



## Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

### Brief Measure Information

**NQF #:** 1932

**Corresponding Measures:**

**Measure Title:** Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

**Measure Steward:** National Committee for Quality Assurance

**sp.02. Brief Description of Measure:** The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

**1b.01. Developer Rationale:** As patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases, screening for diabetes will allow for proper diagnosis and treatment, if warranted.

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**sp.12. Numerator Statement:** Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

**sp.14. Denominator Statement:** Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

**sp.16. Denominator Exclusions:** Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

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**Measure Type:** Process

**sp.28. Data Source:**

Claims

**sp.07. Level of Analysis:**

Integrated Delivery System

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Health Plan

Population: Regional and State

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**IF Endorsement Maintenance – Original Endorsement Date:** 2012-11-02 12:11 PM

**Most Recent Endorsement Date:** 10/26/2018 8:48:00 AM

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**IF this measure is included in a composite, NQF Composite#/title:**

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

**sp.03. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?:**

## 1. 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 sub criteria to pass this criterion and be evaluated against the remaining criteria

**1ma.01. Indicate whether there is new evidence about the measure since the most recent maintenance evaluation. If yes, please briefly summarize the new evidence, and ensure you have updated entries in the Evidence section as needed.**

**[Response Begins]**

Yes

**[Response Ends]**

Please separate added or updated information from the most recent measure evaluation within each question response in the Importance to Measure and Report: Evidence section. For example:

**Current Submission:**

Updated evidence information here.

**Previous (Year) Submission:**

Evidence from the previous submission here.

**1a.01. Provide a logic model.**

*Briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient's health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.*

**[Response Begins]**

**[Response Ends]**

**1a.02. Select the type of source for the systematic review of the body of evidence that supports the performance measure.**

*A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data.*

**[Response Begins]**

**[Response Ends]**

If the evidence is not based on a systematic review, skip to the end of the section and do not complete the repeatable question group below. If you wish to include more than one systematic review, add additional tables by clicking "Add" after the final question in the group.

**Evidence - Systematic Reviews Table (Repeatable)**

Group 1 - Evidence - Systematic Reviews Table

**1a.03. Provide the title, author, date, citation (including page number) and URL for the systematic review.**

[Response Begins]

[Response Ends]

**1a.04. Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the systematic review.**

[Response Begins]

[Response Ends]

**1a.05. Provide the grade assigned to the evidence associated with the recommendation, and include the definition of the grade.**

[Response Begins]

[Response Ends]

**1a.06. Provide all other grades and definitions from the evidence grading system.**

[Response Begins]

[Response Ends]

**1a.07. Provide the grade assigned to the recommendation, with definition of the grade.**

[Response Begins]

[Response Ends]

**1a.08. Provide all other grades and definitions from the recommendation grading system.**

[Response Begins]

[Response Ends]

**1a.09. Detail the quantity (how many studies) and quality (the type of studies) of the evidence.**

[Response Begins]

[Response Ends]

**1a.10. Provide the estimates of benefit, and consistency across studies.**

[Response Begins]

[Response Ends]

**1a.11. Indicate what, if any, harms were identified in the study.**

[Response Begins]

[Response Ends]

**1a.12. Identify any new studies conducted since the systematic review, and indicate whether the new studies change the conclusions from the systematic review.**

[Response Begins]

[Response Ends]

**1a.13. If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, describe the evidence on which you are basing the performance measure.**

[Response Begins]

[Response Ends]

**1a.14. Briefly synthesize the evidence that supports the measure.**

[Response Begins]

[Response Ends]

**1a.15. Detail the process used to identify the evidence.**

[Response Begins]

[Response Ends]

**1a.16. Provide the citation(s) for the evidence.**

[Response Begins]

[Response Ends]

**1b.01. Briefly explain the rationale for this measure.**

*Explain how the measure will improve the quality of care, and list the benefits or improvements in quality envisioned by use of this measure.*

[Response Begins]

As patients with schizophrenia or bipolar disorder are at an increased risk for diabetes, and antipsychotic medications are an expected treatment that increases the risk of metabolic diseases, screening for diabetes will allow for proper diagnosis and treatment, if warranted.

