THE NATIONAL QUALITY FORUM

COMPOSITE MEASURE SUBMISSION FORM
Version 4.0 August 2009

This form will be used by stewards to submit **composite** measures and by reviewers to evaluate the measures.

Measure Stewards: Complete all non-shaded areas of the form. All requested information should be entered directly into this form. The information requested is directly related to NQF's composite measure evaluation criteria and will be used by reviewers to determine if the evaluation criteria have been met. The specific relevant subcriteria language is provided in a Word comment within the form and will appear if your cursor is over the highlighted area.

The measure steward has the opportunity to identify and present the information that demonstrates the measure meets the criteria. Additional materials will only be considered supplemental. Do not rely solely on materials provided at URLs or in attached documents to provide measure specifications or to demonstrate meeting the criteria. If supplemental materials are provided, be sure to indicate specific page numbers/ web page locations for the relevant information (web page links preferred).

For questions about this form, contact the project director at 202-783-1300. Please email this form to the appropriate contact listed in the corresponding call for measures.

Reviewers: Complete all yellow highlighted areas of the form. Evaluate the extent to which each subcriterion is met and then overall, the extent to which each major criterion is met. Provide the rationale for your rating.

Evaluation ratings of the extent to which the criteria are met
H=High (unquestionably demonstrated to meet the criterion)
M=Moderate (demonstrated to moderately meet the criterion)
L=Low (addressed BUT demonstrated to only minimally meet the criterion)
N=No (NOT addressed; OR incorrectly addressed; OR demonstrated to NOT meet the criterion)
NA=Not applicable (only an option for a few subcriteria as indicated)

(for NQF staff use) **NQF Review #:** OT1-029-09 **NQF Project:** Patient Outcomes Phases 1 and 2

Title of Measure: Comprehensive Diabetes Care

Brief description of measure (*including type of score, measure focus, target population, time, e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year*):
The percentage of individuals 18–75 years of age with diabetes (type 1 and type 2) who had each of the following.

- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) *
- Eye exam (retinal) performed
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- BP control (<140/90 mm Hg)

Smoking status and cessation advice or treatment

►**Type of Measure:** ☒ Composite

Select the most relevant priority area(s), quality domain(s), and consumer need(s).

►**National Priority Partners Priority Area** ☐ patient and family engagement ☒ population health ☐ safety ☐ care coordination ☐ palliative and end of life care ☐ overuse

►**IOM Quality Domain** ☒ effectiveness ☒ efficiency ☐ equity ☒ patient-centered ☐ safety ☐

timeliness

►**Consumer Care Need** ☐ Getting Better ☒ Living With Illness ☐ Staying Healthy

CONDITIONS FOR CONSIDERATION BY NQF	
Four conditions must be met before proposed measures may be considered and evaluated for suitability as voluntary consensus standards:	**NQF Staff**
A. The measure is in the public domain or an intellectual property agreement (measure steward agreement) is signed. *Public domain only applies to governmental organizations. All non-government organizations must sign a measure steward agreement even if measures are made publicly and freely available.* ►**Do you attest that the measure steward holds intellectual property rights to the measure and the right to use any aspects of the measure owned by another entity (e.g., component measures, risk model, code set)?** ☒ Yes ►**Measure Steward Agreement** ☒ Signed and Submitted **OR** ☐ Government entity-public domain (If measure steward agreement not signed for non-government entities, do not submit) ►**Please check if either of the following apply:** ☐ Proprietary Measure ☐ Proprietary Complex Measure w/fees	**A** Y☒ N☐
B. The measure owner/steward verifies there is an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every 3 years. ☒ Yes (If no, do not submit)	**B** Y☒ N☐
C. The intended use of the measure includes both public reporting and quality improvement. ►**Purpose:** ☒ Public reporting ☒ Internal quality improvement ☒ Accountability ☒ Accreditation ☒ Payment incentive ☐ Other, describe: (If not intended for both public reporting and quality improvement, do not submit)	**C** Y☒ N☐
D. The requested measure submission information is complete. Generally, measures should be fully developed and tested so that all the evaluation criteria have been addressed and information needed to evaluate the measure is provided. Measures that have not been tested are only potentially eligible for a time-limited endorsement and in that case, measure owners must verify that testing will be completed within 24 months of endorsement. ►**Testing:** ☒ Fully developed and tested ☐ Testing will be completed within 24 months (If not tested and no plans for testing within 24 months, do not submit) **Component Measures** (*All components of the composite must be either NQF-endorsed or submitted for consideration for NQF endorsement*) ☐ All component measures are NQF-endorsed measures ☒ Some or all component measures are not NQF-endorsed and have been submitted using the online measure submission tool ►**Have NQF-endorsed measures been reviewed to identify if there are similar or related measures?** ☒ Yes (If no, do not submit) *If there are similar or related measures, be sure to address items 3b and 3c with specific information.* ►**Is all requested information entered into this form?** ☐ Yes (If no, do not submit)	**D** Y☒ N☐
(for NQF staff use) **Have all conditions for consideration been met?** **Staff Notes (if submission returned):**	**Met** Y☒ N☐

