NATIONAL QUALITY FORUM

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 subcriterion 1b).

Brief Measure Information

NQF #: 0061
De.2. **Measure Title:** Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
Co.1.1. **Measure Steward:** National Committee for Quality Assurance
De.3. **Brief Description of Measure:** The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level taken during the measurement year is <140/90 mm Hg.
1b.1. **Developer Rationale:** This measure aims to improve the quality of care for patients with diabetes by assessing whether their blood pressure was adequately controlled (<140/90 mm Hg). High blood pressure is a major risk factor for microvascular and macrovascular complications in patients with diabetes. Cardiovascular disease is one of the leading causes for early death in people with diabetes. Uncontrolled high blood pressure contributes to the risk of complications and early death due to heart attack, stroke, angina and coronary heart disease. The benefits of quality envisioned by this measure include controlled blood pressure in patients with diabetes and a reduction in complications and early death.

S.4. **Numerator Statement:** Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

The outcome being measured is a blood pressure reading of <140/90 mm Hg, which indicates adequately controlled blood pressure. Adequately controlled blood pressure in patients with diabetes reduces cardiovascular risks and microvascular diabetic complications.
S.7. **Denominator Statement:** Patients 18-75 years of age by the end of the measurement year who had a diagnosis of diabetes (type 1 and type 2) during the measurement year or the year prior to the measurement year. See question S.9 Denominator Details for methods to identify patients with diabetes.
S.10. **Denominator Exclusions:** Exclusions
-Exclude patients who did NOT have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year.
AND either:
-A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year, or
-A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

De.1. **Measure Type:** Outcome
S.23. **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records
S.26. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System

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

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

IF this measure is paired/grouped, NQF#/title:

De.4. **IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?**

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form
FINAL_Evidence_Form_0061_BP_Control.docx

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., the benefits or improvements in quality envisioned by use of this measure)*
This measure aims to improve the quality of care for patients with diabetes by assessing whether their blood pressure was adequately controlled (<140/90 mm Hg). High blood pressure is a major risk factor for microvascular and macrovascular complications in patients with diabetes. Cardiovascular disease is one of the leading causes for early death in people with diabetes. Uncontrolled high blood pressure contributes to the risk of complications and early death due to heart attack, stroke, angina and coronary heart disease. The benefits of quality envisioned by this measure include controlled blood pressure in patients with diabetes and a reduction in complications and early death.

1b.2. **Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.** *(This is required for endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*
The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data is summarized at the health plan level and summarized by the mean, standard deviation, performance percentiles (10th, 25th, 50th, 75th and 90th percentile) and the interquartile range. Data is stratified by year and product line (i.e. commercial, Medicare, Medicaid, HMO and PPO) for the health plan level.

The following data demonstrate the variation in the rate of patients with diabetes that had a blood pressure level <140/90 mm Hg.

Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)
N= Number of plans reporting

Commercial (HMO and PPO Combined)
YEAR|N|MEAN|ST DEV|10TH|25TH|50TH|75TH|90TH|Interquartile Range
2012|331|63%|12%|51%|57%|64%|70%|76%|14%
2013|347|63%|13%|50%|58%|64%|71%|77%|13%
2014|342|62%|13%|49%|56%|63%|71%|75%|14%

Medicaid
YEAR|N|MEAN|ST DEV|10TH|25TH|50TH|75TH|90TH|Interquartile Range
2012|167|61%|14%|46%|54%|64%|70%|75%|16%
2013|188|59%|16%|45%|54%|61%|68%|75%|15%
2014|209|60%|14%|46%|53%|61%|70%|75%|16%

Medicare
YEAR|N|MEAN|ST DEV|10TH|25TH|50TH|75TH|90TH|Interquartile Range
2012|451|62%|12%|49%|56%|64%|70%|75%|14%
2013|499|63%|13%|49%|57%|64%|70%|76%|12%
2014|489|65%|11%|54%|59%|65%|72%|77%|13%

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and average sample size used for reporting. Please note: This measures uses the HEDIS Hybrid sampling methodology.