[Response Ends]

**1b.02. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis.**

*Include mean, std dev, min, max, interquartile range, and scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

[Response Begins]

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at 10th, 25th,

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50th, 75th, and 90th percentile. Data are stratified by year and product line (i.e. Medicaid).

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Medicaid Rate (HMO and PPO Combined)

MEASUREMENT YEAR | MEAN | ST DEV | 10TH | 25TH | 50TH | 75TH | 90TH | Interquartile Range

2015 | 79.8% | 0.1 | 72.7% | 75.7% | 80.1% | 83.8% | 87.0% | 8.1

2016 | 80.4% | 0.1 | 72.3% | 77.4% | 80.7% | 84.0% | 87.2% | 6.6

2017 | 80.7% | 0.1 | 74.0% | 77.5% | 81.0% | 84.2% | 87.4% | 6.7

The data references are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. In 2016, HEDIS measures covered 47 million Medicaid health plan beneficiaries. Below is a description of the denominator for this measure. It includes the number of health plans included in HEDIS data collection and the mean eligible population for the measure across health plans.

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications—Medicaid

YEAR | N Plans | Median Denominator Size per plan

2015 | 143 | 437

2016 | 185 | 804

2017 | 202 | 1,018

[Response Ends]

**1b.03. If no or limited performance data on the measure as specified is reported above, 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. Include citations.**

[Response Begins]

N/A

[Response Ends]

**1b.04. 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.**

*Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included. Include mean, std dev, min, max, interquartile range, and scores by decile. For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

[Response Begins]

HEDIS data are stratified by type of insurance (e.g. Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. The HEDIS 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.

**[Response Ends]**

**1b.05. If no or limited data on disparities from the measure as specified is reported above, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in above.**

**[Response Begins]**

A number of research studies, including several meta-analyses, demonstrate that individuals with serious mental illness have an increased risk for diabetes as well as disparities in their care.

One review article estimated the prevalence of diabetes among individuals with SMI is approximately 12% (Holt and Mitchell, 2015), while the prevalence in the general population is approximately 9% aged ≥18 (CDC, 2017). Additionally, there is a known link between SMI treatments such as mood stabilizers, anticonvulsants and antipsychotic medications to adverse metabolic risks in patients, such as diabetes (Vancampfort, 2016).

A systematic review article assessed 118 cross-sectional, retrospective and prospective studies, and population versus non-population based studies comparing SMI individuals with non-serious mental illness control groups. Based on this evidence review, authors conclude that diabetes is more common among patients with SMI with a relative risk of 2.04 in patients with schizophrenia or related psychotic disorders and 1.89 in patients with bipolar disorder compared to the general population (Vancampfort, 2016).

Evidence suggests that individuals with SMI, specifically those with schizophrenia and bipolar disorder, are at increased risk of developing diabetes due to a higher prevalence of risk factors including tobacco use, poor nutrition and obesity and weight gain from the use of antipsychotics (Mangurian, 2016). Furthermore, these risk factors result in increased morbidity, such as hospitalizations and complications from diabetes, and mortality in the SMI population (Mai et al., 2011; CDC, 2010).

Despite these risks, people with SMI are less likely to have annual A1c testing or glucose screening (Banta 2009; Mai, 2011; Mangurian et al., 2016). A literature review found that up to 70% of individuals on antipsychotics do not receive screening or treatment for diabetes (Mangurian et al., 2016). In another study, only 47.3% of Medicaid psychiatric patients received annual HbA1c testing. Further, researchers in this study found that second-generation antipsychotic medications, used for schizophrenic and bipolar patients, were associated with higher diabetes risk and a reduced likelihood of HbA1c testing. (Banta, 2009)

Another study found that only 37.2% of mental health patients, compared to 42.9% of non-mental health patients, received a recommended HbA1c annual test. In general, patients with mental illness received less ongoing diabetes monitoring and had higher risk for diabetes complications and diabetes-related mortality compared to non-mental health patients (Mai, 2011).