1. IMPORTANCE TO MEASURE AND REPORT	
Extent to which the specific measure focus is important to making significant gains in health care quality	**Eval**

(safety, timeliness, effectiveness, efficiency, equity, patient-centeredness) and improving health outcomes for a specific high impact aspect of healthcare where there is variation in or overall poor performance. ***Measures must be judged to be important to measure and report*** *in order to be evaluated against the remaining criteria.* (composite measure evaluation criteria) If the component measures are determined to meet the importance criteria 1a, 1b, and 1c, then the composite would meet 1a, 1b, and 1c.	
(for NQF staff use) **Specific NPP goal**:	
1d. Purpose/objective of the Composite ►**Describe the purpose/objective of the composite measure:** Over 90% of patients with diabetes have Type 2 diabetes, with the remainder being Type 1. Diabetes of either type may cause life-threatening or life-ending complications. Complications and morbidity from diabetes produces significantly increased health utilization and disability among those afflicted. Because of this, the total annual economic burden of diabetes is believed to approach $100 billion in the United States. Quality improvement measures for this group of diseases are therefore of great importance to patients, providers, and purchasers of health care. ►**Describe the quality construct used in developing the composite:** The majority indicators included in the Comprehensive Diabetes Care composite have been used in both HEDIS Health Plan accreditaion and provider recognition programs which were tested in a feasibility study that analyzed over 1,900 patient records in 29 specialty and general practice sites, leading to standards of diabetes care for both adult and pediatric patients. These key standards were selected based on the scientific evidence supporting their relevancy to improved care for people with diabetes, as supported by the ADA Standards of Medical Care in Diabetes 2006	**1d** H☐ M☐ L☐ N☐
1e. Conceptual construct for quality ►**Describe how the component measures are consistent with and representative of the quality construct:** the composite diabetes compoenents are consistent with guideline evidence and multiple consensus panel recommendations. Each of the individaul components is well supported in clinical guidelines and the the set has been tested and used in multiple settings for several years of data collection	**1e** H☐ M☐ L☐ N☐
Staff Notes to Reviewers:	
Reviewer: Was the threshold criterion, Importance to Measure and Report, met? **Rationale:**	**1** Y☐ N☐
2. 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. (composite measure evaluation criteria)	**Eval**
2a. MEASURE SPECIFICATIONS	
In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained? ►Do you have a web page where current detailed measure specifications can be obtained? ►If yes, provide web page URL: 2a. Precisely Specified **Components of the Composite** (*List the components, i.e., domains/sub-composites and individual measures*) ►**List components:** (*If component measures NQF-endorsed, include NQF measure number*; if not NQF-endorsed, provide date of submission to NQF) Hemoglobin A1c (HbA1c) testing (NQF#0057) •HbA1c poor control (>9.0%) (NQF#0059) •HbA1c control (<8.0%) (NQF#0575) •HbA1c control (<7.0%) *(Submitted January 2010) •Eye exam (retinal) performed (NQF#0055)	**2a-specs** H☐ M☐ L☐ N☐

•LDL-C screening (NQF#0064 -paired with control)
•LDL-C control (<100 mg/dL) (NQF#0064)
•Medical attention for nephropathy (NQF#0062)
•BP control (<140/90 mm Hg) (NQF#0061)

Composite Numerator Statement: Percentage of members 18-75 years of age with diabetes (type 1 and 2) who had each of the following:
HbA1c Testing - An HbA1c test performed during the measurement year as identified by claim/encounter or automated lab data.
2. HbA1c Poor Control >9% - Use automated lab data to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is >9.0% or is missing a result or if an HbA1c test was not done during the measurement year. The member is not numerator compliant if the automated result for the most recent HbA1c test during the measurement year is ≤9.0%.
An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codesand use the most recent code during the measurement year to evaluate whether the member is numerator compliant.
Note: For this indicator, a lower rate indicates better performance (i.e., low rates of poor control indicate better care).
3. HbA1c Control <8% - Use automated laboratory data to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <8.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is ≥8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.
4. HbA1c Control <7% - Use automated laboratory data to identify the most recent HbA1c test during the measurement year. The member is numerator compliant if the most recent automated HbA1c level is <7.0%. The member is not numerator compliant if the automated result for the most recent HbA1c test is ≥7.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.
Note: This indicator uses the eligible population with additional eligible population criteria (e.g., removing members with required exclusions).
5. Eye Exam - An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following.
- A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year, or
- A negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement year