Commercial
YEAR|N Plans|Median Denominator Size per plan
2012| 331|966
2013|347|1,725
2014|342|1,325

Medicaid
YEAR|N Plans|Median Denominator Size per plan
2012|167|467
2013|188|480
2014|209|475

Medicare
YEAR|N Plans|Median Denominator Size per plan
2012|451|669
2013|499|423
2014|489|551

****
The data references are extracted from Diabetes Recognition Program data collection reflecting the most recent years of measurement for this measure. Below is a description of the total number of clinicians (N) submitting data for this measure. This figure (N) includes the total number of individual clinicians (solo practice) and clinicians in group practices. Performance data is summarized by the mean, standard deviation, performance percentiles (10th, 25th, 50th, 75th and 90th percentile) and the interquartile range.

DIABETES RECOGNITION PROGRAM
*Please Note: The Diabetes Recognition Program measure is BP >= 140/90 mm Hg. Lower score = Better quality

Clinicians and Practices Combined
N=Total number of clinicians reporting
YEAR|N|MEAN|ST DEV|10TH|25TH|50TH|75TH|90TH|Interquartile Range
2011|2580|20%|10%|8%|12%|20%|28%|32%|16%
2012|3607|20%|10%|8%|12%|20%|28%|32%|16%
2013|2477|19%|10%|7%|12%|18%|26%|32%|14%

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.*
HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). NCQA does not currently collect performance data stratified by race, ethnicity, or language. Escarce et al. have described in detail the difficulty of collecting valid data on race, ethnicity and language at the health plan level (Escarce, 2011). 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. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine

guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

1b.5. **If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.**
The 2014 National Diabetes Statistics report shows that minority groups are affected by diabetes at higher rates than Whites. Between 2010 and 2012, American Indians/Alaska Natives had the highest rates of diagnosed diabetes (15.9%). Non-Hispanic Blacks and Hispanics had the second and third highest rates at 13.2% and 12.8%, respectively. Nine percent of Asian Americans and 7.6% of Non-Hispanic Whites had diagnosed diabetes (CDC, 2014). The Office of Minority Health also reports on disparities in diabetic complications. Both African Americans and American Indian/Alaska Natives with diabetes are twice as likely to die from diabetes than non-Hispanic whites. African Americans also have higher rates of diabetic complications in comparison to non-Hispanic whites. African American men are 2.7 times as likely to undergo renal replacement therapy related to diabetes when compared to non-Hispanic white men. In addition, African Americans are 1.7 times as likely to be hospitalized for diabetes than Whites (OMH, 2014).

The Centers for Disease Control and Prevention reports similar disparities in cardiovascular disease among patients with diabetes. Between 1998-2006, African Americans with diabetes were discharged from the hospital for major cardiovascular disease at rates 1.5 times higher than Whites with diabetes (CDC, 2011). In 2006, the discharge rates for stroke in patients with diabetes were twice as high in African Americans than Whites (CDC, 2011). The percentage of patients with diabetes and blood pressure levels <140/90 mm Hg is also lower in minority groups. Seventy-seven percent of Non-Hispanic Whites had a blood pressure <140/90 mm Hg between 2003 and 2006 (CDC, 2013). In comparison 71.6% of Non-Hispanic Blacks and 66.8% of Mexican Americans had blood pressure levels <140/90 mm Hg between 2003 and 2006 (CDC, 2013).

Centers for Disease Control and Prevention. 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; 2014.

Centers for Disease Control and Prevention, National Center for Health Statistics, data from the National Health and Nutrition Examination Survey. Statistical analysis by the Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation. 2013. Accessed from http://www.cdc.gov/diabetes/statistics/bp/bp_pct2byraceth.htm

Centers for Disease Control and Prevention. Diabetes Public Health Resource. Age-Adjusted Hospital Discharge Rates for Major Cardiovascular Disease as First-Listed Diagnosis per 1,000 Diabetic Population, by Race, United States, 1988-2006. 2011. Accessed from http://www.cdc.gov/diabetes/statistics/cvdhosp/cvd/fig6.htm

Centers for Disease Control and Prevention. Diabetes Public Health Resource. Age-Adjusted Hospital Discharge Rates for Stroke as First-Listed Diagnosis per 1,000 Diabetic Population, by Race, United States, 1988-2006. 2011. Accessed from http://www.cdc.gov/diabetes/statistics/cvdhosp/cvd/fig6.htm

Office of Minority Health, U. S. Department of Health and Human Services. Diabetes and American Indians/Alaska Natives. 2014. Accessed from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=33

Office of Minority Health, U. S. Department of Health and Human Services. Diabetes and African Americans. 2014. Accessed from http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=18

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. **Demonstrated high priority aspect of healthcare**
Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality
1c.2. **If Other:**

1c.3. **Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.**
Diabetes is the seventh leading cause of death in the United States. Over 29.1 million adults had diabetes in 2012. This is an increase from the 25.8 million with diabetes in 2010. The total cost of diabetes in 2012 was $245 billion. This figure includes $176 billion in direct medical expenses and $69 billion from reduced productivity associated with diabetes.