**References**

Banta JE, Morrato EH, Lee SW, et al. (2009) Retrospective Analysis of Diabetes Care in California Medicaid Patients with Mental Illness. *J Gen Intern Med.* 24:802-8.

Centers for Disease Control and Prevention (CDC). (2010) Diagnosed and undiagnosed diabetes in the United States, all ages, 2010. Retrieved from: <http://www.cdc.gov/diabetes/pubs/estimates11.htm>. Accessed on June 19, 2014.

Centers for Disease Control and Prevention (CDC). National Diabetes Statistics Report, 2017. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Dept of Health and Human Services; 2017.

Holt R.I., Mitchell A.J. (2015). Diabetes mellitus and severe mental illness: mechanisms and clinical implications. *Nat Rev Endocrinol.* 2015 Feb;11(2):79-89. doi: 10.1038/nrendo.2014.203.

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Mai Q, Holman CD, Sanfilippo FM, et al. (2011) Mental illness related disparities in diabetes prevalence, quality of care and outcomes: a population-based longitudinal study. BMC Medicine. 9:118.

Mangurian, C., Newcomer, J.W., Modlin, C. et al. Diabetes and Cardiovascular Care Among People with Severe Mental Illness: A Literature Review. J GEN INTERN MED (2016) 31: 1083. <https://doi.org/10.1007/s11606-016-3712-4>

Mangurian C, Newcomer JW, Vittinghoff E, Creasman JM, Knapp P, Fuentes-Afflick E, Schillinger D. Diabetes Screening Among Underserved Adults With Severe Mental Illness Who Take Antipsychotic Medications. JAMA Intern Med. 2015;175(12):1977–1979. doi:10.1001/jamainternmed.2015.6098

Vancampfort D, Correll CU, Gallinger B, et al. Diabetes mellitus in people with schizophrenia, bipolar disorder and major depressive disorder: a systematic review and large scale meta-analysis. World Psychiatry. 2016;15(2):166-174. doi:10.1002/wps.20309.

**[Response Ends]**



## 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. Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.

**spma.01. Indicate whether there are changes to the specifications since the last updates/submission. If yes, update the specifications in the Measure Specifications section of the Measure Submission Form, and explain your reasoning for the changes below.**

**[Response Begins]**

No

**[Response Ends]**

**spma.02. Briefly describe any important changes to the measure specifications since the last measure update and provide a rationale.**

For annual updates, please explain how the change in specifications affects the measure results. If a material change in specification is identified, data from re-testing of the measure with the new specifications is required for early maintenance review.

*For example, specifications may have been updated based on suggestions from a previous NQF CDP review.*

**[Response Begins]**

No important changes since the last update.

**[Response Ends]**

**sp.01. Provide the measure title.**

*Measure titles should be concise yet convey who and what is being measured (see [What Good Looks Like](#)).*

**[Response Begins]**

Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

**[Response Ends]**

**sp.02. Provide a brief description of the measure.**

*Including type of score, measure focus, target population, timeframe, (e.g., Percentage of adult patients aged 18-75 years receiving one or more HbA1c tests per year).*

**[Response Begins]**

The percentage of patients 18 – 64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.