Refer to codes to identify eye exams. For exams performed in the year prior to the measurement year, a result must be available.
6. LDL-C Screening - An LDL-C test performed during the measurement year, as identified by claim/ encounter or automated laboratory data. The organization may use a calculated or direct LDL for LDL-C screening and control indicators.
7. LDL-C Control <100 mg/dL - Use automated laboratory data to identify the most recent LDL-C test during the measurement year. The member is numerator compliant if the most recent automated LDL-C level is <100 mg/dL. If the automated result for the most recent LDL-C test during the measurement year is ≥100 mg/dL or is missing, or if an LDL-C test was not done during the measurement year, the member is not numerator compliant.
An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes and use the most recent code during the measurement year to evaluate whether the member is numerator compliant.
8. Medical Attention for Nephropathy - A nephropathy screening test or evidence of nephropathy, as documented through administrative data.
9. BP Control <140/90 mmHg - Use automated data to identify the most recent BP reading during the measurement year. Refer to Table CDC-N and use the most recent code to evaluate whether the member is

numerator compliant.
The member is numerator compliant if the BP is <140/90 mm Hg. The member is not compliant if the BP is ≥140/90 mm Hg or if there is no automated BP reading during the measurement year. If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP.
An organization that uses CPT Category II codes to identify numerator compliance for this indicator must search for all codes and use the most recent codes during the measurement year to evaluate whether the member is numerator compliant for both systolic and diastolic levels.
11. Smoking status: PAtients with documentation of smoking status (e.e. non-smoker, smoker, not known) AND date of cessation couseling, OR treatmetn during the meaurement year if the patient is a tombacco smoker.

Numerator Time Window: Measurement Year

Numerator Details:
Codes to identify HbA1c tests
CPT: 83036, 83037
CPT Category II: 3044F, 3045F, 3046F
LOINC: 4548-4, 4549-2, 17856-6
Codes to identify HbA1c levels >9%
-Numerator compliant
CPT Category II: 3046F
-Not numerator compliant
CPT Category II: 3044F, 3045F
Codes to identify HbA1c levels <8%
-Numerator compliant
CPT Category II: 3044F
-Not numerator compliant
CPT Category II: 3045F*, 3046F
* CPT Category II code 3045F indicates most recent HbA1c (HbA1c) level 7.0%–9.0% and is not specific enough to denote numerator compliance for this indicator. For members with this code, the organization may use other sources (laboratory data, hybrid reporting method) to determine if the HbA1c result was <8%.
Codes to identify HbA1c levels <7%
-Numerator compliant
CPT Category II: 3044F
-Not numerator compliant
CPT Category II: 3045F, 3046F
Codes to identify eye exams*
CPT: 67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
CPT Category II**: 2022F, 2024F, 2026F, 3072F***
* Eye exams provided by eye care professionals are a proxy for dilated eye examinations because there is no administrative way to determine that a dilated exam was performed.
** The organization does not need to limit CPT Category II codes or HCPCS S0625 to an optometrist or an ophthalmologist. These codes indicate an eye exam was performed by an eye care professional.
*** CPT Category II code 3072F can only be used if the claim/encounter was during the measurement year because it indicates the member had “no evidence of retinopathy in the prior year.” Additionally, because the code definition itself indicates results were negative, an automated result is not required.
HCPCS: S0620, S0621, S0625**, S3000
ICD-9-CM Diagnosis: V72.0
ICD-9-CM Procedure: 14.1-14.5, 14.9, 95.02-95.04, 95.11, 95.12, 95.16
Codes to identify LDL-C screening
CPT: 80061, 83700, 83701, 83704, 83721
CPT Category II: 3048F, 3049F, 3050F
LOINC: 2089-1, 12773-8, 13457-7, 18261-8, 18262-6, 22748-8, 39469-2, 49132-4
Codes to identify LDL-C levels
-Numerator compliant

