NQF-Endorsed Measures for Endocrine Conditions, 2013-2015: Final Report

TECHNICAL REPORT

November 2015

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task HHSM-500-T0008

NATIONAL QUALITY FORUM

Contents

NQF-Endorsed Measures for Endocrine Conditions, 2013-2015

TECHNICAL REPORT

Executive Summary

Endocrine conditions result from disorders of the endocrine system, most often when either too much or too little of a particular hormone is produced.[1] In the United States, two of the most common endocrine disorders are diabetes and osteoporosis.[2] Diabetes, a group of diseases characterized by high blood glucose levels, affects as many as 29.1 million Americans and ranks as the 7th leading cause of death in the United States.[3] Major complications[4] of diabetes include heart disease and heart attack, stroke, high blood pressure, retinopathy and blindness, chronic kidney disease and end-stage renal disease, peripheral neuropathy, poor wound healing and chronic ulceration, and lower limb amputation. Osteoporosis, a bone disease characterized by low bone mass and density, affects an estimated 10.2 million U.S. adults age 50 and over.[5] Major complications of osteoporosis include hip fracture, spinal compression fracture, and other fragility fractures.[6]

Currently, NQF's Endocrine portfolio includes measures for diabetes and osteoporosis only. Many of the diabetes measures in the portfolio are among NQF's longest-standing measures. Several of the measures in the portfolio currently are used in public and/or private accountability and quality improvement programs.

NQF selected the Endocrine measure evaluation project to pilot a potential change in the measure submission process to allow for more frequent submission and evaluation of measures than what is possible in our current 3-year measure maintenance process. This 25-month project included 3 full endorsement "cycles," allowing for the submission and review of both new and previously endorsed measures every 6 months. This report includes a detailed discussion of lessons learned from the pilot. Based on these results, NQF should consider allowing more frequent opportunities for measure submission and evaluation.

Over the life of this project, the Endocrine Standing Committee evaluated 5 new measures and 18 measures undergoing maintenance review against NQF's standard evaluation criteria. Of the 23 measures evaluated, 22 were recommended for endorsement by the Standing Committee and have been endorsed by NQF. A complete list of measures evaluated in this project appears below.

Measures evaluated in the Endocrine, 2013-2015 project

Cycle 1 measures

- 0055: Comprehensive Diabetes Care: Eye Exam (retinal) Performed
- 0056: Diabetes: Foot Exam
- 0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing
- 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

- 0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy
- 0416: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear*
- 0417: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation*
- 0519: Diabetic Foot Care and Patient Education Implemented
- 0545: Adherence to Statins for Individuals with Diabetes Mellitus
- 0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
- 2362: Glycemic Control – Hyperglycemia
- 2363: Glycemic Control – Hypoglycemia
- 2416: Laboratory Investigation for Secondary Causes of Fracture
- 2417: Risk Assessment/Treatment After Fracture
- 2418: Discharge Instructions – Emergency Department**
- 2467: Adherence to ACEIs/ARBs for Individuals with Diabetes Mellitus
- 2468: Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus

* *Withdrawn from consideration in cycle 1 but brought back in cycle 2*

***Not recommended for endorsement*

Cycle 2 measures

- 0037: Osteoporosis Testing in Older Women
- 0045: Communication with the Physician or Other Clinician Managing On-Going Care Post Fracture for Men and Women Aged 50 Years and Older
- 0046: Screening for Osteoporosis for Women 65-85 Years of Age
- 0053: Osteoporosis Management in Women Who Had a Fracture
- 0416: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear
- 0417: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

Cycle 3 measures

- 0061: Comprehensive Diabetes Care: Blood Pressure Control
- 0729: Optimal Diabetes Care

Introduction

Endocrine conditions result from disorders of the endocrine system—the network of glands that produce and release hormones that regulate many bodily functions such as growth and development, metabolism, and reproduction.[7] Endocrine disorders most often result when either too much or too little of a particular hormone is produced.[8] In the United States, two of the most common endocrine disorders are diabetes and osteoporosis.[9]

Diabetes

Diabetes is a group of diseases characterized by high blood glucose levels. An estimated 29.1 million people in the United States have the disease, including 8.1 million people who are currently undiagnosed.[10] Diabetes affects all age groups but is most prevalent in those ages 45-64 (16.2%) and in those ages 65 and older (25.9%).[11] It is the 7th leading cause of death in the United States and is associated with an estimated $176 billion in direct medical costs and $69 billion in indirect costs related to disability, work loss, and premature mortality.[12] Major complications[13, 14] of diabetes include:

- **Heart disease and heart attack** (heart disease mortality is 1.7 times higher in those with diabetes)
- **Stroke** (stroke risk is 2-4 times higher among those with diabetes)
- **High blood pressure** (71% of those with diabetes have high blood pressure — ≥140/90 mmHg or use prescription medications to lower their blood pressure)
- **Retinopathy and blindness** (over one-quarter of those ages 40 and older with diabetes have diabetic retinopathy, and diabetes is the leading cause of new cases of blindness for people ages 20-74 years)
- **Chronic kidney disease/end-stage renal disease** (diabetes is the leading cause of kidney failure)
- **Peripheral neuropathy** (as many as 60-70% of those with diabetes have nervous system damage)
- **Peripheral arterial disease**
- **Poor wound healing/chronic ulceration**
- **Lower limb amputation** (60% of nontraumatic amputations occur among those with diabetes)
- **Hypoglycemia** (causes more than 280,000 emergency visits in adults with diabetes per year)

Osteoporosis

Osteoporosis is bone disease characterized by low bone mass and density. An estimated 10.2 million U.S. adults age 50 and over have osteoporosis.[15] Overall, osteoporosis is more common in women than in men (15.4% vs. 4.3%).[16] In women, the prevalence increases for each decade after age 50, but in men, the prevalence remains fairly stable between the ages of 50 and 80, but increases substantially afterwards.[17] Osteoporosis can be diagnosed either through the occurrence of fragility fractures (breaks caused by falls from standing height or less, usually in spine, wrist, or hip) or through measurement of bone mineral density.[18,19] The major complications[20] of osteoporosis include:

- **Hip fracture**. Hip fracture is more common in women than in men (>250,000 per year vs. >75,000 per year), and an estimated 33% of women and 17% of men will have a hip fracture by

age 90. Typically, half of women with hip fracture do not recover full functionality post-fracture. Approximately 1 in 5 older adults die within 1 year following hip fracture, although the risk is higher for men than for women.