**[Response Ends]**

**sp.04. Check all the clinical condition/topic areas that apply to your measure, below.**

*Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.*

*Please do not select:*

- *Surgery: General*

**[Response Begins]**

Behavioral Health

Endocrine: Diabetes

**[Response Ends]**

**sp.05. Check all the non-condition specific measure domain areas that apply to your measure, below.**

**[Response Begins]**

Primary Prevention

**[Response Ends]**

**sp.06. Select one or more target population categories.**

*Select only those target populations which can be stratified in the reporting of the measure's result.*

*Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.*

*Please do not select:*

- *Populations at Risk: Populations at Risk*

**[Response Begins]**

**[Response Ends]**

**sp.07. Select the levels of analysis that apply to your measure.**

*Check ONLY the levels of analysis for which the measure is SPECIFIED and TESTED.*

*Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.*

*Please do not select:*

- *Clinician: Clinician*
- *Population: Population*

**[Response Begins]**

Health Plan

Integrated Delivery System

Population: Regional and State

**[Response Ends]**

**sp.08. Indicate the care settings that apply to your measure.**

*Check ONLY the settings for which the measure is SPECIFIED and TESTED.*

**[Response Begins]**

Other

Outpatient Services

**[Response Ends]**

**sp.09. 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. If no URL is available, indicate "none available".*

**[Response Begins]**

Not Applicable

**[Response Ends]**

**sp.12. Attach the data dictionary, code table, or value sets (and risk model codes and coefficients when applicable). Excel formats (.xlsx or .csv) are preferred.**

*Attach an excel or csv file; if this poses an issue, [contact staff](#). Provide descriptors for any codes. Use one file with multiple worksheets, if needed.*

**[Response Begins]**

No data dictionary/code table – all information provided in the submission form

**[Response Ends]**

**sp.13. State the numerator.**

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

*DO NOT include the rationale for the measure.*

**[Response Begins]**

Among patients 18-64 years old with schizophrenia or bipolar disorder, those who were dispensed an antipsychotic medication and had a diabetes screening testing during the measurement year.

**[Response Ends]**

**sp.14. Provide details needed to calculate the numerator.**

*All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets.*

*Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.*

**[Response Begins]**

A glucose test (Glucose Tests Value Set) or an HbA1c test (HbA1c Tests Value Set) performed during the measurement year, as identified by claim/encounter or automated laboratory data.

See corresponding Excel document for the Glucose Tests Value Set and the HbA1c Tests Value Set.

**[Response Ends]**

**sp.15. State the denominator.**

*Brief, narrative description of the target population being measured.*

**[Response Begins]**

Patients ages 18 to 64 years of age as of the end of the measurement year (e.g., December 31) with a schizophrenia or bipolar disorder diagnosis and who were prescribed an antipsychotic medication.

**[Response Ends]**

**sp.16. Provide details needed to calculate the denominator.**

*All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets.*

*Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.*

**[Response Begins]**

Follow the steps below to identify the eligible population.

Identify members with schizophrenia or bipolar disorder as those who met at least one of the following criteria during the measurement year.

- At least one acute inpatient encounter, with any diagnosis of schizophrenia or bipolar disorder. Any of the following code combinations meet criteria:
  - BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
  - BH Stand Alone Acute Inpatient Value Set with Other Bipolar Disorder Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set.
  - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Bipolar Disorder Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of schizophrenia. Any two of the following code combinations meet criteria:
  - BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
  - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
  - ED Value Set with Schizophrenia Value Set.
  - BH ED Value Set with ED POS Value Set with Schizophrenia Value Set.
  - BH Stand Alone Nonacute Inpatient Value Set with Schizophrenia Value Set.
  - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Schizophrenia Value Set.
- At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or nonacute inpatient setting, on different dates of service, with any diagnosis of bipolar disorder. Any two of the following code combinations meet criteria:

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- BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Outpatient/PH/IOP Value Set with Other Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
- BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Bipolar Disorder Value Set.
- ED Value Set with Bipolar Disorder Value Set.
- ED Value Set with Other Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Bipolar Disorder Value Set.
- BH ED Value Set with ED POS Value Set with Other Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Bipolar Disorder Value Set.
- BH Stand Alone Nonacute Inpatient Value Set with Other Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Bipolar Disorder Value Set.
- BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set with Other Bipolar Disorder Value Set.

