority for individuals with advanced illness.

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).
Patients who received an eye screening for diabetic retinal disease. This includes people with diabetes who had the following:
-a retinal or dilated eye exam by an eye care professional (optometrists or ophthalmologist) in the measurement year
–a negative retinal exam or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

For exams performed in the year prior to the measurement year, a result must be available.

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).
Time period for data: a measurement year (12 months)

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying numerator events for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD: At a minimum, documentation in the medical record must include one of the following:

- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
-Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
-Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings). Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

The patient is numerator compliant if the eye exam was performed in the measurement year or a negative eye exam was documented in the year prior to the measurement year. The patient is not numerator compliant if the eye exam or negative result are missing. Ranges and thresholds do not meet criteria for this measure.

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 or type 2) during the measurement year or the year prior to the measurement year.

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).
Patients with diabetes can be identified two ways:
-CLAIM/ENCOUNTER DATA: Patients who had two face-to-face encounters, in an outpatient setting, observations visits, ED setting on different dates of service, or nonacute inpatient setting with a diagnosis of diabetes, or one face-to-face encounter in an acute inpatient, with a diagnosis of diabetes, during the measurement year or the year prior to the measurement year. Organizations may count services that occur over both years.
*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

-PHARMACY DATA: Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (TABLE CDC-A):
Alpha-glucosidase inhibitors:
Acarbose, Miglitol

Amylin analogs:
Pramlinitide

Antidiabetic combinations:
Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empaglifozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metaformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metaformin-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

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclusions (optional):
-Exclude patients who did not have a diagnosis of diabetes, in any setting, AND who had a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
-Exclude patients 65 and older with an advanced illness condition and frailty

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.)*
ADMINISTRATIVE CLAIMS:
Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients 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).

ADMINISTRATIVE CLAIMS: Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:
-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and had a diagnosis of polycystic ovaries any time in the patient's history through December 31 of the measurement year.
OR
-Exclusionary evidence in the medical record must include a note indicating the patient did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year and a diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

S.10. **Stratification Information** *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*
N/A

S.11. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in measure testing attachment)
No risk adjustment or risk stratification
If other:

S.12. **Type of score:**
Rate/proportion
If other:

S.13. **Interpretation of Score** *(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)*
Better quality = Higher score

S.14. **Calculation Algorithm/Measure Logic** (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*
STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.

-AGES: 18-75 years as of December 31 of the measurement year.
-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.
Claim/Encounter Data:
-Patients who had at least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
-Patients with at least one acute inpatient encounter with a diagnosis of diabetes.
*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:
Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.
*SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN QUESTION S.7

STEP 2. Determine the number of patients in the eligible population who had a recent eye exam (retinal) performed during the measurement year through the search of administrative data systems.
STEP 3. Identify patients with a most recent eye exam (retinal) performed and the result.
STEP 4. Identify the most recent eye exam (retinal) during the measurement year or a negative result prior to the measurement year (numerator compliant). Identify missing eye exam or missing eye exam result (not numerator compliant).
STEP 5. Exclude from the eligible population patients from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured.
*SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.8
STEP 6. Calculate the rate (number of patients with an eye exam (retinal) performed during the measurement year or negative result prior to the measurement year).

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.
N/A

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, Electronic Health Data, Paper Medical Records

S.18. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*
IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.
This measure uses a combination of administrative claims data and medical records. Eye screening for diabetic retinal disease can be identified by the following administrative data:
-Retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year.
-A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year.
-Bilateral eye enucleation anytime during the patient's history through December 31 of the measurement year

Codes in the following value sets will meet these criteria:
-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year.
-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional during the year prior to the measurement year, with a negative result (negative for retinopathy).
-Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a diagnosis of diabetes without complications

-Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the measurement year.
-Any code in the Diabetic Retinal Screening with Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy).
-Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year.
-Unilateral eye enucleation (Unilateral Eye Enucleation Value Set) with a bilateral modifier (Bilateral Modifer Value Set)
-Two unilateral eye enucleations (Unilateral Eye Enucleation Left Value Set) with service dates 14 days or more part.
-Left unilateral eye enucleation (Unilateral Eye Enucleation Left Value Set) and right unilateral eye enucleation (Unilateral Eye Enucleation Right Value Set) on the same or different dates of service

The minimum medical record documentation includes one of the following:
- A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
- A chart or photograph indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
-Evidence that the member had bilateral eye enucleation or acquired absence of both eyes. Look as far back as possible in the member's history through December 31 of the measurement year.
-Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings). Documentation does not have to state specifically "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

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)*
Clinician : Group/Practice, Clinician : Individual, Health Plan

S.21. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Outpatient Services
If other:

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

2. Validity – See attached Measure Testing Submission Form
nqf_testing_0055_Eye_Exam_7.1_updated_4.18.18.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), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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**.