- **Spinal compression fracture.** Spinal compression fractures are more common in women that in men (>500,000 per year vs. >175,000 per year); the lifetime risk is approximately 12% for both men and women.
- **Other fragility fractures**. These fractures, which include wrist/forearm fractures, pelvic fractures, and other types of fractures, comprise an estimated 59% of osteoporosis-related fractures.[21]

Such fractures decrease quality of life and increase the likelihood of functional impairment, morbidity, and mortality.[22] As much as $20 billion in direct medical costs can be attributed to osteoporosis.[23]

Trends and Performance

Studies have shown that providing routine preventive care (e.g., foot and eye exams) and controlling risk factors (e.g., blood pressure, cholesterol level, blood glucose levels) can prevent or ameliorate some complications of diabetes.[24,25] The proportions of patients receiving these preventive services have increased since the mid-1990s, when performance measures for these activities were first developed.[26,27] Similarly, the proportions of diabetic patients with well-controlled HbA1c, blood pressure, and LDL levels have increased.[28,29] There has also been an overall decrease in the United States in several of the major complications of diabetes, including visual impairment, mortality due to hyperglycemic crises, end-stage renal disease, and lower-extremity amputations, and these decreases have been due, at least in part, to quality measurement efforts.[30,31] Localized impact of measurement also has been quantified. For example, after implementation of the 5-component Optimal Diabetes Care composite (NQF #0729) in Minnesota, performance on the measure increased from 4% to 38%; for one large regional health plan, this led to 387 fewer heart attacks, 69 fewer leg amputations, and 777 fewer members who developed vision complications.[32]

Results from the Healthcare Effectiveness Data and Information Set (HEDIS) indicate relatively small, yet steady, increases since 2007 in the percentage of older women who received a bone density test to screen for osteoporosis and in the percentage older women with a fracture who had a bone density test or pharmacological treatment within 6 months of the fracture.[33] Data spanning the 18-year period between 1986 and 2004 indicate a decrease in the incidence of hip fracture since the mid-1990s among both men and women, as well as a decrease in post-hip fracture mortality since 2002.[34]

NQF Portfolio of Performance Measures for Endocrine Conditions

Currently, NQF's portfolio of endocrine measures includes measures for diabetes and osteoporosis only. This portfolio contains 42 measures: 28 process measures, 13 outcome and resource use measures, and 1 composite measure (see Table 1 below).

Table 1. NQF Endocrine Portfolio of Measures

	Process	Outcome/Resource Use	Composite
Diabetes	22	12	1
Osteoporosis	6	1	0
Total	**28**	**13**	**1**

Twenty-three of the measures in the portfolio were evaluated by the Endocrine Committee during this project. The remaining 19 measures included in the portfolio are assigned, for various reasons, to other projects. These include various diabetes assessment and screening measures (Health and Well-being/Behavioral Health project), eye care measures (EENT project), ACEI/ARB medication measures (Cardiovascular project), complications and outcomes measures (Health and Well-Being/Surgery projects), and one cost and resource use measure (Cost and Resource Use project).

Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multistakeholder committees composed of clinicians and other experts from hospitals and other healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, legislative mandate requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Over time, and for various reasons, some previously endorsed endocrine-related measures have been dropped from the NQF portfolio (see Appendix A). In some cases, the measure steward may not want to continue maintaining the measure for endorsement (e.g., updating specifications as new drugs/tests become available or as diagnosis/procedure codes evolve; participating in NQF's measure maintenance process). In other cases, measures may lose endorsement upon maintenance review. Loss of endorsement can occur for many different reasons including—but not limited to—a change in evidence without an associated change in specifications, high performance on a measure signifying no further opportunity for improvement, and endorsement of a superior measure.

National Quality Strategy

NQF-endorsed measures for endocrine conditions support the National Quality Strategy (NQS). NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, state, and national) to improve the quality of healthcare in the U.S. The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities. It focuses on 6 priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care.*

Quality measures for diabetes and osteoporosis care align with several of the NQS priorities, including:

- **Effective Prevention and Treatment of Illness.** Diabetes is the 7th leading cause of death in the United States, and both diabetes and osteoporosis rank as 2 of the 20 high-impact Medicare conditions.[35]
- **Communication and Care Coordination.** Coordination is a priority because, often, care for individuals with diabetes occurs across provider types (e.g., primary care clinicians, endocrinologists, podiatrists, optometrists) and similarly, fractures due to osteoporosis require both acute and post-acute care across settings (e.g., emergency departments, inpatient facilities, rehabilitation facilities). Also, improving care for these conditions can reduce complications, thus helping to decrease the number of hospital admissions and readmissions.
- **Best Practices for Healthy Living.** Engagement in healthy behavior (e.g., weight control, smoking cessation) and accessing preventive services such as screening are critical for the prevention and management of both diabetes and osteoporosis.

Use of Measures in the Portfolio

Many of the diabetes measures in the portfolio are among NQF's most long-standing measures, several of which have been endorsed since 2002. Many are in use in at least one federal program.[36] Also, several of the diabetes measures have been included in the Diabetes Family of Measures[37] by the NQF-convened Measure Applications Partnership (MAP). The osteoporosis measures in the portfolio currently are used in at least one federal program, as well as in various internal quality improvement accreditation programs. See Appendix B for details of federal program use for the measures in the portfolio.

Improving NQF's Endocrine Portfolio

Measurement Frameworks

The Endocrine portfolio of measures is organized—for diabetes and osteoporosis separately—according to NQF's Episode of Care model.[38] This patient-centric framework, which broadly applies to both acute and chronic conditions, can be used to map existing performance measures and highlight gaps in measurement.

The model for diabetes[39] was developed in 2008 by a panel of experts in diabetes and performance measurement in an effort designed to recommend a path forward for diabetes quality measurement (see Appendix A). The model reflects the full spectrum of the disease by incorporating 4 trajectories specific to diabetes type and related outcomes/comorbidities. Key measurement opportunities portrayed in the model include prevention through behavioral and lifestyle interventions and glycemic, lipid, and blood pressure management (phase 1), screening and diagnosis and prevention/screening/early treatment for complications (phase2), and management and treatment of complications (phase 3). The Endocrine Standing Committee did not make modifications to this model.

A similar framework for osteoporosis initially was developed by NQF staff as part of this project; this model was then modified slightly by the Endocrine Standing Committee (see Appendix C). In this model, 3 trajectories for measurement are described: one reflecting ongoing control and management of the disease that is needed for those who are relatively healthy, and two reflecting the exacerbation of the disease, including fracture and other complications.

NQF's Endocrine portfolio includes at least a few measures for each of the Episode of Care phases for both diabetes and osteoporosis. However, as mentioned earlier, most are process measures and therefore do not address the need for patient-reported outcomes that are noted in the diabetes model. Also, several of the issues noted in the models (e.g., need for consideration of access, psychosocial needs, therapy risk) are not reflected in the measures that currently are included in the portfolio.