(See corresponding Excel document for the above value sets)

**[Response Ends]**

**sp.17. Describe the denominator exclusions.**

*Brief narrative description of exclusions from the target population.*

**[Response Begins]**

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

Exclude patients with diabetes during the measurement year or the year prior to the measurement year.

Exclude patients who had no antipsychotic medications dispensed during the measurement year.

**[Response Ends]**

**sp.18. Provide details needed to calculate the denominator exclusions.**

*All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at sp.11.*

**[Response Begins]**

Exclude members who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Patients are excluded from the denominator if they have diabetes (during the measurement year or the year prior to the measurement year). There are two ways to identify patients with diabetes: 1) pharmacy data or 2) claim/encounter data. Both methods should be used to identify patients with diabetes, but a patient only needs to be identified by one method to be excluded from the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data: Patients who were dispensed insulin or oral hypoglycemics/antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis (Diabetes Medications List).

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Claim/encounter data: Patients who met at any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years).

- At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (Diabetes Value Set). Visit type need not be the same for the two encounters.
- At least one acute inpatient encounter (Acute Inpatient Value Set) with a diagnosis of diabetes (Diabetes Value Set).

PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES (Diabetes Medications List):

Alpha-glucosidase inhibitors:

Acarbose, Miglitol

Amylin analogs:

Pramlintide

Antidiabetic combinations:

Alogliptin-metformin, Alogliptin-pioglitazone, Canagliflozin-metformin, Dapagliflozin-metformin, Empagliflozin-linagliptin, Empagliflozin-metformin, Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Linagliptin-metformin, Metformin-pioglitazone, Metformin-repaglinide, Metformin-rosiglitazone, Metformin-saxagliptin, Metformin-sitagliptin, Sitagliptin-simvastatin

Insulin:

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

Meglitinides:

Nateglinide, Repaglinide

Glucagon-like peptide-1 (GLP1) agonists:

Dulaglutide, Exenatide, Liraglutide, Albiglutide

Sodium glucose cotransporter 2 (SGLT2) inhibitor:

Canagliflozin, Dapagliflozin, Empagliflozin

Sulfonylureas:

Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide

Thiazolidinediones:

Pioglitazone, Rosiglitazone

Dipeptidyl peptidase-4 (DDP-4) inhibitors:

Alogliptin, Linagliptin, Saxagliptin, Sitagliptin

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Exclude patients who had no antipsychotic medications dispensed during the measurement year. There are two ways to identify dispensing events: by claim/encounter data and by pharmacy data. The organization must use both methods to identify dispensing events, but an event need only be identified by one method to be counted.

- Claim/encounter data. An antipsychotic medication (Long-Acting Injections Value Set).
- Pharmacy data. Dispensed an antipsychotic medication (Antipsychotic Medications List; Antipsychotic Combination Medications List) on an ambulatory basis.

ANTIPSYCHOTIC MEDICATIONS:

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(Antipsychotic Medications List)

Miscellaneous antipsychotic agents:

Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurasidone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone

Phenothiazine antipsychotics:

Chlorpromazine, Fluphenazine, Perphenazine, Prochlorperazine, Thioridazine, Trifluoperazine

Thioxanthenes:

Thiothixene

Long-acting injections:

Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone

(Antipsychotic Combination Medications List)

Psychotherapeutic combinations:

Fluoxetine-olanzapine, Perphenazine-amitriptyline

See corresponding Excel document for the value sets referenced above.

**[Response Ends]**

**sp.19. Provide all information required to stratify the measure results, if necessary.**

*Include the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate. Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format in the Data Dictionary field.*

**[Response Begins]**

None.

