



## 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 #:** 0060

**Corresponding Measures:**

**De.2. Measure Title:** Hemoglobin A1c (HbA1c) Testing for Pediatric Patients

**Co.1.1. Measure Steward:** National Committee for Quality Assurance

**De.3. Brief Description of Measure:** The percentage of children aged 5 to 17 years of age with diabetes (type 1 and type 2) that had a Hemoglobin A1c (HbA1c) test during the measurement year.

**1b.1. Developer Rationale:** Testing hemoglobin A1c levels in diabetic patients is an important component of diabetes treatment and care. Results from this tests aids clinicians in providing patients with optimal treatment that will maximize diabetes control.

**S.4. Numerator Statement:** Children who had an HbA1c test performed during the measurement year.

**S.7. Denominator Statement:** Patients aged 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics for at least 12 months.

**S.10. Denominator Exclusions:** Children with gestational or steroid-induced diabetes should be excluded from the denominator.

**De.1. Measure Type:** Process

**S.23. Data Source:** Claims, Electronic Health Data, Other, Paper Medical Records

**S.26. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**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:**

**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**  
[0060\\_HbA1c\\_Peds\\_2013\\_Evidence\\_Form\\_FINAL-635228944362910201.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)**  
Testing hemoglobin A1c levels in diabetic patients is an important component of diabetes treatment and care. Results from this tests

aids clinicians in providing patients with optimal treatment that will maximize diabetes control.

**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 Child Core Set includes 26 measures including NCQA's PA1C Annual Pediatric Hemoglobin A1C Testing (NQF#0060). We have requested from CMS access to this measure's performance data from the 11 states reporting the measure and are awaiting clearance. We will provide to NQF once we have received from CMS.

**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.*

N/A

**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.**

Studies suggest that children from minority groups and lower socioeconomic status have higher A1c levels when compared to Whites and children in higher socioeconomic status. A study conducted in 2003 examined the mean hemoglobin A1c levels for Hispanic children. The study assessed type 1 diabetic children (n=183) based on their family income, insurance type, parent marital status, parent education, and race. The sample size included 183 children. Results from the study found a statistically significant ( $p < 0.02$ ) difference in mean HbA1c based on race/ethnicity. On average, Hispanic children had a mean HbA1c at  $8.1 \pm 1.5\%$  and White non-Hispanic children had a mean HbA1c of  $8.3 \pm 1.2\%$ . The results also found that children in families with lower incomes had poorer glycemic control (Gallegos-Macias et al., 2003). A more recent study conducted in 2010 examined HbA1c levels in African American and White children with Type 1 diabetes. The study consisted on 276 (n=276) children and found higher HbA1c levels in African American children (Kamps et al., 2010).

Gallegos-Macias AR, Macias SR, Kaufman E, Skipper B, Kalishman N. 2003. Relationship between glycemic control, ethnicity and socioeconomic status in Hispanic and white non-Hispanic youths with type 1 diabetes mellitus. *Pediatric Diabetes*. 4:19-23.

Kamps JL, Hempe JM, Chalew SA. 2010. Racial disparity in A1c independent of mean blood glucose in children with type 1 diabetes. *Diabetes Care*. 33:1025-1027. Retrieved from <http://care.diabetesjournals.org/content/33/5/1025.full.pdf+html>.

**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, Frequently performed procedure, High resource use, Patient/societal consequences of poor quality, Severity of illness

**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.

As the seventh leading cause of death in the U.S., diabetes kills nearly 70,000 people a year (CDC Estimates 2011, CDC FastStats 2013). Diabetes is a group of diseases marked by high blood glucose levels, resulting from the body's inability to produce or use insulin (CDC Estimates 2011, ADA Basics 2013). Especially when unmanaged, diabetes can cause serious health complications,

including heart disease and stroke, hypertension, blindness, kidney disease, nervous system disease, amputations, dental disease and pregnancy complications (CDC Fact Sheet 2011).

In 2012, diabetes cost the U.S. an estimated \$245 billion: \$176 billion in direct medical costs and \$69 billion in reduced productivity. This is a 41 percent increase from the estimated \$174 billion spent on diabetes in 2007 (ADA Economic 2013). If current trends continue, the CDC estimates that one in three U.S. adults could have diabetes by 2050 (CDC Facts 2011).