Committee Input on Gaps in the Portfolio

During their discussions the Committee identified numerous areas where additional measure development is needed, including:

- Measures of other endocrine-related conditions, particularly thyroid disease, both for adults and for the pediatric population
- Incidence of heart attacks and strokes among persons with diabetes, measured at the health plan level
- Measures of overuse, particularly for thyroid conditions (e.g., ultrasound for thyroid nodules, overdiagnosis/overtreatment of thyroid cancer)
- Measures for pre-diabetes/metabolic syndrome
- "Delta" measures for intermediate clinical outcomes (e.g., HbA1c levels)
- Education measures (e.g., for diabetes) that go beyond asking if education was provided and instead assess whether the patient was able to understand and apply the education (needed at diagnosis, not just when complications arise)
- Measures that use other types of patient information (e.g., time-in-range measures for patients with continuous glucose monitors)
- More complex measures, including composite measures, for diabetes screening and for neuropathy care
- Measures of hypoglycemia among the elderly, including medication safety measures
- Measures of occurrence and severity of hypoglycemia in the outpatient setting
- Measures focusing on the use of testosterone
- Measures of Body Mass Index (BMI) in adult patients with diabetes mellitus

Additional gaps in diabetes and osteoporosis measurement have been identified by MAP[40] and NQF staff (as part of an analysis[41] of the full NQF portfolio). These include:

- Patient-centered measures of lifestyle management and health-related quality of life
- Access to care and medications
- Treatment preferences, psychosocial needs, shared decisionmaking, family engagement, cultural diversity, and health literacy
- Communication, coordination, and transitions of care
- General prevention and treatment of diabetes, as well as measures of the sequelae of diabetes
- Glycemic control for complex patients (e.g., geriatric population, those with multiple chronic conditions) and for the pediatric population at the clinician, facility, and system levels of analysis
- Evaluation of bone density, and prevention and treatment of osteoporosis in ambulatory settings

Endocrine Measure Evaluation

Piloting More Frequent Submission and Evaluation

NQF's current endorsement process includes the evaluation of new measures as well as periodic re-evaluation (or "maintenance") of previously endorsed measures to ensure that they are still the best-available measures and reflect current science. Typically, the endorsement process for measures in a particular topic area is conducted every 3 to 4 years, depending on the funding available and the number of measures involved. However, measure development timelines do not always mesh with NQF's evaluation schedules, and this can lead to unintended negative consequences for stakeholders in the endorsement process. For example, rushing to meet submission deadlines may result in incomplete or otherwise nonresponsive submissions, which in turn require extra effort on the part of staff, developers, and committees. Even more concerning, if a measure developer misses a submission opportunity, it may be months, or even years, before another opportunity arises, potentially depriving the field of important measures in the meantime.

In an effort to address these concerns, NQF selected the Endocrine project to pilot a process of more frequent submission and evaluation of measures than what is possible in our current 3-year measure maintenance process. Specifically, NQF structured the 25-month project to conduct 3 full endorsement "cycles," allowing for the submission and review of both new and previously endorsed measures every 6 months.

Although the frequency of the measure submission and evaluation changed for this pilot project, the remainder of the endorsement process remained the same. The Standing Committee evaluated all measures submitted in each cycle against the NQF Measure Evaluation Criteria (see Appendix C). All stakeholders were able to attend meetings and conference calls and provide comments, and NQF members had the opportunity to vote on endorsement recommendations.

Summary of the Evaluation

Over the 3 cycles of the Endocrine Measure Evaluation pilot project, the Endocrine Standing Committee evaluated 5 new measures and 18 measures undergoing maintenance review against NQF's standard evaluation criteria (see Table 2). Sixteen measures were related to diabetes, and 7 were related to osteoporosis. The Committee evaluated the cycle 1 measures during their February 26-27, 2014, in-person meeting and in a follow-up call on March 12, 2014. The Committee evaluated the cycle 2 measures during 2 conference calls held on July 8 and July 11, 2014. The Committee evaluated the cycle 3 measures during two conference calls held on January 22 and January 28, 2015. Separate reports for cycle 1, cycle 2, and cycle 3 of the project include details of the Committee's discussion and ratings of the measures against the evaluation criteria.

Table 2. Endocrine Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	18	5	23
Measures withdrawn from consideration	0	0	0
Measures recommended	18	4	22
Measures not recommended	0	1	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 0 Overall – 0 Competing Measure – 0	Importance – 1 Scientific Acceptability – 0 Overall – 0 Competing Measure – 0	

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. Specifically, NQF invites comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). NQF also solicits member and public comments during a 14-day period prior to the evaluation of measures and during a 30-day comment period after measures have been evaluated by the Committee and a report of the proceedings has been drafted.

A total of 178 comments were received across the three cycles (see Table 3). The majority of the comments expressed support of the measures and/or the Committee's recommendations regarding endorsement. There was, however, some disagreement with the Committee's recommendation not to endorse measure #2418 (Discharge Instructions – Emergency Department) and with the Committee's recommendation to endorse measure #0729: Optimal Diabetes Care. Several comments also requested clarification regarding measure specifications. Additional details regarding comments received are included in the individual reports for the 3 cycles of the project. In addition, all comments and the Committee responses to the comments are posted on NQF's Endocrine project webpage.

Table 3. Commenting Period Summary

	Cycle 1	Cycle 2	Cycle 3
Ongoing via QPS	No comments received	No comments received	No comments received
Pre-evaluation comment period	Date: January 21 – February 7, 2014 76 comments received	Date: June 16 - 30, 2014 No comments received	Date: December 20, 2014 – January 12, 2015 No comments received
Post-evaluation comment period	Date: April 3 – May 2, 2014 83 comments received	Date: August 8 – September 8, 2014 13 comments received	Date: March 5 – April 3, 2015 6 comments received

Overarching Issues

Three overarching issues (threshold values, implications for removing endorsement, and competing measures) emerged and were factored into the Committee's ratings and recommendations for multiple measures over the 3 evaluation cycles of the project.

Threshold Values

The issue of threshold values was relevant to measures evaluated in cycle 1 and cycle 3 of the project. Committee members noted the arbitrary nature of many threshold values but acknowledged the need for them in many performance measures (particularly for intermediate clinical outcomes such as HbA1c levels). However, they also noted the potential for unintended negative consequences for some patients with the use of threshold values, particularly if the patient values are close to the threshold values.