**[Response Ends]**

**sp.20. Is this measure adjusted for socioeconomic status (SES)?**

**[Response Begins]**

**[Response Ends]**

**sp.21. Select the risk adjustment type.**

*Select type. Provide specifications for risk stratification and/or risk models in the Scientific Acceptability section.*

**[Response Begins]**

No risk adjustment or risk stratification

**[Response Ends]**

**sp.22. Select the most relevant type of score.**

*Attachment: If available, please provide a sample report.*

**[Response Begins]**

Rate/proportion

[Response Ends]

**sp.23. Select the appropriate interpretation of the measure score.**

*Classifies interpretation of score according to whether better quality or resource use is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score*

[Response Begins]

Better quality = Higher score

[Response Ends]

**sp.24. Diagram or describe the calculation of the measure score as an ordered sequence of steps.**

*Identify the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period of data, aggregating data; risk adjustment; etc.*

[Response Begins]

Step1. Determine the eligible population: identify patients 18-64 years of age by the end of the measurement year.

Step 2. Search for an exclusion in the patient's history: Exclude patients from the eligible population if they meet the following criteria:

- Patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

- Patients with diabetes during the measurement year or the year prior to the measurement year.

- Patients who had no antipsychotic medications dispensed during the measurement year.

Step 3. Determine the numerator: the number of patients who had a diabetes screening test during the measurement year.

Step 4. Calculate the rate.

[Response Ends]

**sp.27. If measure testing is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.**

*Examples of samples used for testing:*

- Testing may be conducted on a sample of the accountable entities (e.g., hospital, physician). The analytic unit specified for the particular measure (e.g., physician, hospital, home health agency) determines the sampling strategy for scientific acceptability testing.

- The sample should represent the variety of entities whose performance will be measured. The [2010 Measure Testing Task Force](#) recognized that the samples used for reliability and validity testing often have limited generalizability because measured entities volunteer to participate. Ideally, however, all types of entities whose performance will be measured should be included in reliability and validity testing.

- The sample should include adequate numbers of units of measurement and adequate numbers of patients to answer the specific reliability or validity question with the chosen statistical method.

- When possible, units of measurement and patients within units should be randomly selected.

[Response Begins]

Not applicable.

[Response Ends]



**sp.30. Select only the data sources for which the measure is specified.**

**[Response Begins]**

Claims

**[Response Ends]**

**sp.31. Identify the specific data source or data collection instrument.**

*For example, provide the name of the database, clinical registry, collection instrument, etc., and describe how data are collected.*

**[Response Begins]**

This measure is based on administrative claims and medical record documentation collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from health plans via NCQA's online data submission system.

**[Response Ends]**

**sp.32. Provide the data collection instrument.**

**[Response Begins]**

No data collection instrument provided

**[Response Ends]**

**2ma.01. Indicate whether additional empirical reliability testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Reliability - Testing. Include information on all testing conducted (prior testing as well as any new testing).**

*Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:*

**Current Submission:**

*Updated testing information here.*

**Previous Submission:**

*Testing from the previous submission here.*

**[Response Begins]**

Yes

**[Response Ends]**

**2ma.02. Indicate whether additional empirical validity testing at the accountable entity level has been conducted. If yes, please provide results in the following section, Scientific Acceptability: Validity - Testing. Include information on all testing conducted (prior testing as well as any new testing).**

*Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:*

**Current Submission:**

*Updated testing information here.*

**Previous Submission:**

*Testing from the previous submission here.*

**[Response Begins]**

Yes

**[Response Ends]**

**2ma.03. For outcome, patient-reported outcome, resource use, cost, and some process measures, risk adjustment/stratification may be conducted. Did you perform a risk adjustment or stratification analysis?**

**[Response Begins]**

**[Response Ends]**

**2ma.04. For maintenance measures in which risk adjustment/stratification has been performed, indicate whether additional risk adjustment testing has been conducted since the most recent maintenance evaluation. This may include updates to the risk adjustment analysis with additional clinical, demographic, and social risk factors.**

**Please update the Scientific Acceptability: Validity - Other Threats to Validity section.**

**Note: This section must be updated even if social risk factors are not included in the risk adjustment strategy.**

**[Response Begins]**

**[Response Ends]**

Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate fields in the Scientific Acceptability sections of the Measure Submission Form.