The American Diabetes Association (ADA) reports that 215,000 children, adolescents, and young adults under the age of 20 have diabetes (ADA, 2013). This figure shows a drastic increase from data reported between 2002 and 2005. Between these years, the SEARCH for Diabetes in Youth study reported that 19,200 children, adolescents, and young adults under age 20 had diabetes (NDEP, 2011). Within that figure, 15,600 had type 1 diabetes and 3,600 had type 2 diabetes (NDEP, 2011). Five to 10% of all children with diabetes are diagnosed with type 1 diabetes (NDEP, 2011). However, as childhood obesity rates increase, more children are diagnosed with type 2 diabetes, especially in minority groups (NDEP, 2011).

#### 1c.4. Citations for data demonstrating high priority provided in 1a.3

- American Diabetes Association. 2013. Diabetes Statistics. Retrieved from <http://www.diabetes.org/diabetes-basics/diabetes-statistics/>.
- National Diabetes Education Program. 2011. Overview of Diabetes in Children and Adolescents. Retrieved from [http://www.ndep.nih.gov/media/youth\\_factsheet.pdf](http://www.ndep.nih.gov/media/youth_factsheet.pdf).
- Centers for Disease Control and Prevention. 2012. Preventive Care Practices-Age Adjusted Percentage of A1c Adults Aged = 18 Years with Diabetes, United States 2000-2010. Retrieved from [http://www.cdc.gov/diabetes/statistics/preventive/fy\\_ac1test.htm](http://www.cdc.gov/diabetes/statistics/preventive/fy_ac1test.htm).
- Centers for Disease Control and Prevention. 2010. Diabetes data for A1c Tests by State. Retrieved from <http://apps.nccd.cdc.gov/DDTSTRS/Index.aspx?stateId=30&state=Montana&cat=preventive&Data=map&view=TO&trend=a1ctests&id=7>.
- Centers for Disease Control and Prevention (CDC). 2011. Diabetes Public Health Resource. 2011 National Diabetes Fact Sheet: National Estimates. [www.cdc.gov/diabetes/pubs/estimates11.htm#10](http://www.cdc.gov/diabetes/pubs/estimates11.htm#10) (June 19, 2013)
- Centers for Disease Control and Prevention (CDC). 2013. FastStats: Deaths and Mortality. [www.cdc.gov/nchs/fastats/deaths.htm](http://www.cdc.gov/nchs/fastats/deaths.htm) (June 19, 2013)
- Centers for Disease Control and Prevention. 2011. National diabetes fact sheet: national estimates and general information on diabetes and prediabetes in the United States, 2011. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. [www.cdc.gov/diabetes/pubs/pdf/ndfs\\_2011.pdf](http://www.cdc.gov/diabetes/pubs/pdf/ndfs_2011.pdf) (June 19, 2013)
- Centers for Disease Control and Prevention. 2011. CDC Features. Get the Facts on Diabetes. [www.cdc.gov/features/diabetesfactsheet/](http://www.cdc.gov/features/diabetesfactsheet/) June 19, 2013.
- American Diabetes Association. 2013. Diabetes Basics. [www.diabetes.org/diabetes-basics/?loc=GlobalNavDB](http://www.diabetes.org/diabetes-basics/?loc=GlobalNavDB) (June 19, 2013)
- American Diabetes Association (ADA). April 2013. Economic Costs of Diabetes in the U.S. in 2012. Diabetes Care. Vol. 36 no. 4 1033–46. <http://care.diabetesjournals.org/content/36/4/1033.full>

**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):  
Endocrine, Endocrine : Diabetes

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

**S.1. Measure-specific Web Page** (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

**S.2a. If this is an eMeasure**, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

[This is not an eMeasure](#) **Attachment:**

**S.2b. Data Dictionary, Code Table, or Value Sets** (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

**Attachment Attachment:** [0060\\_CDC\\_HbA1c\\_Testing\\_Pediatric-635219473448163024.xlsx](#)

**S.3. For endorsement maintenance**, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

[N/A](#)

**S.4. Numerator Statement** (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm.

[Children who had an HbA1c test performed during the measurement year.](#)

**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.

**MEDICAL RECORD:**

[The number of patients in the sample who have documentation of date and result for the most recent HbA1c test during the 12-month abstraction period.](#)

[The following is not acceptable documentation of HbA1c testing:](#)

- [- Fructosamine](#)
- [- Hgb](#)
- [- Hemoglobin](#)
- [- Hb and Hg without reference to either “glycated,” “glycosylated” and “A1” or “A1c” and findings reported on progress notes or other non-laboratory documentation](#)