Implications of Removing Endorsement

In cycle 1 of the project, Committee members were concerned with the implications of removal of endorsement. In particular, they wanted to ensure that a recommendation against endorsement would not be interpreted as meaning that the associated care process is unimportant. They acknowledged the evolving needs for performance measurement, especially policy or programmatic reasons for endorsing particular measures that may or may not still apply in the current healthcare environment. They also briefly discussed the "higher bar" for endorsement because of changes in evaluation criteria and guidance, as well as the potential for unintended consequences due to how measures eventually may be used. Ultimately, however, the Committee did not recommend removal of endorsement for any of the measures under maintenance review in cycle 1 of the project.

Competing Measures

Competing measures were an issue in cycles 2 and 3 of the project. All 4 of the osteoporosis measures evaluated in cycle 2 are either competing or related to each other and/or to the 2 facility-level

osteoporosis measures evaluated in cycles 1 of the project. Because the competing measures have different levels of accountability (e.g., clinician vs. health plan or facility), NQF did not ask the Committee to select a superior measure; instead, as with the related measures, Committee members were asked to make recommendations, as appropriate, for harmonization. For the most part, Committee members agreed that differences in specifications were justified. However, they did recommend that measure #0053 (Osteoporosis Management in Women Who Had a Fracture) be re-specified so as to include men as well as women. They also suggested adding linkage to a fracture liaison service to the measure numerator as an alternative management approach.

One of the diabetes foot care measures evaluated in cycle 2 of the pilot (#0417) is a competing measure to a measure recommended for endorsement in cycle 1 of the pilot (#0056). Because both measures apply to the clinician office setting and hold the individual clinician or clinician group/ practice accountable, NQF asked the Committee to identify, if possible, which of the two they considered the superior measure. After review of the comments submitted and additional discussion, Committee members were unable to select one of the measures as superior and instead agreed to recommend both measures for endorsement. Members suggested that endorsement of both measures might result in more people with diabetes having their feet examined than what might be possible if only one measure is endorsed. While most members were comfortable with continued endorsement of both measures at the current time, they expressed a desire for one measure in the future that combines the elements from the two measure numerators and is useable by the broadest range of providers.

Finally, the individual blood pressure control measure (#0061) that was evaluated in cycle 3 of the project also is included as a component in the all-or-none composite measure (#0729) that was evaluated in that cycle. NQF staff asked the Committee to discuss whether there is justification for continued endorsement of the individual measure if the composite measure retains endorsement. The Committee ultimately agreed that while the composite measure is useful to assess patient-centric performance across a variety of clinical areas, endorsement of the individual measure also can be beneficial, particularly for users who want to focus on blood pressure control components specifically or for those who have data collection constraints and cannot use the composite. The Committee therefore recommended continued endorsement of both the individual measure and the composite measure.

Lessons Learned From the Pilot

The major goal of the pilot project was to discover the potential benefits and challenges of offering more frequent opportunities for measure submission and evaluation for the stakeholders who participate in NQF's endorsement processes (e.g., NQF staff, measure developers, members, volunteers, etc.). Accordingly, as a part of this pilot effort, NQF solicited feedback throughout the project duration via surveys and structured discussions with project staff, the project Standing Committee, measure developers, and those who provided comments, votes, or attended project meetings. Data from these surveys and discussions were used to compile the following “lessons learned” from the pilot.

- Both the Endocrine Standing Committee and the developers who submitted measures to the project liked the opportunity for more frequent measure submission and evaluation and would like to see it implemented in some fashion going forward.

- The opportunity for more frequent measure submission and evaluation was beneficial for several developers who participated in the Endocrine project.

  Two specific examples illustrate the benefits realized. First, changes to 2 key clinical practice guidelines (for high blood pressure and cholesterol) were pending at the beginning of the project, and both NQF staff and developers knew that changes to several measures would be needed. Accordingly, those measures scheduled for maintenance were slated for cycle 3 of the project (i.e., approximately 14 months after project initiation). Thus, developers were assured very early in the project that they would have time to modify their measures as needed without the risk of losing endorsement and/or duplicating work (i.e., if a later ad hoc review was needed once the guidelines were published).

  Second, in cycle 1 of the project, a developer withdrew 2 measures from consideration prior to the end of the cycle because the Standing Committee did not recommend continued endorsement due to concerns with the measure specifications. This developer worked with NQF staff to revise the submissions and re-submit them in cycle 2 of the project. Both measures were subsequently re-endorsed.

- A more frequent evaluation process will be more helpful for some topic areas and measure developers than for others.

  As noted earlier, a backlog of new measures awaiting endorsement can accrue if there is substantial time between endorsement opportunities. For the Endocrine topic area, however, this was not the case. Only 5 new endocrine measures were submitted throughout the project, and all of these were submitted in cycle 1. In contrast, recent activities in other topic areas (e.g., cardiovascular, patient safety, person- and family-centered care) funded as phased projects providing submission opportunities approximately 9-12 months apart have demonstrated that such backlogs do exist for some topic areas (i.e., new measures have been submitted during each phase) and that an agile planning and scheduling process is needed to most effectively evaluate newly developed measures.

  Similarly, some measure developers have an extensive catalog of new and previously endorsed measures that they want to bring to NQF for endorsement and re-endorsement. Having a known and flexible schedule for measure evaluation will allow those developers to better allocate resources needed for the process.

- NQF staff believes that a 6-month interval between the start of evaluation cycles is too frequent.

  During the pilot, the CDP timeline was not changed; that is, each cycle in the pilot followed the same number of steps and the same timeline. What did change was the frequency with which measures could be submitted and evaluated. With measures being submitted every 6 months, there was overlap between the latter steps of the endorsement process in one cycle (e.g., CSAC, voting, and appeals) and the earlier steps (e.g., measure evaluation) of the subsequent cycle. This overlap caused substantial confusion for staff, likely because the measures were quite similar but were in very different stages of the process. Project co-chairs, who participated in

the CSAC discussions, also found the overlap challenging. A 9- or 10-month interval between cycles would solve this overlap problem because each CDP cycle would be completed before the next would begin.

Most stakeholders found the 6-month interval between the cycles acceptable. At the beginning of the pilot, NQF staff had concerns that the additional meetings, reports, commenting opportunities, etc. from multiple cycles would be overly burdensome. In reality, however, most stakeholders—including measure developers—did not perceive the 3 cycles of the project as different from 3 separate projects and did not object to the "extra" meetings, etc. Staff, on the other hand, perceived many of the process steps in cycles 2 and 3 as onerous, as the full CDP was conducted in each case even though the number of measures evaluated in these cycles (6 and 2, respectively) was small. This perception might have differed if more measures had been evaluated in each cycle.