CPT Category II: 3048F
-Not numerator compliant
CPT Category II: 3049F, 3050F
Codes to identify nephropathy screening tests
CPT: 82042, 82043, 82044, 84156
CPT Category II: 3060F, 3061F
LOINC: 1753-3, 1754-1, 1755-8, 1757-4, 2887-8, 2888-6, 2889-4, 2890-2, 9318-7, 11218-5, 12842-1, 13801-6, 14956-7, 14957-5, 14958-3, 14959-1, 13705-9, 14585-4, 18373-1, 20621-9, 21059-1, 21482-5, 26801-1, 27298-9, 30000-4, 30001-2, 30003-8, 32209-9, 32294-1, 32551-4, 34366-5, 35663-4, 40486-3, 40662-9, 40663-7, 43605-5, 43606-3, 43607-1, 44292-1, 47558-2, 49023-5, 50949-7, 53121-0, 53530-2, 53531-0, 53532-8
Codes to identify evidence of nephropathy
-Urine macroalbumin test
CPT: 81000-81003, 81005
CPT Category II: 3062F
LOINC: 5804-0, 20454-5, 50561-0, 53525-2
-Evidence of treatment for nephropathy
CPT: 36145, 36800, 36810, 36815, 36818, 36819-36821, 36831-36833, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 90920, 90921, 90924, 90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512
CPT Category II: 3066F
HCPCS: G0257, G0314-G0319, G0322, G0323, G0326, G0327, G0392, G0393, S9339
ICD-9-CM Diagnosis: 250.4, 403, 404, 405.01, 405.11, 405.91, 580-588, 753.0, 753.1, 791.0, V42.0, V45.1, V56
ICD-9-CM Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6
UB Revenue: 0367, 080x, 082x-085x, 088x
UB Type of Bill: 72x
POS: 65
-ACE inhibitor/ARB therapy
CPT Category II: 4009F
Codes to identify systolic and diastolic BP levels <130/80
-Numerator compliant
Systolic CPT Category II: 3074F
Diastolic CPT Category II: 3078F
-Not numerator compliant
Systolic CPT Category II: 3075F, 3077F
Diastolic CPT Category II: 3079F, 3080F
Codes to identify systolic and diastolic BP levels <140/90
-Numerator compliant
Systolic CPT Category II: 3074F, 3075F
Diastolic CPT Category II: 3078F, 3079F
-Not numerator compliant
Systolic CPT Category II: 3077F
Diastolic CPT Category II: 3080F
Smoking numerator complaint: CPT Category II:1034F, 4000F, 4001F
Foot examination numerator complaince: CPT Category II: 2028F

Composite Denominator Statement: Members with diabetes (type 1 and 2) as of December 31 of the measurement year

Denominator Time Window: Mesurement year

Denominator Details: Eligible Population:
1. Collected by Commercial, Medicaid, Medicare plans
2. Must be 18-75 years as of Dec 31 of the measurement year with continuous enrollment in the measurement year
3. Must have diabetes (type 1 or 2) identified by pharmacy data and by claim/encounter data. When identifying diabetic members using pharmacy data, members must have been dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior on an ambulatory basis.

When identifying diabetic members using claim/encounter data, members must have had two face-to-face encounters with a diagnosis of diabetes on different dates of service in an outpatient setting or nonacute inpatient setting OR one face-to-face encounter in an acute inpatient or ED setting during the measurement year or year prior.

Codes to identify diabetes
ICD-9-CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0
Codes to identify visity type
-Outpatient
CPT: 92002, 92004, 92012, 92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456
UB Revenue: 051x, 0520-0523, 0526-0529, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
-Nonacute inpatient
CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337
UB Revenue: 0118, 0128, 0138, 0148, 0158, 019x, 0524, 0525, 055x, 066x
-Acute inpatient
CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291
UB Revenue: 010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159, 016x, 020x-022x, 072x, 080x, 0987
-Emergency Department
CPT: 99281-99285
UB Revenue: 045x, 0981

Composite Denominator Exclusions: Exclusions for the HbA1c Control <7% indicator ONLY:
1. 65-75 years of age in the measurement year
2. Members discharged alive for CABG or PTCA in the measurement year or year prior
3. Members with at least one outpatient visit w/ an IVD diagnosis OR at least one acute inpatient claim/encounter w/ an IVD diagnosis
4. Members who had at least one encounter, in any setting, w/chronic heart failure
5. Members who had at least one encounter, in any setting, w/any code to identify MI
6. Members who had at least one encounter, in any setting, w/ any code to identify CRF/ESRD
7. Members who had at least one encounter, in any setting, w/ any code to identify dementia
8. Members who had at least one encounter, in any setting, w/ any code to identify blindness
9. Members who had at least one encounter, in any setting, w/ any code to identify lower extremity amputation

Denominator Exclusion Details: Codes to identify Required Exclusions
-MI
ICD-9-CM Diagnosis: 410, 412
-CRF/ESRD
CPT: 36145, 36800-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90940, 90945, 90947, 90957-90962, 90965, 90966, 90969, 90970, 90989, 90993, 90997, 90999, 99512
HCPCS: G0257, G0311-G0319, G0321-G0323, G0325-G0327, G0392, G0393, S9339
ICD-9-CM Diagnosis: 585.4, 585.5, 585.6, V42.0, V45.1, V56
ICD-9-CM Procedure: 38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98
UB Revenue: 080x, 082x-085x, 088x
UB Type of Bill: 72x
POS: 65
-Blindness
ICD-9-CM Diagnosis: 369.0, 369.1, 369.2, 369.4, 369.6, 369.7
-Amputation (lower extremity)
CPT: 27290, 27295, 27590-27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825
ICD-9-CM Procedure: 84.1

►**Type of Score:** Rate/proportion ► If "Other", please describe:

►**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 ► If "Other", please describe:

Method of Scoring/Aggregation: all-or-none **If "other" scoring method, describe:**

Missing Component Scores (*Indicate how missing component scores are handled*): Missing variables are not considered to be numerator compliant