**S.7. Denominator Statement** (Brief, narrative description of the target population being measured)

[Patients aged 5-17 years old with a diagnosis of diabetes and/or notation of prescribed insulin or oral hypoglycemics/antihyperglycemics for at least 12 months.](#)

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

[Children, 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)*

#### CODES TO IDENTIFY DIABETES

ICD-9-CM Diagnosis: 250, 357.2, 362.0, 366.41, 648.0

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#### PRESCRIPTIONS TO IDENTIFY CHILDREN WITH DIABETES

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlintide

Antidiabetic combinations:

Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosiglitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin

Insulin:

Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human

Meglitinides:

Nateglinide, Repaglinide

Miscellaneous antidiabetic agents:

Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin

Sulfonylureas:

Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

#### **S.10. Denominator Exclusions** (Brief narrative description of exclusions from the target population)

Children with gestational or steroid-induced diabetes should be excluded from the denominator.

**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)

#### CODES TO IDENTIFY EXCLUSIONS

ICD-9 CM Diagnosis:

-Steroid-induced diabetes: 249, 251.8, 962.0

-Gestational diabetes: 648.8

#### MEDICAL RECORD:

-Exclusionary evidence in the medical record must include a note indicating the child had a diagnosis of gestational or steroid-induced diabetes during the measurement year or year prior to the measurement year.

**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 children who meet all the specified criteria.

-AGES: 5-17 years as of December 31 of the measurement year.

-EVENT/DIAGNOSIS: Identify children with diabetes in two ways: by claim/encounter data and by pharmacy data. Both methods must be used to identify the eligible population, but a child only needs to be identified by one method to be included in the measure. Children may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Claim/Encounter Data:

-Children who had at least two outpatient visits, observation 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.

-Children with at least one acute inpatient encounter with a diagnosis of diabetes.

-Children with at least one ED visit with a diagnosis of diabetes.

\*SEE ATTACHED EXCEL FILE FOR CODE VALUE SETS INCLUDED IN QUESTION S.2B

Pharmacy Data:

Children 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. Determine the number of children in the eligible population who had a recent HbA1c test during the measurement year through the search of administrative data systems.

STEP 3. Identify children with a most recent HbA1c test performed.

STEP 4. Identify the most recent HbA1c test with result (numerator compliant). Identify a missing result or no HbA1c test done during the measurement year (not numerator compliant).

STEP 5. Exclude from the eligible population children from step 2 for whom administrative system data identified an exclusion to the service/procedure being measured. \*SEE DENOMINATOR EXCLUSION CRITERIA IN QUESTION S.10

STEP 6. Calculate the rate (number of children that had an HbA1c test).

**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
<p><b>S.20. Sampling</b> (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)  <u>IF a PRO-PM</u>, identify whether (and how) proxy responses are allowed.  N/A</p> <p><b>S.21. Survey/Patient-reported data</b> (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)  <u>IF a PRO-PM</u>, specify calculation of response rates to be reported with performance measure results.  N/A</p> <p><b>S.22. Missing data</b> (specify how missing data are handled, e.g., imputation, delete case.)  <u>Required for Composites and PRO-PMs.</u>  N/A</p>
<p><b>S.23. Data Source</b> (Check <u>ONLY</u> the sources for which the measure is SPECIFIED AND TESTED).  If other, please describe in S.24.  <a href="#">Claims</a>, <a href="#">Electronic Health Data</a>, <a href="#">Other</a>, <a href="#">Paper Medical Records</a></p> <p><b>S.24. Data Source or Collection Instrument</b> (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)  <u>IF a PRO-PM</u>, 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 children enrolled in a state Medicaid and/or CHIP program. NCQA uses the Centers for Medicare and Medicaid Services (CMS) Secretary's Annual Report as a data source to access the performance data for this measure. The report summarizes state-specific and national performance measurement rates.</p> <p><b>S.25. Data Source or Collection Instrument</b> (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)  No data collection instrument provided</p> <p><b>S.26. Level of Analysis</b> (Check <u>ONLY</u> the levels of analysis for which the measure is SPECIFIED AND TESTED)  <a href="#">Clinician : Group/Practice</a>, <a href="#">Clinician : Individual</a></p> <p><b>S.27. Care Setting</b> (Check <u>ONLY</u> the settings for which the measure is SPECIFIED AND TESTED)  <a href="#">Outpatient Services</a>  If other:</p> <p><b>S.28. COMPOSITE Performance Measure</b> - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</p>
<p><b>2a. Reliability</b> – See attached Measure Testing Submission Form</p> <p><b>2b. Validity</b> – See attached Measure Testing Submission Form</p> <p><a href="#">0060_HbA1c_Peds_2013_Testing_Form_FINAL.docx</a></p>

