



**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).

<b>Brief Measure Information</b>
<p><b>NQF #: 0056</b></p> <p><b>Corresponding Measures:</b></p> <p><b>De.2. Measure Title:</b> Diabetes: Foot Exam</p> <p><b>Co.1.1. Measure Steward:</b> National Committee for Quality Assurance</p> <p><b>De.3. Brief Description of Measure:</b> The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection and sensory exam with mono filament and a pulse exam) during the measurement year.</p> <p><b>1b.1. Developer Rationale:</b> This measure promotes regular foot examinations in adults with diabetes (ages 18-75). Because of macrovascular compromise leading to arterial insufficiency and microvascular effects on nerve function, surveillance of skin integrity is very important for patients with diabetes. Poor foot care can lead to infections and ultimately amputations of the toe, foot, lower limb, or upper limb. As a result of amputations, patients often experience drastic declines in quality of life. In order to maintain optimal quality of life for persons with diabetes, it is vital to maintain the highest quality of foot care in diabetic populations.</p>
<p><b>S.4. Numerator Statement:</b> Patients who received a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.</p> <p><b>S.6. Denominator Statement:</b> 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.</p> <p><b>S.8. Denominator Exclusions:</b> -Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes)</p> <p>-Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period.</p> <p>-Exclude patients who were in hospice care during the measurement year</p>
<p><b>De.1. Measure Type:</b> Process</p> <p><b>S.17. Data Source:</b> Electronic Health Data, Paper Medical Records</p> <p><b>S.20. Level of Analysis:</b> Clinician : Group/Practice, Clinician : Individual</p>
<p><b>IF Endorsement Maintenance – Original Endorsement Date:</b> Aug 10, 2009 <b>Most Recent Endorsement Date:</b> Oct 25, 2018</p>
<p><b>IF this measure is included in a composite, NQF Composite#/title:</b></p> <p><b>IF this measure is paired/grouped, NQF#/title:</b></p> <p><b>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?</b></p>

<b>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</b>
<p>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. <i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i></p>
<p><b>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form</b></p>

[nqf\\_evidence\\_0056\\_Foot\\_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.

No

**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 foot examinations in adults with diabetes (ages 18-75). Because of macrovascular compromise leading to arterial insufficiency and microvascular effects on nerve function, surveillance of skin integrity is very important for patients with diabetes. Poor foot care can lead to infections and ultimately amputations of the toe, foot, lower limb, or upper limb. As a result of amputations, patients often experience drastic declines in quality of life. In order to maintain optimal quality of life for persons with diabetes, it is vital to maintain the highest quality of foot care in diabetic populations.

**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.*

This measure is used NCOA'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). Below is performance data for this measure in the program.

Diabetes Recognition Program

YEAR|N|MEAN|ST DEV|MIN|10TH|25TH|50TH|75TH|90TH|MAX

2015|4989|74.3%|28.8%|0.0%|22.9%|65.4 |84.6%|95.4%|100.0%|100.0%

2016|4458|71.7%|29.2%|0.0%|20.0%|56.0%|84.0%|92.8%|98.9%|100.0%

2017|3971|75.2%|25.9%|0.0%|32.0%|64.0 |84.0%|94.8%|100.0%|100.0%

PQRS

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

Mean: 56.3%

St dev: 32.0%

**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.*

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 those data are available to a practice. See response in 1b.5 for more information.

**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**

The Centers for Disease Control and Prevention examined the proportion of diabetic adults (over age 18) that received a foot exam in a given year. This data was categorized based on race/ethnicity, age, sex, and education level. In 2010, Hispanics had the lowest percentage of foot exams (59%) in comparison to Whites (71%) and Blacks (77%) (CDC, 2012). In the same year, smaller disparities were seen according to age. Nearly 75% of all adults with diabetes between ages 65-74 received a foot exam, about 73% of adults between ages 45-64 and 71.5% of adults over age 75 (CDC, 2012). There were not significant disparities by gender: In 2010, 72.3% of males and 70.7% of females received foot exams (CDC, 2012). Adults with an education greater than high school received foot exams at 70% while adults with only a high school education received foot exams at 67.8%; this gap widens for adults that achieved less than a high school education with only 59.1% receiving foot exams (CDC, 2012).