Seventy-one percent of adults 18 years of age and older with diabetes also have high blood pressure (BP >= 140/90 mm Hg) or take prescription medications to lower their blood pressure. Uncontrolled blood pressure can lead to heart attacks, stroke and death. In 2010, adults 20 years of age and older with diabetes were 1.8 times more likely to be hospitalized for a heart attack than those without diabetes. In the same year, adults 20 years of age and older with diabetes were 1.5 times more likely to be hospitalized for a stroke than those without diabetes. Death rates from cardiovascular disease are also 1.7 times higher in patients with diabetes compared to those without diabetes. Additional research shows that controlling blood pressure in patients with diabetes can significantly reduce the risk for poor renal outcomes. One study found that patients with diabetes and a systolic blood pressure >= 140 mm Hg were 15% more likely to have worsening estimated glomerular filtration rates (eGFR). This is in comparison to patients with diabetes and a systolic blood pressure < 140 mm Hg.

1c.4. **Citations for data demonstrating high priority provided in 1a.3**
Anderson RJ, Bahn GD, Emanuele NV, Marks JB, Duckworth WC. 2014. Blood Pressure and Pulse Pressure Effects on Renal Outcomes in the Veterans Affairs Diabetes Trial (VADT). Diabetes Care. 31:10. 2782-2788. Accessed from http://care.diabetesjournals.org/content/37/10/2782.short

Centers for Disease Control and Prevention. 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; 2014. Accessed from http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf

1c.5. **If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful.** *(Describe how and from whom their input was obtained.)*

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 subcriteria 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):*
Cardiovascular : Hypertension, Endocrine : Diabetes

De.6. **Cross Cutting Areas** *(check all the areas that apply):*
Prevention

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 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)
No HQMF specs **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:** 0061_CDC_BP_Control_Value_Sets.xlsx

S.3. **For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.
The measure developers made the following revisions in the methods used to identify patients with diabetes:

Claim/Encounter data: The ED visit requirement was revised to require at least two ED visits with a diagnosis of diabetes instead of at least one ED visit with a diagnosis of diabetes.

Pharmacy data: The list of prescriptions to identify patients with diabetes was revised to add 1) dapaglifozin to the Sodium glucose cotransporter 2 (SGLT2) inhibitor category and 2) albiglutide to the Glucagon-like peptide-1 (GLP1) agonists category.

These changes were made to ensure that only patients with diabetes are included in the denominator.

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)*
IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.
Patients whose most recent blood pressure level was <140/90 mm Hg during the measurement year.

The outcome being measured is a blood pressure reading of <140/90 mm Hg, which indicates adequately controlled blood pressure. Adequately controlled blood pressure in patients with diabetes reduces cardiovascular risks and microvascular diabetic complications.

S.5. **Time Period for Data** *(What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)*
The measurement year (12 month period)

S.6. **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, 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.
ADMINISTRATIVE
Use automated data to identify the most recent blood pressure reading taken during an outpatient visit or nonacute inpatient encounter during the measurement year. The patient is numerator compliant if the blood pressure reading is <140/90 mm Hg. The patient is not numerator compliant if the blood pressure is =140/90 mm Hg, if there is no blood pressure reading during the measurement year or if the reading is incomplete (e.g. the systolic or the diastolic level reading is missing). If there are multiple blood pressures on the same date of service, use the lowest systolic and the lowest diastolic blood pressure as the representative blood pressure.

Organizations that use the CPT Category II codes to identify numerator compliance must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both the systolic and diastolic levels:

VALUE SET / NUMERATOR COMPLIANCE
Systolic Less than 140 Value Set / Systolic compliant
Systolic Greater Than/Equal to 140 Value Set / Systolic not compliant
Diastolic Less than 80 Value Set / Diastolic compliant

Diastolic 80-89 Value Set / Diastolic Compliant
Diastolic Greater Than/Equal to 90 Value Set / Diastolic Not Compliant

MEDICAL RECORD
The organization should use the medical record that it uses to collect data for other diabetes care indicators such as the HbA1c <8 mg/dL indicator. If the organization does not collect data for other diabetes care indicators, it should use the medical record of the provider that manages the patient's diabetes. If that medical record does not contain a blood pressure, the organization may use the medical record of another primary care provider or specialist from whom the patient receives care.