Recommendations Based on the Pilot

Overall, stakeholders found several benefits to more frequent submission and evaluation of measures. Several refinements to the CDP would be needed, however, in order to accommodate this type of change. Some of these include:

- *Increasing* the *number of Committee "refreshers" pertaining to evaluation criteria, guidance, and process.* The current process provides orientation and tutorial calls for new Standing Committees, but these calls typically are not repeated for projects with already-seated Committees. Accordingly, in the Endocrine pilot, staff did not schedule any of these calls in cycles 2 or 3. This seemed particularly appropriate given the short (i.e., 6-month) gap between the evaluations. However, the Endocrine Committee specifically noted their need and desire for such ongoing education, even with the short gap between the evaluations.

- *Considering* potential *changes to the evaluation meeting format.* In the Endocrine pilot, the evaluation of measures was done in a 2-day in-person meeting for cycle 1 but in two 2-hour webinars for cycles 2 and 3. This structure reflected the differing number of measures under consideration in each cycle, and as such, was appropriate. However, in general, both the Standing Committee and measure developers preferred the in-person format. At a minimum, staff should plan to utilize as many features of the webinar platform (e.g., the raise-your-hand functionality) as possible to enhance the experience when evaluation meetings are conducted via webinar.

- Reconsidering *"project initiation" steps.* Many of the process steps undertaken when beginning a new evaluation effort presuppose the "project" structure that follows the current 3-year sequencing. However, moving to more frequent submission and evaluation will necessitate changes to some of these processes. For example, the current process adequately attends to the scheduling of meetings, calls, and webinars well in advance. For the Endocrine project, this was true for meetings in cycle 1. However, in cycles 2 and 3, even though there was more-than-adequate lead time, meetings were not always scheduled in a timely manner (i.e., these steps were neglected because the project had already

been "initiated"). This contributed to difficulties in reaching quorum (particularly in cycle 2, when the evaluation was done over the summer months).

- *Being more deliberate in "assigning" measures to a particular evaluation cycle*. NQF assumes that if a transition to more frequent submission and evaluation of measures is implemented, the timing of the "cycles" will be known in advance. Accordingly, staff should be willing to slate measures to later cycles as needed. In our current project-based process, all new measures that are submitted typically are evaluated, as later opportunities are not guaranteed. If later cycles are assured, however, staff should shift both new and maintenance measures as needed (for example, to better accommodate related and competing discussions, to "even out" the number of measures evaluated, etc.). This was not done in the Endocrine pilot, which made the discussion of related and competing osteoporosis measures more difficult, as some were evaluated in cycle 1 and some in cycle 2.

- *Redesigning project reports*. Currently, CDP project reports are designed to reflect the 3-year evaluation cycle. However, much of the report content (e.g., introduction of the topic, impact, and use of measures) would be duplicative if reissued as part of more frequent submission and evaluation of measures. Ideas for potential redesign include creation of a static "introductory" report that is updated periodically, along with "update" reports that focus on measures under consideration in a particular cycle; a more "virtual" type of report that takes advantage of ability to hyperlink to web content; or some combination of these or other approaches.

- *Reducing the number of measures evaluated in each cycle*. In each cycle of the Endocrine pilot, fewer measures were evaluated than is typically the case in most endorsement projects (15 in cycle 1, 6 in cycle 2, and 2 in cycle 3). The Standing Committee, in particular, found this a positive feature of the project, as members were able to review submitted materials more thoroughly and had relatively more time for discussion. Measure developers saw both pros and cons in having fewer measures evaluated in a particular cycle. They acknowledged that having fewer measures facilitated a more thorough discussion than would otherwise be possible, but they also expressed some concern that it allowed discussion of what might be considered very minor points. Although it is difficult to specify an optimal number of measures to be evaluated if a process of more frequent submission and evaluation is implemented, experience from the pilot suggests that this number should be greater than 6 (as was done in cycle 2) but less than 17 (as was done in cycle 1).

Given the positive feedback regarding the pilot from most stakeholders, NQF should consider allowing more frequent opportunities for measure submission and evaluation, assuming that a funding mechanism could be implemented to support the change. Evaluation opportunities should be at least 9 to 10 months apart, but possibly longer, depending on the topic area and the likely backlog of new measures to be evaluated. The recent changes to the maintenance process, including a more simplified evaluation for maintenance measures, likely would facilitate implementing more frequent opportunities for evaluation. In addition, experiences from recently "phased" projects (such as cardiovascular, patient safety, and person- and family-centered care) should be considered as "natural experiments" with which to compare the experiences of the Endocrine pilot and inform process refinements.

References

[1] WebMD. Endocrine disorders website. http://www.webmd.com/diabetes/endocrine-system-disorders. Last accessed March 2014.

[2] Golden SH, Robinson KA, Saldanha I, et al. Clinical review: prevalence and incidence of endocrine and metabolic disorders in the United States: a comprehensive review. *J Clin Endocrinol Metab.* 2009;94(6):1853-1878.

[3] Centers for Disease Control and Prevention (CDC). *National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States, 2014*. Atlanta, GA: U.S. Department of Health and Human Services (HHS); 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html.

[4] CDC. *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the United States, 2011*. Atlanta, GA: HHS, CDC; 2011.

[5] Wright NC, Looker AC, Saag KG et al. The recent prevalence of osteoporosis and low bone mass in the united states based on bone mineral density at the femoral neck and lumbar spine. *J Bone Miner Res*. 2014;29(11):2520-2526.

[6] Duque G, Troen BR. Osteoporosis. In: Halter JB, Ouslander JG, Tinetti ME, et al., eds. *Hazzard's Geriatric Medicine and Gerontology, 6th ed.* New York: McGraw-Hill; 2009:1421-1434.

[7] Hiller-Sturmhofel S, Bartke A. The Endocrine system: an overview. *Alcohol Health Res World*. 1998;22(3):153-164.

[8] WebMD. Endocrine disorders website. http://www.webmd.com/diabetes/endocrine-system-disorders. Last accessed March 2014.

[9] Golden SH, Robinson KA, Saldanha I, et al. Clinical review: prevalence and incidence of endocrine and metabolic disorders in the United States: a comprehensive review. *J Clin Endocrinol Metab*. 2009;94(6):1853-1878.

[10] CDC. *National Diabetes Statistics Report, 2014.* Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[11] CDC. *National Diabetes Statistics Report, 2014*. Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[12] CDC. *National Diabetes Statistics Report, 2014*. Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[13] CDC. *National Diabetes Statistics Report, 2014*. Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[14] CDC. *National Diabetes Statistics Report, 2014.* Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[15] CDC. *National Diabetes Statistics Report, 2014*. Atlanta, GA: HHS, CDC; 2014. Available at http://www.cdc.gov/diabetes/data/statistics/2014StatisticsReport.html. Last accessed August 2015.