Centers for Disease Control and Prevention (CDC). 2012. CDC's Diabetes Program-Data and Trends-Prevalence of Diabetes-Percent of Foot Exam in the Last Year for Adults Aged =18 Years, by Race/Ethnicity. Retrieved from <http://www.cdc.gov/diabetes/statistics/preventive/tNewFtChkRace.htm>.

Centers for Disease Control and Prevention (CDC). 2012. CDC's Diabetes Program-Data and Trends-Prevalence of Diabetes-Percent of Foot Exam in the Last Year for Adults Aged =18 Years, by Age. Retrieved from <http://www.cdc.gov/diabetes/statistics/preventive/tNewFtChkAgeTot.htm>.

Centers for Disease Control and Prevention (CDC). 2012. CDC's Diabetes Program-Data and Trends-Prevalence of Diabetes-Percent of Foot Exam in the Last Year for Adults Aged =18 Years, by Sex. Retrieved from <http://www.cdc.gov/diabetes/statistics/preventive/tNewFtChkSex.htm>.

Centers for Disease Control and Prevention (CDC). 2012. CDC's Diabetes Program-Data and Trends-Prevalence of Diabetes-Percent of Foot Exam in the Last Year for Adults Aged =18 Years, by Education. Retrieved from <http://www.cdc.gov/diabetes/statistics/preventive/tNewFtChkEduc.htm>.

## 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):

**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.)

**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:** 0056\_CDC\_Foot\_Exam\_Value\_Set\_.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.

N/A

**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 a foot exam (visual inspection and sensory exam with monofilament and pulse exam) during the measurement period.

**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 a note indicating the date when the exam was performed and the result. The patient is numerator compliant if a foot exam during the measurement year and result are documented. The patient is not numerator compliant if the result for the foot exam and result during the measurement year 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.

**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).*

**ENCOUNTER:** Patients who had a visit (office visit, face to face encounter, preventive care services, home healthcare services, annual wellness) during the measurement period

**PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES:**

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

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

- Patients with a diagnosis of secondary diabetes due to another condition (e.g. a diagnosis of gestational or steroid-induced diabetes)
- Patients who have had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee before or during the measurement period.
- Exclude patients who were in hospice care 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.*)

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.

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MEDICAL RECORD

Exclusionary evidence in the medical record must include a note indicating a diagnosis of gestational or steroid-induced diabetes, patients who had either a bilateral amputation above or below the knee, or both a left and right amputation above or below the knee, or who are in hospice care.

**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 reporting period.

-EVENT/DIAGNOSIS:

Identify patients who had a diagnosis of diabetes with a visit during the measurement period.

\*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S2.B

STEP 2. Determine the number of patients in the eligible population who had a recent foot exam (visual inspection with a sensory exam and a pulse exam) exam during the measurement year through the search of administrative data systems.

STEP 3. Identify patients with a most recent foot exam performed and the result.

STEP 4. Identify the most recent foot exam with a result during the reporting period (numerator compliant). Identify the most recent result foot exam without a result or a missing foot exam (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.9

STEP 6. Calculate the rate (number of patients that received a foot exam during 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.

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 electronic health data and medical records. Foot exams can be identified by the following administrative data: receipt of a foot exam (visual inspection and sensory exam with mono filament and a pulse exam).

Codes in the following value set will meet these criteria:

- Any code in the Physical Exam, Performed: Visual Exam of Foot value set
- Any code in the Physical Exam, Performed: Sensory Exam of Foot
- Any code in Physical Exam, Performed: Pulse Exam of Foot

The minimum medical record documentation includes a note indicating the date when the exam was performed and the result.