To determine if blood pressure is adequately controlled, the organization must identify the representative blood pressure following the steps below.

Identify the most recent blood pressure reading noted during the measurement year. DO NOT include blood pressure readings that meet the following criteria:
-Taken during an acute inpatient stay or an ED visit.
-Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
-Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).
-Reported by or taken by the patient.

Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date. The patient is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).

S.7. **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 and type 2) during the measurement year or the year prior to the measurement year. See question S.9 Denominator Details for methods to identify patients with diabetes.

S.8. **Target Population Category** *(Check all the populations for which the measure is specified and tested if any):*
Populations at Risk

S.9. **Denominator Details** *(All information required to identify and calculate the target population/denominator such as definitions, 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)*
Patients with diabetes can be identified with two methods: by claim/encounter data (claims for a diagnosis for diabetes type 1 or type 2) and by pharmacy data. Organizations must use both methods to identify patients in the denominator, but a patient only needs to be identified by one method to be included in the measure. Patients can be identified as having diabetes during the measurement year or the year prior to the measurement year. Details to identify patients with each method are provided below.

CLAIMS/ENCOUNTER DATA:
Patients who met any of the following criteria during the measurement year of the year prior to the measurement year (count services that occur over both years):
-At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
-At least one acute inpatient encounter with a diagnosis of diabetes.

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.

PHARMACY DATA:
Patients who were dispensed insulin or hypoglycemic/antihyperglycemics on an ambulatory basis during the measurement year or

the year prior. Note: Only prescriptions from the list below can be used to identify patients with diabetes for this measure. Metformin as a solo agent is not included in the list because it is used to treat conditions other than diabetes. Patients with diabetes on metformin as a sole medication may be identified through diagnosis codes only.

PRESCRIPTIONS TO IDENTIFY MEMBERS WITH DIABETES:
Alpha-glucosidase inhibitors:
Acarbose, Miglitol

Amylin analogs:
Pramlinitide

Antidiabetic combinations:
Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin, Alogliptin pioglitazone, Alogliptin metformin

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

Meglitinides:
Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:
Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:
Canagliflozin, Dapagliflozin

Sulfonylureas:
Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:
Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:
Alogliptin, Linagliptin, Saxagliptin, Sitaglipin

S.10. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Exclusions
-Exclude patients who did NOT have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year.
AND either:
-A diagnosis of polycystic ovaries, in any setting, any time in the patient's history through December 31 of the measurement year, or
-A diagnosis of gestational or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year.

S.11. **Denominator Exclusion Details** *(All information required to identify and calculate exclusions from the denominator such as definitions, 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: Codes associated with identifying the denominator exclusions for this measure are attached in a separate file with code value sets. See code value sets located in question S.2b.

MEDICAL RECORD:
-Exclusionary evidence in the medical record must include a note indicating the patient did NOT have a diagnosis of diabetes, in any

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

*Please note: a patient WITH a diagnosis of diabetes AND a diagnosis of either polycystic ovaries or gestational or steroid induced diabetes is NOT excluded from the denominator.

S.12. **Stratification Details/Variables** *(All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)*
N/A

S.13. **Risk Adjustment Type** (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)
No risk adjustment or risk stratification
If other:

S.14. **Identify the statistical risk model method and variables** *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)*
N/A

S.15. **Detailed risk model specifications** *(must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)*
Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. **Detailed risk model specifications** (*if not provided in excel or csv file at S.2b*)

S.16. **Type of score:**
Rate/proportion
If other:

S.17. **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.18. **Calculation Algorithm/Measure Logic** *(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; aggregating data; risk adjustment; etc.)*
STEP 1. Determine the eligible population. To do so, identify patients who meet all the specified criteria.
-AGES: 18-75 years as of December 31 of the measurement year.
-EVENT/DIAGNOSIS: Identify patients with diabetes in two ways: by claim/encounter data and by pharmacy data.