Weighting: ☐ **Equal** ☒ **Differential** **If differential weighting, describe:** Differential weighting is used for Provider recognition

Scored Measures	Threshold (% of patients in sample)	Weight
HbA1c Control >9.0 %*	15%	10.0
HbA1c Control <8.0 %	25%	5.0
HbA1c Control <7.0%	40%	5.0
Blood Pressure Control >140/90 mm Hg*	35%	25.0
LDL Control >130 mg/dl*	37%	10.0
LDL Control <100 mg/dl	36%	10.0
Eye Examination	60%	10.0
Nephropathy Assessment	80%	10.0
Smoking Status and Cessation Advice or Treatment	80%	15.0

Total Possible Points = 100.0
Points to Achieve Recognition = 75.0

►**Calculation Algorithm** (*Describe the calculation of the measure as a flowchart or series of steps*)**:**
Step 1. Determine the eligible population. The eligible population is all members who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollement requirement.
Step 2. Search administrative systems to identify numerator events for all members in the eligible population.
Step 3. If applicable, for members for whom administrative data do not show a positive numerator event, search administrative data for an exclusion to the service/procedure being measured. Note: This step applies only to measures for which optional exclusions are specified and for which the organization has chosen to search for exclusions. The organization is not required to search for optional exclusions.
Step 4. Exclude from the eligible population members from step 3 for whom administrative system data identified an exclsuion to the service/procedure being measured.
Step 5. Calculate the rate.

►**Describe the method for discriminating performance** *(e.g., significance testing)***:**
After a measure is created, it will go through a first-year analysis to discriminate performance. This anaysis will consist of data completeness, national results, regional results, and a review of the eligible population and prevalence. These first-year results will be compared by data collection methodology, and health plan accreditation status and finally, compared to the field test results.

►**Sampling (Survey) Methodology** *If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate)*:
N/A

►**Stratification Details/Variables (***All information required to stratify the measure including the stratification variables, all codes, logic, and definitions***):**
N/A

►**Data Source** *Check all the source(s) used in the component measures.*

- ☒ Electronic administrative data/ claims
- ☒ Electronic Health/Medical Record
- ☒ Electronic Clinical Data *(e.g., MDS)*
- ☐ Registry data (or database)
- ☒ Lab data
- ☒ Pharmacy data
- ☐ Survey-patient *(e.g., CAHPS)*
- ☐ Survey-provider
- ☐ Documentation of original self-assessment *(e.g., SF-36)*
- ☐ Management data
- ☐ Public health data/vital statistics

☐ Paper Medical Record/flowsheet | ☐ Special or unique data, specify:

▶**Level of Measurement/Analysis** (*For what entity will the scores be computed?*)
Check the level(s) for which the measure is specified and tested.

Clinician: ☒ Individual ☒ Group ☒ Other Health Plan (MCO/PPO)
☐ Facility/Agency (e.g., hospital, nursing home)
☐ Multi-site/corporate chain
☐ Integrated delivery system
☐ Health plan
☐ Prescription drug plan

Program: ☐ Disease management ☐ QIO ☐ Other
Population: ☐ National ☐ Regional/network ☐ State ☐ Counties/Cities ☐ Other (*Please describe*): ☒ All levels

▶**Applicable Care Settings**
Check the setting(s) for which the measure is specified and tested.
Ambulatory Care: ☐ Amb Surgery Center ☒ Office ☐ Clinic ☐ Emergency Dept ☐ Hospital Outpatient

☐ Assisted Living
☐ Behavioral health/psychiatric unit
☐ Dialysis Facility
☐ Emergency medical services/ambulance
☐ Group Home
☐ Home
☐ Hospice
☐ Hospital
☐ Long term acute care hospital
☐ Nursing home/ Skilled Nursing Facility (SNF)
☐ Rehabilitation Facility
☐ Other (*Please describe*):
☐ Unspecified or "not applicable"
☒ All settings

TESTING/ANALYSIS

2i. Component item/measure analysis to justify inclusion in composite

Data/sample: National Health Plan (HMO/PPO) sample reporting HEDIS

Analytic Method:

Testing Results:

	Commercial			Medicare			Medicaid		
Measure*	2007	2008	2009	2007	2008	2009	2007	2008	2009
HbA1c Testing	87.5	88.1	89.0	87.2	88.1	88.3	78.0	77.3	80.5
Poor HbA1c Control (>9%)	29.6	29.4	28.4	27.3	29.0	29.4	48.7	47.9	44.8
HbA1c Control (<8%)	--	--	42.0	--	--	61.7	--	--	44.3
HbA1c Control (<7% with exclusions)	--	--	28.7	--	--	--	--	--	32.9
Eye Exams	54.7	55.1	56.5	62.3	62.7	60.8	51.4	49.9	52.8
LDL-C screening	83.4	83.9	84.8	84.8	85.7	86.3	71.1	74.4	74.1
LDL-C Control	43.0	43.8	45.5	46.9	46.8	48.7	30.6	31.3	33.8
Monitoring for Nephropathy	79.7	80.6	82.4	85.3	85.7	87.9	74.6	74.4	76.6
Blood Pressure Control (<140/90)	61.4	63.9	65.6	57.8	58.9	59.5	57.3	55.5	56.9

**Data for the Foot exam and Smoking cessation meaures are currently being reprogrammed and will be submitted as soon as upated performance data is available.