Some data elements are in defined fields in electronic sources

3b.2. **If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.** For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

To allow for widespread reporting across health plans and health care practices, this measure is collected through multiple data sources (administrative data, electronic clinical data, and paper records). We anticipate as electronic health records become more widespread the reliance on paper record review will decrease.

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 are 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

STATE OF HEALTH CARE ANNUAL 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. In 2017, the report included results from calendar year 2016 for health plans covering a record 136 million people, or 43 percent of the U.S. population

HEALTH PLAN RANKINGS/REPORT CARDS: This measure is used to calculate health plan rakings 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.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, 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.

MEDICARE ADVANTAGE PLAN RATING: This measure is included in the composite Medicare Advantage Star Rating. CMS calculates a Star Rating (1-5) for all Medicare Advantage health plans based on 53 performance measures. Medicare beneficiaries can view the star rating and individual measure scores on the CMS Plan Compare website. The Star Rating is also used to calculate bonus payments to health plans with excellent performance. The Medicare Advantage Plan Rating program covers 11.5 million Medicare beneficiaries in 455 health plans across all 50 states.

CMS QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs).

ACCOUNTABLE CARE ORGANIZATION ACCREDITATION: This measure is used in NCQA's ACO Accreditation program, that helps health care organizations demonstrate their ability to improve quality, reduce costs and coordinate patient care. ACO standards and guidelines incorporate whole-person care coordination throughout the health care system.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of commercial, Medicaid, and Medicare health plans. As of Fall 2017, a total of 184 Medicare Advantage health plans were accredited using this measure among others covering 9.2 million Medicare beneficiaries; 451 commercial health plans covering 113 million lives; and 125 Medicaid health plans covering 35 million lives. Health plans are scored based on performance compared to benchmarks.

DIABETES RECOGNITION PROGRAM: This measure is used NCQA's Diabetes Recognition Program (DRP) that assesses clinician performance on key quality measures that are based on national evidence based guidelines in diabetes care. The program currently has more than 10,000 clinicians in solo and group practice who hold recognition for providing quality care for their patients with diabetes. The DRP Program has 6 measures which cover other areas such as: HbA1c control, blood Pressure control, eye examinations, nephropathy assessment, smoking and tobacco use and cessation advice or treatment, and foot examinations. Individual clinicians or clinicians within a group practice must have face to face contact with and submit data on care delivered for a 12-month period to at least 25 different eligible adults patients with diabetes.

INTEGRATED HEALTHCARE ASSOCIATION (IHA) CALIFORNIA PAY FOR PERFORMANCE: This measure is used in the California P4P program which is the largest non-governmental physician incentive program in the United States. Founded in 2001, it is managed by the Integrated Healthcare Association (IHA) on behalf of eight health plans representing 10 million insured persons. IHA is responsible for collecting data, deploying a common measure set, and reporting results for approximately 35,000 physicians in nearly 200 physician groups. This program represents the longest running U.S. example of data aggregation and standardized results reporting across diverse regions and multiple health plans. California consumers benefit from the availability of standardized performance results from a common measure set, which are available to the public through the State of California, Office of the Patient Advocate

QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible clinicals (ECs).

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, as described in Section 3c.1.

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 using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. 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.**
Questions received through the Policy Clarification Support system have generally centered around clarification on which type of health care professional can conduct and review eye exams, types of photography that can count as an eye exam, and whether specific documentation counts as a negative or positive diagnosis for retinopathy

4a2.2.3. **Summarize the feedback obtained from other users**
This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the PQRS and the Qualified Health Plan Quality Rating System.

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.**
We have provided minor clarifications about the measure during the annual update process in order to address questions received through the Policy Clarification Support system.

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.
Overall, this measure has shown slight improvement for Medicare plans, a slight decline in performance for commercial plans, and a no change for Medicaid plans over the past three years. (see section 1b.2 for summary of data from commercial, Medicaid, and Medicare Health Plans). These data are nationally representative.

Since 2013, there has been an increase in the number of reporting physicians seeking recognition in NCQA's DRP program and an increase in performance, however from 2015-2017 there has been a slight decline in number of physicians and practices (see summary data in 1b.2.)

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 unexpected findings during testing or since implementation of this measure.