Claim/Encounter Data:
-Patients who met any of the following criteria during the measurement year of the year prior to the measurement year (count services that occur over both years):
-At least two outpatient visits, observation visits, ED visits or nonacute inpatient encounters on different dates of service, with a diagnosis of diabetes. Visit type need not be the same for the two visits.
-At least one acute inpatient encounter with a diagnosis of diabetes.
*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:
Patients who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year. *SEE PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES IN S.9

STEP 2: Exclude patients who meet the exclusion criteria. SEE S.10 AND S.11 FOR DENOMINATOR EXCLUSION CRITERIA AND DETAILS.
STEP 3: Determine the number of patients in the eligible population who had a blood pressure reading during the measurement year through the search of administrative data systems or medical record data.
STEP 4: Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record.
STEP 5. Determine whether the result was <140/90 mm Hg.
STEP 6: Calculate the rate by dividing the numerator (Step 5) by the denominator (after exclusions) (Step 2).

S.19. **Calculation Algorithm/Measure Logic Diagram URL or Attachment** *(You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)*
No diagram provided

S.20. **Sampling** *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*
IF a PRO-PM, identify whether (and how) proxy responses are allowed.
N/A

S.21. **Survey/Patient-reported data** *(If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)*
IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.
N/A

S.22. **Missing data** (specify how missing data are handled, e.g., imputation, delete case.)
Required for Composites and PRO-PMs.
N/A

S.23. **Data Source** *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*
If other, please describe in S.24.
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Pharmacy, Paper Medical Records

S.24. **Data Source or Collection Instrument** *(Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)*
IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.
This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan patients. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. When collected by clinicians for the NCQA Diabetes Recognition Program, data is collected using the DRP Data Collection Tool (DCT)

S.25. **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.26. **Level of Analysis** *(Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)*
Clinician : Group/Practice, Clinician : Individual, Health Plan, Integrated Delivery System

S.27. **Care Setting** *(Check ONLY the settings for which the measure is SPECIFIED AND TESTED)*
Ambulatory Care : Clinician Office/Clinic
If other:

S.28. **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

2a. Reliability – See attached Measure Testing Submission Form
2b. Validity – See attached Measure Testing Submission Form
FINAL_Testing_Form_0061_BP_Control.docx

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. **Data Elements Generated as Byproduct of Care Processes.**
Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)
If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. **To what extent are the specified data elements available electronically in defined fields?** *(i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)*
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.**
To allow for widespread reporting across health plans and health care practices, this measure is collected through multiple data sources (administrative data, electronic clinical data, and paper records). We anticipate as electronic health records become more widespread, the reliance on paper record review will decrease.

3b.3. **If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.**
No feasibility assessment **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. **Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.
NCQA recognizes that, despite the clear specifications defined for HEDIS measures, data collection and calculation methods may vary, and other errors may taint the results, diminishing the usefulness of HEDIS data for managed care organization (MCO) comparison. In order for HEDIS to reach its full potential, NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO´s ability

to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.
The HEDIS Compliance Audit addresses the following functions:
1) information practices and control procedures
2) sampling methods and procedures
3) data integrity
4) compliance with HEDIS specifications
5) analytic file production
6) reporting and documentation
In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measure. This system is vital to the regular re-evaluation of NCQA measures.
Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

3c.2. **Describe any fees, licensing, or other requirements to use any aspect of the measure as specified** *(e.g., value/code set, risk model, programming code, algorithm)*.
Broad public use and dissemination of this measure is encouraged. NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. **Current and Planned Use**

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

Planned	Current Use (for current use provide URL)
	Public Reporting Health Plan Ranking http://reportcard.ncqa.org/plan/external/plansearch.aspx http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality.aspx Annual State of Health Care Quality Payment Program IHA California Pay for Performance http://www.iha.org/manuals_operations_2014.html Regulatory and Accreditation Programs

	NCQA Accreditation http://www.ncqa.org/tabid/123/Default.aspx Accountable Care Organizations (ACO) http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx Professional Certification or Recognition Program NCQA Diabetes Recognition Program http://www.ncqa.org/Programs/Recognition/Clinicians/DiabetesRecognitionProgramDRP.aspx Quality Improvement with Benchmarking (external benchmarking to multiple organizations) Quality Compass http://www.ncqa.org/tabid/177/Default.aspx Annual State of Health Care Quality http://www.ncqa.org/ReportCards/HealthPlans/StateofHealthCareQuality.aspx