2i
H☐ M☐ L☐ N☐

2j. Component item/measure analysis of contribution to variability in composite score

Data/sample: N/A

Analytic Method:

Testing Results:

2j
H☐ M☐ L☐ N☐

2k. Analysis to support differential weighting of component scores

Data/sample: N/A

Analytic Method:

Testing Results:

2k
H☐ M☐ L☐ N☐

Describe how the method of scoring/aggregation achieves the stated purpose and represents the quality construct:

Indicate if any alternative scoring/aggregation methods were tested and why not chosen:

2l. Analysis of missing component scores

Data/sample: N/A

Analytic Method:

Testing Results:

2l
H☐
M☐
L☐
N☐

2b. Reliability testing of composite score

►**Data/sample** *(description of data/sample and size)*: N/A

►**Analytic Method** *(type of reliability & rationale, method for testing)*:

►**Testing Results** *(reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:

2b
H☐
M☐
L☐
N☐

2c. Validity testing of composite score

►**Data/sample** *(description of data/sample and size)*: N/A

►**Analytic Method** *(type of validity & rationale, method for testing)*:

►**Testing Results** *(statistical results, assessment of adequacy in the context of norms for the test conducted)*:

2c
H☐
M☐
L☐
N☐

2f. Identification of Meaningful Differences in Performance

►**Data/sample from Testing or Current Use** *(description of data/sample and size)*: National sample from MCO/PPO results

►**Methods to identify statistically significant and practically/meaningfully differences in performance** *(type of analysis & rationale)*:
Because of the absence of externally defined benchmarks, NCQA defines organization performance at the 90th percentile and above nationally as "best current practice." National and regional thresholds are based on audited HEDIS results and the distribution by percentiles for all reporting organizations. NCQA uses the 10 regions defined by CMS.

Based on audited data in NCQA's national HEDIS database, NCQA publishes rates for the national benchmarks (90th percentile) and for national and regional thresholds representing the 25th percentile, the 50th percentile and the 75th percentile of rates for each measure. NCQA arrives at the organization's score for the HEDIS clinical measures and CAHPS 4.0H results by performing the following actions.

- Comparing HEDIS clinical measure results for each measure to the national benchmarks and national and regional thresholds
  - NCQA averages the organization's performance compared to regional and national thresholds and uses either the average of the two point scores or the points based on comparison to national thresholds only, whichever is higher, for a total HEDIS measure score

► **Provide Measure Scores from Testing or Current Use** *(description of scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)* :

	Commercial			Medicare			Medicaid		
Measure*	2007	2008	2009	2007	2008	2009	2007	2008	2009
HbA1c Testing	87.5	88.1	89.0	87.2	88.1	88.3	78.0	77.3	80.5
HbA1c Mgmt (>9%)	29.6	29.4	28.4	27.3	29.0	29.4	48.7	47.9	44.8

2f
H☐
M☐
L☐
N☐

HbA1c Control (<8%)	--	--	42.0	--	--	61.7	--	--	44.3
HbA1c Control (<7%)	--	--	28.7	--	--	37.6	--	--	32.9
Eye Exams	54.7	55.1	56.5	62.3	62.7	60.8	51.4	49.9	52.8
LDL-C screening	83.4	83.9	84.8	84.8	85.7	86.3	71.1	74.4	74.1
LDL-C Control	43.0	43.8	45.5	46.9	46.8	48.7	30.6	31.3	33.8
Monitoring-Nephropathy	79.7	80.6	82.4	85.3	85.7	87.9	74.6	74.4	76.6
Bp Control (<140/90)	61.4	63.9	65.6	57.8	58.9	59.5	57.3	55.5	56.9

Most recent testing data:
HbA1c <7% for a select population

National - Performance Rates				Percentiles (Distribution of Rates)				
	N	Mean	Std Dev	10th	25th	50th	75th	90th
Commercial	116	28.68	17.85	4.21	10.18	31.51	43.77	50.11
Medicaid	60	32.87	11.38	19.21	25.54	34.84	40.58	44.69
Medicare	38	37.60	19.93	7.26	25.93	39.37	51.43	62.72