4b2.2. **Please explain any unexpected benefits from implementation of this measure.**
There were no identified unexpected benefits during testing or since implementation of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures
Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
No

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

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;
OR
The differences in specifications are justified

5a.1. **If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):**
Are the measure specifications harmonized to the extent possible?
No

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:**

Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
Co.2 **Point of Contact:** Bob, Rehm, nqf@ncqa.org, 202-955-1728-
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.
DIABETES EXPERT PANEL:
Bill Herman (Chair), MD, Univ. of Michigan Health System
David Aron, MD, Department of Veteran's Affairs
James Fain, PhD, RN, University of Massachussetts
Jerry Cavallerano, OD, Beetham Eye Institute
John Thompson, MD, Retina Specialists
Judith Fradkin, MD, NIDDK/NIH
Lynne Levitsky, MD, Massachusetts General Hospital
Mark Cziraky, PharmD, Healthcore
Richard Hellman, MD, Private Practice, Diabetes & Endocrinology
Seth Rubenstein, DPM, Reston Hospital Center, INOVA Fair Oaks Hospital
Stephen Fadem, MD, Baylor College of Medicine
Ted Ganiats, MD, Univ. of California, San Diego
Nancy Van Vessem, MD, Capital Health Plan

HEDIS EXPERT CODING PANEL
Glen Braden, MBA, CHCA, Attest Health Care Advisors, LLC
Denene Harper, RHIA, American Hospital Association
DeHandro Hayden, BS, American Medical Association
Patience Hoag, RHIT, CPHQ, CHCA, CCS, CCS-P, Aqurate Health Data Management, Inc.

Nelly Leon-Chisen, RHIA, American Hospital Association
Alec McLure, MPH, RHIA, CCS-P, Verscend Technologies
Michele Mouradian, RN, BSN, Change HealthCare
Craig Thacker, RN, CIGNA HealthCare
Mary Jane F. Toomey, RN CPC, WellCare Health Plans, Inc.

COMMITTEE ON PERFORMANCE MEASUREMENT:
Bruce Bagley, MD, FAAFP, Independent Consultant
Andrew Baskin, MD, Aetna
Jonathan D. Darer, MD, Siemens Healthineers
Helen Darling, MA, Strategic Advisor on Health Benefits & Health Care
Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas
Kate Goodrich, MD, MHS, Centers for Medicare and Medicaid Services
David Grossman, MD, MPH, Washington Permanente Medical Group
Christine Hunter, MD, (Co-Chair) US Office of Personnel Management
Jeffrey Kelman, MMSc, MD, United States Department of Health and Human Services
Nancy Lane, PhD, Independent Consultant
Bernadette Loftus, MD, The Permanente Medical Group
Adrienne Mims, MD, MPH, Alliant Quality
Amanda Parsons, MD, MBA, Montefiore Health System
Wayne Rawlins, MD, MBA, ConnectiCare
Rodolfo Saenz, MD, MMM, FACOG, Riverside Medical Clinic
Eric C. Schneider, MD, MSc (Co-Chair), The Commonwealth Fund
Marcus Thygeson, MD, MPH, Adaptive Health
JoAnn Volk, MA, Reforms
Lina Walker, PhD, AARP

CLINICAL PROGRAMS COMMITTEE
Randall Curnow, MD, MBA, FACP, FACHE, FACPE (Chair), TriHealth
Suzanne Berman, MD, FAAP, Plateau Pediatrics
Brooks Daveman, MPP, Tennessee Division of Health Care Finance and Administration
Marcus Friedrich, MD, MBA, FACP, New York State Department Health Empire State Plaza, Coming Towne
Jennifer Gutzmore, MD, Cigna
Melissa Hogan, MPH, Aon
Adriana Matiz, MD, FAAP, Ambulatory Care Network
Lisa Morrise, Marts, LAM Professional Services, LLC
Deborah Murph, MBA, BSN, RN, Cherokee Health Systems
Amy Nguyen Howell, MD, MBA, CAPG
Marc Rivo, MD, Population Health Innovations
Julie Schilz, BSN, MBA, Anthem
Pamela Slaven-Lee, DNP, FNP-C, CHSE, The George Washington University School of Nnursing
Lina Walker, PhD, AARP

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.2 **Year the measure was first released:** 1999
Ad.3 **Month and Year of most recent revision:** 12, 2013
Ad.4 **What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines have changed significantly.
Ad.5 **When is the next scheduled review/update for this measure?** 12, 2019

Ad.6 **Copyright statement:** The performance measures and specifications were developed by and are owned by the National Committee for Quality Assurance
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