[16] Wright NC, Looker AC, Saag KG et al. The recent prevalence of osteoporosis and low bone mass in the united states based on bone mineral density at the femoral neck and lumbar spine. *J Bone Miner Res*. 2014;29(11):2520-2526.

[17] Wright NC, Looker AC, Saag KG et al. The recent prevalence of osteoporosis and low bone mass in the united states based on bone mineral density at the femoral neck and lumbar spine. *J Bone Miner Res*. 2014;29(11):2520-2526.

[18] Duque G, Troen BR. Osteoporosis. In: Halter JB, Ouslander JG, Tinetti ME, et al., eds. *Hazzard's Geriatric Medicine and Gerontology. 6th ed.* New York: McGraw-Hill; 2009:1421-1434.

[19] National Institute for Health and Care Excellence (NICE). *Osteoporosis: Assessing the Risk of Fragility Fracture. NICE Clinical Guideline 146.* London, England: NICE; 2014. Available at http://www.nice.org.uk/nicemedia/live/13857/60399/60399.pdf. Last accessed March 2015

[20] Duque G, Troen BR. Osteoporosis. In: Halter JB, Ouslander JG, Tinetti ME, et al., eds. *Hazzard's Geriatric Medicine and Gerontology, 6th ed.* New York: McGraw-Hill; 2009:1421-1434.

[21] Burge R, Dawson-Hughes B, Solomon DH, et al. Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. *J Bone Miner Res*. 2007;22(3):465-475.

[22] Duque G, Troen BR. Osteoporosis. In: Halter JB, Ouslander JG, Tinetti ME, et al., eds. *Hazzard's Geriatric Medicine and Gerontology, 6th ed.* New York: McGraw-Hill; 2009:1421-1434.

[23] Burge R, Dawson-Hughes B, Solomon DH, et al. Incidence and economic burden of osteoporosis-related fractures in the United States, 2005-2025. *J Bone Miner Res. 2007*;22(3):465-475.

[24] Agency for Healthcare Research and Quality (AHRQ). *2012 National Healthcare Quality Report.* Rockville, MD: AHRQ; 2014. Report No.: 13-0002. Available at http://www.ahrq.gov/research/findings/nhqrdr/nhqr12/2012nhqr.pdf. Last accessed August 2015.

[25] O'Connor PJ, Bodkin NL, Fradkin J, et al. Diabetes performance measures: current status and future directions. *Diabetes Care*. 2011;34(7):1651-1659.

[26] CDC. Diabetes data and statistics website. http://www.cdc.gov/diabetes/data/index.html. Last accessed August 2015.

[27] Ali MK, Bullard KM, Saaddine JB, et al. Achievement of goals in US diabetes care, 1999-2010. *N Engl J Med*. 2013;368(17):1613-1624.

[28] CDC. Diabetes data and statistics website. http://www.cdc.gov/diabetes/data/index.html. Last accessed August 2015.

[29] Ali MK, Bullard KM, Saaddine JB, et al. Achievement of goals in US diabetes care, 1999-2010. *N Engl J Med*. 2013;368(17):1613-1624.

[30] CDC. Diabetes data and statistics website. http://www.cdc.gov/diabetes/data/index.html. Last accessed August 2015.

[31] Ali MK, Bullard KM, Saaddine JB, et al. Achievement of goals in US diabetes care, 1999-2010. *N Engl J Med*. 2013;368(17):1613-1624.

[32] Boelens A, Bolon M. *Composite Measures: A New Gold Standard in Diabetes Care.* Washington, DC: Aligning Forces for Quality; 2014. Available at http://www.google.com/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=1&cad=rja&uact=8&ved=0CCsQFjAA&url=http%3A%2F%2Fforces4quality.org%2Faf4q%2Fdownload-document%2F7229%2F4205&ei=8eE6U7e7OcmwsASX5oGgBQ&usg=AFQjCNFpwrte8P64wH3kgKoXIv4tpyG8oA. Last accessed April 2014.

[33] National Committee for Quality Assurance (NCAQ). Improving Quality and Patient Experience: The State of Health Care Quality 2013. Washington, DC:NCQA; 2014.

[34] Brauer CA, Coca-Perraillon M, Cutler DM, et al. Incidence and mortality of hip fractures in the United States. *JAMA*. 2009;302(14):1573-1579.

[35] National Quality Forum (NQF). *Report From the National Quality Forum: 2012 NQF Measure Gap Analysis*. Washington, DC: NQF; 2013.

[36] NQF. *Report From the National Quality Forum: 2012 NQF Measure Gap Analysis*. Washington, DC: NQF; 2013.

[37] NQF. *MAP Families of Measures: Safety, Care Coordination, Cardiovascular Conditions, Diabetes.* Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=71952. Last accessed August 2015

[38] NQF. Measurement framework: *Evaluating efficiency across patient-focused episodes of care website.* http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx. Last accessed August 2015.

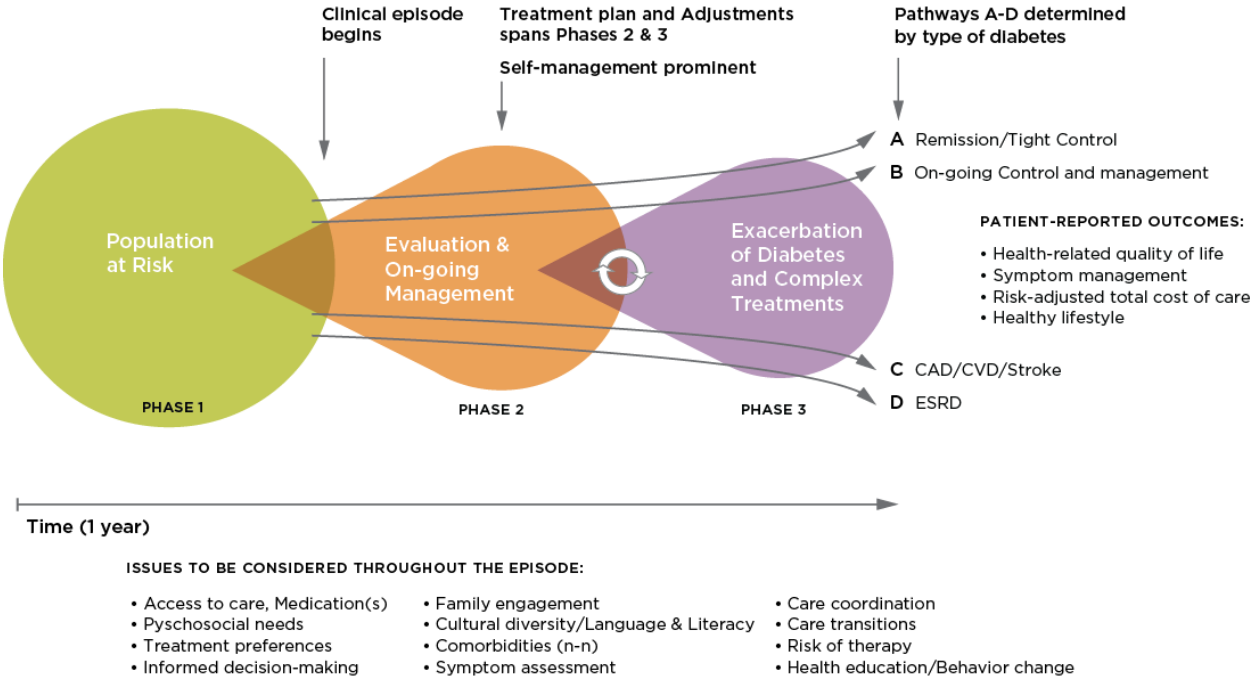
[39] NQF. *Towards a Comprehensive Diabetes Measure Set: Value-Based Episodes of Care.* Work summary presented at NQF: September 23, 2008;Washington, DC.