**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

**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

[0056\\_Foot\\_Exam\\_2018\\_Testing\\_Form\\_updated\\_4.18.18-636627538887050441.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 physicians and clinical 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.

Feedback on use of this measure in CMS QPP and NCQA's Diabetes Recognition Program has been positive with few questions raised by participating clinicians to the CMS vendor and NCQA. NCQA also works with the CMS vendor to review any questions or issues raised with the measure on a bi-weekly basis.

**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).

N/A

**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

**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).

**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.

**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.**

The Diabetes Recognition Program (DRP) data submission portal provides a guided process for practice/clinician to submit their patient data (manually or electronically). Practices/Clinicians can see their results within the data portal. The portal is equipped to immediately score the data to determine if it meets the measure performance requirements. The DRP publication provides instruction on the required data points for this measure, reference to guidelines used to curate the measure requirements and additional information for achieving recognition. NCQA provides monthly webinars to instruct customers on the measure, the specifications, data entry in the portal and recognition readiness. These live webinars also provide the opportunity to ask additional questions related to DRP, the measure, the recognition process and other program related questions.

**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.**

For the Diabetes Recognition Program (DRP) practices/clinicians submit data (manually or electronically) when they are ready and their data meet the performance thresholds for the measure. Practices/clinicians can see their results within the data portal. The portal is equipped to immediately score the data to determine if it meets the measure performance requirements. Practices/Clinicians can see the results for this measure and remaining measures in DRP to determine if the entity has met the required score to achieve DRP recognition. Additional questions can be submitted for response using NCQA's Policy Clarification

System (PCS). PCS providers NCQA staff and customers a unified space to submit inquires and clarification requests.

**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.

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

Questions received through NCQA's Policy Clarification Support system have generally centered around clarification on what constitutes a foot exam, whether documentation must specify that all three exams (visual inspection and sensory exam with mono filament and a pulse exam) were completed, and if a mono filament is required for the sensory exam.

**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 Diabetes Recognition Program.

**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.**

Since 2015, there has been a decrease in the number of reporting physicians seeking recognition in NCQA's Diabetes Recognition Program (see summary data in 1b.2). However, we are pleased that rates in performance have remained relatively stable.

**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.

Yes

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

0417 : Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation

**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.**

Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year.

**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.)**

0056 has a long history of use and is implemented in two national programs (PQRS and DRP).

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**RESPONSE TO 5a.2 (insufficient space above)**

Measure 0056 identifies adults with diabetes (age 18-75) that had a foot exam (visual inspection with sensory and pulse exam) during the reporting year. Measure 0417 identifies adults with diabetes (age 18 and older) who had a lower extremity neurological exam at least once during the measurement year.

**HARMONIZED ELEMENTS:**

Both measures are harmonized on the target population of diabetic adults and the measure focus of lower extremity exam. The denominator for each measure are harmonized to include all adult patients with a diagnosis of diabetes mellitus. The care setting is harmonized for measure 0056 and 0417 in at least one care setting (Ambulatory Care: Clinician Office/ Clinic). In addition, the data source (administrative claims) and level of analysis (clinicians: individual) are harmonized for both measures.

**UNHARMONIZED MEASURE ELEMENTS:**

Data Source: Measure 0056 is specified for paper medical records, administrative claims and electronic clinical data while measure 0417 is specified for administrative claims only. Measure 0056 is included in the CMS PQRS program and in NCQA's Diabetes Recognition Program (DRP) for physician reporting.

**IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN:** Measure 0056 provide more options for reporting based on available data sources. Measure 0417 is specified for only administrative claims.

## 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.2 Point of Contact:** [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-1728-](#)

**Co.3 Measure Developer if different from Measure Steward:** [National Committee for Quality Assurance](#)

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## 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.**

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**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:** 01, 2010

**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, 2014

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