<b>3. Feasibility</b>
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.
<p><b>3a. Byproduct of Care Processes</b>  For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).</p>



**3a.1. Data Elements Generated as Byproduct of Care Processes.**

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

**3b. Electronic Sources**

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

**3b.1. To what extent are the specified data elements available electronically in defined fields?** (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*)

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.**

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.

This measure was previously included in NCQA's Diabetes Provider Recognition Program with strong support from our Expert Panels and our Clinical Programs Committee. The measure was well-received by providers, however the number of Pediatricians who pursued recognition was very limited, therefore denominator size for this measure was too small to continue reporting in this program. The measure was included in the Center for Medicaid and CHIP Services Child Core Set (11 States) and we are awaiting release of results from CMS, which we will provide to NQF with our interpretation of results.

**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*).

**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)
	<p>Public Reporting Center for Medicaid and CHIP Services Child Core Set (11 States) <a href="http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf">http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/InitialCoreSetResourceManual.pdf</a></p> <p>Professional Certification or Recognition Program Diabetes Recognition Program <a href="http://www.ncqa.org/Programs/Recognition/DiabetesRecognitionProgramDRP.aspx">http://www.ncqa.org/Programs/Recognition/DiabetesRecognitionProgramDRP.aspx</a></p>

**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

**CMS CORE SET OF CHILDREN'S HEALTH CARE QUALITY MEASURES FOR MEDICAID AND CHIP (CHILD CORE SET):** The "Core Set of Children's Health Care Quality Measures Technical Specifications and Resource Manual" is for use by states that seek to voluntarily report the core set of quality measures for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Although reporting the child core set measures is voluntary, the Centers for Medicare & Medicaid Services (CMS) encourages states to report on as many of the measures as feasible. The more states that collect and report the child core set of measures, the greater the potential for states and others to benefit from this information. CMS is developing data information systems to standardize reporting and make access to quality data more available to states for comparison purposes. States will be able to use these quality data in designing and implementing their quality improvement initiatives. The Child Core Set includes 26 measures including NCQA's PA1C Annual Pediatric Hemoglobin A1C Testing (NQF#0060). We have requested from CMS access to this measure's performance data from the 11 states reporting the measure and are awaiting clearance. We will provide to NQF once we have received from CMS.

**DIABETES RECOGNITION PROGRAM:** This measure is used NCQA's Diabetes Recognition Program (DRP) that assesses clinician performance on key quality measures that are based on national evidence based guidelines in diabetes care. The 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. Note: Due to low Pediatrician participation in the DRP program, this measure was removed from reporting due to extremely low denominator size for children with diabetes 5-17 from physicians seeking recognition.

**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.)**

We have requested from CMS access to this measure's performance data from the 13 states reporting the measure and are awaiting clearance. We will provide to NQF once we have received from CMS.

**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

We have requested from CMS access to this measure's performance data from the 13 states reporting the measure and are awaiting clearance. We will provide a response on improvement once we have received data from CMS.

**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.**

We have requested from CMS access to this measure's performance data from the 13 states reporting the measure and are awaiting clearance. We will provide a response on improvement once we have received data from CMS.

**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.**

None reported.

## 5. Comparison to Related or Competing Measures

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

**5. Relation to Other NQF-endorsed Measures**

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

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

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

**5a. Harmonization**

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?**

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

**5b. Competing Measures**

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

**OR**

Multiple measures are justified.

**5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):**

**Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)**

N/A

## Appendix

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

**Attachment:**

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## Additional Information

**Ad.1 Workgroup/Expert Panel involved in measure development**

**Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.**

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**Measure Developer/Steward Updates and Ongoing Maintenance**

**Ad.2 Year the measure was first released:** 1999

**Ad.3 Month and Year of most recent revision:** 01, 2010

**Ad.4 What is your frequency for review/update of this measure?** Approximately every 3 years, sooner if the clinical guidelines have changed significantly.

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2014

**Ad.6 Copyright statement:** © 1999 by the National Committee for Quality Assurance

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