[40] NQF. *MAP 2014 Recommendations on Measures for More Than 20 Federal Programs*. Washington, DC: NQF; 2014.

[41] NQF. *Report From the National Quality Forum: 2012 NQF Measure Gap Analysis*. Washington, DC: NQF; 2013.

Appendix A: NQF Endocrine Portfolio and Related Measures

Patient-Focused Episode of Care for Diabetes



NQF-Endorsed Diabetes Measures

**Denotes measures that are applicable to persons with diabetes but were not evaluated in the Endocrine project.*

Phase 1: Population at Risk

Assessment and Screening

0024 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*

0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*

1932 Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications (SSD)*

Phase 2: Evaluation and On-Going Management

Eye Care

0055 Comprehensive Diabetes Care: Eye Exam

0088 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy*

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care*

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam*

Foot Care

0056 Diabetes: Foot exam

0416 Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear

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

0519: Diabetic Foot Care and Patient Education Implemented Blood glucose control

0057 Comprehensive Diabetes Care: Hemoglobin A1c testing

Blood Glucose Control

1934 Diabetes Monitoring [A1c and LDL-C] for People with Diabetes and Schizophrenia (SMD)*

0059 Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9%)

0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) control (<8%)

2362 Glycemic Control – Hyperglycemia

2363 Glycemic Control – Severe Hypoglycemia

2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing*

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)*

Cardiovascular

0066 Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)*

0061 Comprehensive Diabetes Care: Blood Pressure Control (<140/90)

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)*

Kidney disease

0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy*

Medication Adherence

0541 Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category*

0545 Adherence to Statins for Individuals with Diabetes Mellitus

2467 Adherence to ACEI/ARBs for Individuals with Diabetes Mellitus

2468 Adherence to Oral Diabetes Agents for Individuals with Diabetes Mellitus

Composite

0729 Optimal Diabetes Care

Phase 3: Exacerbation and Complex Treatments

Outcomes

0272 Diabetes Short-Term Complications Admission Rate (PQI 1)*

0274 Diabetes Long-Term Complications Admission Rate (PQI 3)*

0285 Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)*

0638 Uncontrolled Diabetes Admission Rate (PQI 14)*

Resource Use

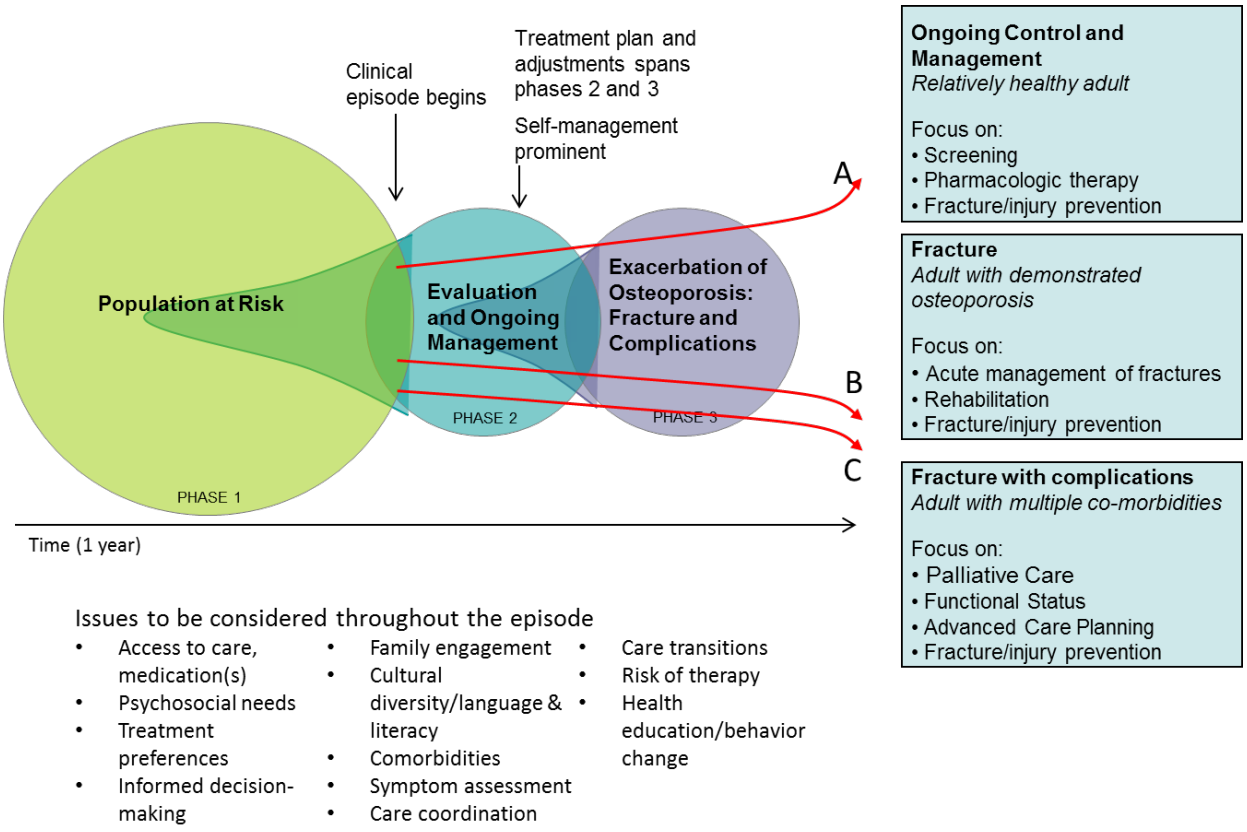
1557 Relative Resource Use for People with Diabetes (RDI)*