HbA1c <8%

National - Performance Rates				Percentiles (Distribution of Rates)				
	N	Mean	Std Dev	10th	25th	50th	75th	90th
Commercial	299	41.98	25.06	4.25	16.72	51.34	64.17	68.98
Medicaid	107	44.25	13.04	27.82	37.62	45.79	52.55	60.12
Medicare	292	61.73	17.63	38.93	53.29	66.19	74.91	79.81

2h. Disparities in Care

2h
H☐ M☐ L☐ N☐ NA☐

►**If measure is stratified, provide stratified results** *(scores by stratified categories/cohorts)*:
N/A

►**If disparities have been reported/identified, but measure is not specified to detect disparities, provide follow-up plans:**

Staff Notes to Reviewers:

Reviewers: Overall, to what extent was the criterion, *Scientific Acceptability of Measure Properties*, met?
Rationale:

2
H☐ M☐ L☐ N☐

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (composite measure evaluation criteria)

Eval

3a. Meaningful, Understandable, and Useful Information

Current Use: ☒ In use ☐ Not in use, but testing completed ☐ Testing not yet completed

If used in a public reporting initiative, Name of initiative(s), locations, Web page URL(s): HEDIS health plan accreditation/ Diabetes Provider Recognition Program (DRP)

If used in other programs/initiatives (e.g., quality improvement), Name of initiative(s), locations, web page URL(s): www.ncqa.org

Testing of Interpretability (*Testing that demonstrates the results are understood by the potential users for public reporting and quality improvement*)

►**Data/sample** *(description of data/sample and size)*: N/A

3a
H☐ M☐ L☐ N☐

▶**Methods** *(methods, e.g., focus group, survey, QI project)*: ▶**Results** *(qualitative and/or quantitative results and conclusions)*:	
3b/3c. Relation to other NQF-endorsed measures *Identify similar or related NQF-endorsed measures* (available at ***www.qualityforum.org*** *under Core Documents)* ☐ Other measures for same target population ☒ Other measures on same topic ☐ No similar measures **NQF # and Title of similar or related measures:** Hemoglobin A1c (HbA1c) testing (NQF#0057) •HbA1c poor control (>9.0%) (NQF#0059) •HbA1c control (<8.0%) (NQF#0575) •Eye exam (retinal) performed (NQF#0055) •LDL-C control (<100 mg/dL) (NQF#0064) •Medical attention for nephropathy (NQF#0062) •BP control (<140/90 mm Hg) (NQF#0061) **Describe the distinctive or additive value this measure provides to existing NQF-endorsed measures:** Coordinating the care of diabetics using endorsed measures leads to short and long term improved outcomes .	
3b. Harmonization ▶**Are the component measure specifications harmonized, or if not, why?** Yes	**3b** H☐ M☐ L☐ N☐ NA☐
3c. Distinctive or Additive Value ▶**Describe the distinctive, improved, or additive value this measure provides to existing NQF-endorsed measures:** Currently, this measure is an integral part of appropriate care delivery for HEDIS. This composite would offer a more valid/efficient way to measure care for this population.	**3c** H☐ M☐ L☐ N☐ NA☐
3d. Decomposition of Composite ▶**Describe the information from decomposing the composite into its components that is available:** Each indicator is reported as a separate rate of the composite to further identify specific opportunities for improvement. Though rates for many of these measures continue to trend upward, there remains significant room for improvement.	**3d** H☐ M☐ L☐ N☐
3e. Achieved stated purpose **Describe how the results reported above demonstrate that the composite achieves the stated purpose:** The performance of each indicator have improved on an annual basis since the mesasure's inception. This is leading to improved care for pateins idenitified with diabetes	**3e** H☐ M☐ L☐ N☐
Staff Notes to Reviewers (including additions/changes to related or similar measures):	
Steering Committee/TAP: Overall, to what extent was the criterion, *Usability*, met? **Rationale:**	**3** H☐ M☐ L☐ N☐
4. FEASIBILITY	
Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (composite measure evaluation criteria)	**Eval**

4a. Data Generated as a Byproduct of Care Processes

How are all the data elements that are needed to compute measure scores generated? *Check all that apply*

☒ Data are generated as a byproduct of care processes during care delivery (*Data are generated and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition)*
☒ Coding/abstraction performed by someone other than person obtaining original information *(e.g., DRG, ICD-9 codes on claims; chart abstraction for quality measure, registry)*
☐ Other *(e.g., patient experience of care surveys, provider surveys, observation), Please describe*:

4a H☐ M☐ L☐ N☐ NA☐

4b. Electronic Sources

►**Are all the data elements available electronically?** (*elements that are needed to compute measure scores are in defined, computer-readable fields, e.g., electronic health record, electronic claims*)
☐ Yes ☒ No
►**If no, specify the near-term path to achieve electronic capture by most providers.**
The diabetes measures in the comprehensive diabetes measure set are currently being retooled as part of a NQF project to translate existing measure specifications into a machine readable format and enter them into NQF's QDS measure database. We expect that this work will be completed sometime in the third quarter of 2010

Note: Measure stewards will be asked to specify the data elements for electronic health records at a later date

4b H☐ M☐ L☐ N☐

4d. Susceptibility to Inaccuracies, Errors, or Unintended Consequences

►**Identify susceptibility to inaccuracies, errors, or unintended consequences of the measure and describe how these potential problems could be audited. If audited, provide results.**
All measure data for the Comprehensive Diabetes Care composite must be audited prior to submission to NCQA. This singificantly increases the accuracy of the data submitted and the number of errors present in the calculation of performance.