4a.1. **For each CURRENT use, checked above, provide:**

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

HEALTH PLAN RANKING: NCQA ranks health plans using the methodology we have used every year since 2005. For the 2014-2015 rankings, NCQA studied almost 1,400 health plans and ranked more than 1,000 of them based on clinical performance, member satisfaction and results from NCQA Accreditation surveys

ANNUAL STATE OF HEALTH CARE QUALITY: NCQA produces the State of Health Care Quality Report yearly to focus on key quality issues facing the United States and to drive improvement in the delivery of evidence-based medicine. The report documents performance trends over time, tracks variations in care and recommends quality improvements. The 2014 report provides data for the 2013 calendar year. Data in the report comes from 814 HMOs and 353 PPOs, representing more than 171 million people or 54 percent of the U.S. population.

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

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

NCQA DIABETES RECOGNITION PROGRAM: 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. As of December 2014, the DRP Program has 11 measures which cover other areas such as: HbA1c control, blood pressure control, LDL control, eye examinations, nephropathy Assessment, smoking and tobacco use and cessation advice or treatment. Eligible clinicians will abstract data from the charts of diabetes patients (25 patients for a single applicant) and submit this information to NCQA for review.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

4a.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

4a.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

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)
Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- **Progress (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**

HEALTH PLAN RANKING: NCQA ranks health plans using the methodology we have used every year since 2005. For the 2014-2015 rankings, NCQA studied almost 1,400 health plans and ranked more than 1,000 of them based on clinical performance, member satisfaction and results from NCQA Accreditation surveys

ANNUAL STATE OF HEALTH CARE QUALITY: NCQA produces the State of Health Care Quality Report yearly to focus on key quality issues facing the United States and to drive improvement in the delivery of evidence-based medicine. The report documents performance trends over time, tracks variations in care and recommends quality improvements. The 2014 report provides data for the 2013 calendar year. Data in the report comes from 814 HMOs and 353 PPOs, representing more than 171 million people or 54 percent of the U.S. population.

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

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

NCQA DIABETES RECOGNITION PROGRAM: 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. As of December 2014, the DRP Program has 11 measures which cover other areas such as: HbA1c control, blood pressure control, LDL control, eye examinations, nephropathy Assessment, smoking and tobacco use and cessation advice or treatment. Eligible clinicians will abstract data from the charts of diabetes patients (25 patients for a single applicant) and submit this information to NCQA for review.

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan, conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

4b.2. 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.

4c. 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).

4c.1. **Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.**

There were no unintended negative consequences to individuals identified during the testing and long-standing use 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)**

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

NQF 0729 Optimal Diabetes Care (Minnesota Community Measurement)

5a. Harmonization

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 completely harmonized?

No

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

Measure 0061 is NQF endorsed as single measure that uses health plan reported data to assess the percentage of patients 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure level is <140/90 mm Hg. Measure 0729 is a composite measure (all or nothing) that uses physician reported data to assess the percentage of adult diabetes patients who have optimally managed modifiable risk factors including blood pressure and four other indicators. NCQA's measure 0061 is included with five other NCQA diabetes measures. The five other diabetes measures are individually NQF endorsed (Endocrine Maintenance Phase 1). Together, the six NCQA individual diabetes measures (including measure 0061) make a set of diabetes HEDIS measures, but are not considered all or nothing. NCQA uses individual measures to provide health plans and others the opportunity to measure, report and incentivize each aspect of quality care for the diabetes population. HARMONIZED MEASURE ELEMENTS: Measures 0061 and 0729 both focus on an adult patient population 18-75 years of age with diabetes (type 1 and type 2). Both measures assess whether the patient's most recent blood pressure level in the measurement period was <140/90 mm Hg. Both measures also specify denominator visit criteria to include patients with at least two outpatient visits in the last two years with a diagnosis of diabetes. UNHARMONIZED MEASURE ELEMENTS: -Data Source: Measure 0061 is collected through administrative claims and/or medical record. Measure 0729 is collected through medical record abstraction. -Level of Accountability: Measure 0061 is a health plan level measure and is used in NCQA's clinical quality and recognition programs (See 4.1 Usability and Use). Measure 0729 is a physician

level measure. -Data Elements: Measure 0061 uses two methods to identify patients in the denominator 1) claims/encounter data with a diagnosis of diabetes and 2) pharmacy data for insulin or hypoglycemic/antihyperglycemics (see S.9 Denominator Details). Measure 0729 uses encounter data with a diagnosis for diabetes to identify patients in the denominator. NCQA uses two identification methods to ensure that only patients with diagnosed diabetes are included in the denominator. -Exclusions: Exclusions for measures 0061 and 0729 are substantially aligned with some variation due to differences in health plan and clinician level reporting. IMPACT ON INTERPRETABILITY AND DATA COLLECTION BURDEN: The differences between these measures do not have an impact on interpretability of publically reported rates. There is no added burden of data collection because the data for each measure is collected from different data sources by different entities.