Previously Endorsed Diabetes Measures

Portfolio	Measure Title	Measure Steward	Reason (potential options: retired, lost endorsement)	Date
Endocrine	**0003:** Bipolar Disorder: Assessment for Diabetes	Center for Quality Assessment and Improvement in Mental Health	Retired	Sept 2014
	0060: HbA1c Testing for Pediatric Patients	NCQA	Retired	Jan 2014
	0063: Comprehensive Diabetes Care: LDL-C screening	NCQA	Retired	July 2014
	0064: Comprehensive Diabetes Care: LDL-C control <100	NCQA	Retired	July 2014
	0546: Diabetes: Appropriate Treatment of Hypertension	PQA	Retired	June 2015
	0603: Adult(s) Taking Insulin with Evidence of Self-Monitoring Blood Glucose Testing	Ingenix	Retired	Nov 2013
	0604: Adult(s) with Diabetes Mellitus That Had a Serum Creatinine in Last 12 Reported Months	Ingenix	Retired	Nov 2013
	0618: Diabetes with LDL greater than 100 – Use of a Lipid Lowering Agent	Active Health Management	Retired	Nov 2013
	0619: Diabetes with Hypertension or Proteinuria - Use of an ACE Inhibitor or ARB	Active Health Management	Retired	Nov 2013
	0630: Diabetes and Elevated HbA1C – Use of Diabetes Medications	Active Health Management	Retired	Nov 2013
	0731: Comprehensive Diabetes Care	NCQA	Retired	Dec 2013
Cardiovascular	**0632**: Primary Prevention of Cardiovascular Events in Diabetics – Use of Aspirin or Antiplatelet Therapy	Active Health Management	Retired	Nov 2013

NQF-Endorsed Osteoporosis Measures

Patient-Focused Episode of Care for Osteoporosis



NQF-Endorsed Measures for Patients with Osteoporosis

**Denotes measures that are applicable to persons with osteoporosis but were not evaluated in the Endocrine project.*

Phase 1: Population at Risk

0037 Osteoporosis Testing in Older Women

Phase 2: Evaluation and On-Going Management

0046 Osteoporosis: Screening or Therapy for Women Aged 65 Years and Older

Phase 3: Exacerbation of Osteoporosis: Fracture and Complications

0045 Osteoporosis: Communication with the Physician Managing On-Going Care Post Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

0053 Osteoporosis Management in Women Who Had a Fracture

0354 Hip Fracture Mortality Rate (IQI 19)*

2416 Laboratory Investigation for Secondary Causes of Fracture

2417 Risk Assessment/Treatment After Fracture

Previously Endorsed Osteoporosis Measures

Portfolio	Measure Title	Measure Steward	Reason (potential options: retired, lost endorsement)	Date
Endocrine	**0048:** Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	NCQA	Retired	July 2014
	0049: Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	NCQA	Retired	July 2014
	0614: Steroid Use-Osteoporosis screening	Active Health Management	Retired	Nov 2013
	0633: Osteopenia and Chronic Steroid Use - Treatment to Prevent Osteoporosis	Active Health Management	Retired	Nov 2013
	0634: Osteoporosis - Use of Pharmacological Treatment	Active Health Management	Retired	Nov 2013

Appendix B: Endocrine Portfolio—Use In Federal Programs

NQF #	Title	Federal Programs: Finalized as of August, 2015
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	Children's Health Insurance Program Reauthorization Act Quality Reporting; Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0055	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0056	Diabetes: Foot Exam	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Part C Plan Rating; Medicare Shared Savings Program; Physician Compare; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Part C Plan Rating; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0066	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	Medicare Shared Savings Program; Physician Compare; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0089	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0272	Diabetes Short-Term Complications Admission Rate (PQI 01)	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults

NQF #	Title	Federal Programs: Finalized as of August, 2015
0416	Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0417	Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Medicare Shared Savings Program; Physician Compare; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0519	Diabetic Foot Care and Patient Education Implemented	Home Health Compare; Home Health Quality Reporting
0541	Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category	Medicare Part D Plan Rating

Appendix C: Project Standing Committee and NQF Staff

STANDING COMMITTEE

William Golden, MD, MACP (Co-Chair)
Arkansas Medicaid
Little Rock, AR

James Rosenzweig, MD (Co-Chair)
RTI Health Solutions
Durham, NC

Robert Bailey, MD
Janssen Scientific Affairs, LLC
Venice, FL

Tracey Breen, MD
North Shore-LIJ Department of Medicine
New Hyde Park, NY

William Curry, MD, MS
Pennsylvania State University College of Medicine
Hershey Park, PA

Vicky Ducworth
The Boeing Company
Charleston, SC

R. James Dudl, MD
Kaiser Permanente
San Diego, CA

Ingrid Duva, RN, PhD
Veterans Administration
Norcross, GA

Starlin Haydon-Greatting, MS, BSPharm, FAPhA
Illinois Pharmacists Association
Springfield, IL

Ann Kearns, MD, PhD
Mayo Clinic
Rochester, MN

M. Sue Kirkman, MD
University of North Carolina
Chapel Hill, NC

Anne Leddy, MD, FACE
Glouchester-Mathews Free Clinic
Moon, VA

Grace Lee, MD
Virginia Mason Medical Center
Seattle, Washington

Laura Makaroff, DO
Health Resources Services Administration
Rockville, MD

Anna McCollister-Slipp
Galileo Analytics
Washington, DC

Patricia McDermott, RN
Aetna, Inc.
St. Charles, IL

Janice Miller, DNP, CRNP, CDE
Thomas Jefferson University
Philadelphia, PA

Claudia Shwide-Slavin, MS, RD, DC-ADM, CDE
American Association of Diabetes Educators (AADE)
New York, NY

Janet Sullivan, MD
Westchester Medical Center
Hawthorne, NY

William Taylor, MD
Department of Population Medicine, Harvard Medical School
Boston, MA

NQF STAFF

Helen Burstin, MD, MPH
Chief Scientific Officer

Marcia Wilson, PhD, MBA
Senior Vice President

Karen Johnson, MS
Senior Director

Kathryn Streeter, MS
Senior Project Manager

Poonam Bal, MHSA
Project Analyst

Kaitlynn Robinson-Ector, MPH
Project Analyst

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

ISBN 978-0-9828420-9-6