4d H☐ M☐ L☐ N☐

4e. Data Collection Strategy/Implementation

►**Describe what you have learned/modified as a result of testing and/or operational use of the composite/component measures regarding data collection, availability of data/missing data, timing/frequency of data collection, patient confidentiality, time/cost of data collection, other feasibility/ implementation issues:**

►**Costs to implement the measure** (*costs of data collection, fees associated with proprietary measures*)**:**

►**Evidence for costs:**
►**Business case documentation:**

4e H☐ M☐ L☐ N☐

Staff Notes to Reviewers:

Reviewers: Overall, to what extent was the criterion, Feasibility, met?
Rationale:

4 H☐ M☐ L☐ N☐

Reviewers: Overall, to what extent were all the criteria met?
Rationale:

H☐ M☐ L☐

Steering Committee only
Recommendation: ☐ **Endorsement** ☐ **Time-limited endorsement** ☐ **Do not recommend**

Conditions: ☐ No ☐ Yes, Specify:

CONTACT INFORMATION

Measure Steward (Intellectual Property Owner)
Organization: National Committee for Quality Assurance (NCQA)
Street Address: 1100 13th Street NW, Suite 1000 **City:** Washington **State:** DC **ZIP:** 20005

Point of Contact: First Name: Ben **MI:** **Last Name:** Hamlin **Credentials (MD, MPH, etc.):** MPH
Email: hamlin@ncwa.org **Telephone:** 202-955-1716 ext:

Measure Developer If different from Measure Steward
Organization:
Street Address: **City:** **State:** **ZIP:**

Point of Contact: First Name: **MI:** **Last Name:** **Credentials (MD, MPH, etc.):**
Email: **Telephone:** ext:

Submitter If different from Measure Steward Point of Contact
First Name: **MI:** **Last Name:** **Credentials (MD, MPH, etc.):**
Email: **Telephone:** ext:
Organization: ☐ Measure Steward ☐ Measure Developer

Additional Measure Developer Organizations:

ADDITIONAL INFORMATION

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.

Joseph Selby, MD, MPH
Co-Chair
Kaiser Permanente

William Herman, MD, MPH
Co-Chair
University of Michigan Health System

Mikhail Kosiborod, MD, FACC
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Rebecca Burkholder, JD
National Consumers League

Jerry Cavallerano, OD, Ph.D.
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Reston Hospital Center INOVA Fair Oaks Hospital

James Fain, PhD, RN, BC-ADM, FAAN
University of Massachusetts
Dartmouth College of Nursing

Amanda Bartelme
Avalere Health, LLC

►**If adapted, provide name of original measure:**
►**If adapted, provide original specifications** ☐ **attachment or web page URL:**

Measure Developer/Steward Updates and Ongoing Maintenance
►Year the measure was first released: 2000
►Month and Year of most recent revision: 2009
►What is the frequency for review/update of this measure? 3 years
►When is the next scheduled review/update for this measure? 2012

Copyright statement/disclaimers:

Additional Information web page URL: Www.ncqa.org

I have checked that the submission is complete and all the information needed to evaluate the measure is provided in the form; any blank fields indicate that no information is provided. ☒

Date of Submission (*MM/DD/YY*)**:** 01/13/10

The weighting (points) are derived from the weights developed through the same expert panel that created the weights for the DRP. Changes have been made to accommodate measures that are in the DRP and not in the HEDIS composite. We feel that these measures are all reportable for both physician and health plans and are all NQF endorsed or up for consideration.

Performance Criteria and Scoring for Diabetes composite

Clinical Measures (Required)	Criteria	Points
HbA1c Poor Control >9.0%*	≤15% of patients in sample	10.0
HbA1c Control (<8%)	25% of patients in sample	5.0
HbA1c Control for special pop (<7.0%)	40% of patients in sample	5.0
Blood Pressure Control ≥ 140/90 mm Hg*	≤35% of patients in sample	25.0
Eye Examination	60% of patients in sample	10.0
Smoking Status and Cessation Advice or Treatment	80% of patients in sample	15.0
LDL Control ≥130 mg/dl*	≤37% of patients in sample	10.0
LDL Control <100 mg/dl	36% of patients in sample	10.0
Nephropathy Assessment	80% of patients in sample	10.0
	Total Points	**100.0**
	Points Needed to Achieve Recognition	**75.0**