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.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.
No appendix **Attachment:**

Contact Information

Co.1 **Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance
Co.2 **Point of Contact:** Bob, Rehm, nqf@ncqa.org, 202-955-1728-
Co.3 **Measure Developer if different from Measure Steward:** National Committee for Quality Assurance
Co.4 **Point of Contact:** Jill Marie, Farrell, farrell@ncqa.org, 202-955-1785-

Additional Information

Ad.1 **Workgroup/Expert Panel involved in measure development**
Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
DIABETES MEASUREMENT ADVISORY PANEL
Amanda Bartelme, Avalere Health
Bill Herman (Chair), MD, Univ. of Michigan Health System
David Aron, MD, Department of Veteran's Affairs
James Fain, PhD, RN, University of Massachussetts
Jerry Cavallerano, OD, Beetham Eye Institute
John Thompson, MD, Retina Specialists
Judith Fradkin, MD, NIDDK/NIH
Linda Humphrey, MD, Ohio State Univ.
Lynne Levitsky, MD, Massachusetts General Hospital
Mark Cziraky, PharmD, Healthcore
Michael Pignone, MD, Univ. of North Carolina, Chapel Hill
Mikhail Kosiborod, MD, St. Luke's Mid-America Heart Institute
Rebecca Burkholder, JD, National Consumers League
Richard Hellman, MD, Private Practice, Diabetes & Endocrinology
Samuel "Chris" Durso, MD, Johns Hopkins School of Medicine

Seth Rubenstein, DPM, Reston Hospital Center, INOVA Fair Oaks Hospital
Stephen Fadem, MD, Baylor College of Medicine
Sue Kirkman, MD, American Diabetes Association
Ted Ganiats, MD, Univ. of California, San Diego

CARDIOVASCULAR MEASUREMENT ADVISORY PANEL
Stephen Persell, MD, MPH (Chair), Northwestern University
Tom Kottke, MD, HealthPartners
Eduardo Ortiz, MD, MPH, Wolters Kluwer Health
David Goff, Jr., MD, PhD, FAHA, FACP, University of Colorado
Kathy Berra, MSN, ANP, FAAN, Stanford University
Michael Pignone, MD, MPH, University of North Carolina at Chapel Hill
Randall S. Stafford, MD, PhD, Stanford University
Tracy Wolff, MD, Agency for Healthcare Research and Quality
Corinne Husten, MD, MPH, U.S. Food and Drug Administration

COMMITTEE ON PERFORMANCE MEASUREMENT
Peter Bach, MD, Memorial Sloan Kettering Cancer Center
Bruce Bagley, MD, TransforMED
Andrew Baskin, MD, Aetna
A. John Blair lll, MD, Taconic IPA, Inc
Patrick Conway, MD, MSC, Center for Medicare & Medicaid Services
Jonathan D. Darer, MD, Geisinger Health System
Helen Darling, National Business Group on Health
Foster Gesten, MD, NYSDOH Office of Managed Care
Marge Ginsburg, Center for Healthcare Decisions
Christine Hunter, MD, (Co-Chair) US Office of Personnel Management
Jeffrey Kelman, MMSc, MD, Centers for Medicare & Medicaid Services
Philip Madvig, MD, The Permanente Medical Group
J. Brent Pawlecki, MD MMM, The Goodyear Tire & Rubber Company
Susan Reinhard, RN, PhD, AARP
Eric C. Schneider, MD, MSc (Co-Chair), RAND Corporation
Marcus Thygeson, MD, MPH Blue Shield of California

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 **Year the measure was first released:** 2009

Ad.3 **Month and Year of most recent revision:** 07, 2014

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?**

Ad.7 **Disclaimers:** These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications. THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Ad.8 **Additional Information/Comments:** Publication of each Measure is to be accompanied by the following notice:

NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.
These performance measures were developed and are owned by NCQA. They are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or