- Measures must be tested for all the data sources and levels of analyses that are specified. If there is more than one set of data specifications or more than one level of analysis, contact NQF staff about how to present all the testing information in one form.
- All required sections must be completed.
- For composites with outcome and resource use measures, Questions 2b.23-2b.37 (Risk Adjustment) also must be completed.
- If specified for multiple data sources/sets of specifications (e.g., claims and EHRs), Questions 2b.11-2b.13 also must be completed.
- An appendix for supplemental materials may be submitted (see Question 1 in the Additional section), but there is no guarantee it will be reviewed.
- Contact NQF staff with any questions. Check for resources at the [Submitting Standards webpage](#).
- For information on the most updated guidance on how to address social risk factors variables and testing in this form refer to the release notes for the [2021 Measure Evaluation Criteria and Guidance](#).

#1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using  
Antipsychotic Medications (SSD), Submission Last Updated: Oct 18, 2022

Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the testing results for this measure meet NQF's evaluation criteria for testing.

2a. Reliability testing demonstrates the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period and/or that the measure score is precise. For instrument-based measures (including PRO-PMs) and composite performance measures, reliability should be demonstrated for the computed performance score.

2b1. Validity testing demonstrates that the measure data elements are correct and/or the measure score correctly reflects the quality of care provided, adequately identifying differences in quality. For instrument based measures (including PRO-PMs) and composite performance measures, validity should be demonstrated for the computed performance score.

2b2. Exclusions are supported by the clinical evidence and are of sufficient frequency to warrant inclusion in the specifications of the measure;

AND

If patient preference (e.g., informed decision-making) is a basis for exclusion, there must be evidence that the exclusion impacts performance on the measure; in such cases, the measure must be specified so that the information about patient preference and the effect on the measure is transparent (e.g., numerator category computed separately, denominator exclusion category computed separately).

2b3. For outcome measures and other measures when indicated (e.g., resource use):

- an evidence-based risk-adjustment strategy (e.g., risk models, risk stratification) is specified; is based on patient factors (including clinical and social risk factors) that influence the measured outcome and are present at start of care; 14,15 and has demonstrated adequate discrimination and calibration

OR

- rationale/data support no risk adjustment/ stratification.

2b4. Data analysis of computed measure scores demonstrates that methods for scoring and analysis of the specified measure allow for identification of statistically significant and practically/clinically meaningful 16 differences in performance;

OR

there is evidence of overall less-than-optimal performance.

2b5. If multiple data sources/methods are specified, there is demonstration they produce comparable results.

2b6. Analyses identify the extent and distribution of missing data (or nonresponse) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders) and how the specified handling of missing data minimizes bias.

2c. For composite performance measures, empirical analyses support the composite construction approach and demonstrate that:

2c1. the component measures fit the quality construct and add value to the overall composite while achieving the related objective of parsimony to the extent possible; and

2c2. the aggregation and weighting rules are consistent with the quality construct and rationale while achieving the related objective of simplicity to the extent possible.

(if not conducted or results not adequate, justification must be submitted and accepted)

## Definitions

Reliability testing applies to both the data elements and computed measure score. Examples of reliability testing for data elements include, but are not limited to: inter-rater/abstractor or intra-rater/abstractor studies; internal consistency for multi-item scales; test-retest for survey items. Reliability testing of the measure score addresses precision of measurement (e.g., signal-to-noise).

Validity testing applies to both the data elements and computed measure score. Validity testing of data elements typically analyzes agreement with another authoritative source of the same information. Examples of validity testing of the measure score include, but are not limited to: testing hypotheses that the measure scores indicate quality of care, e.g., measure scores are different for groups known to have differences in quality assessed by another valid quality measure or method; correlation of measure scores with another valid indicator of quality for the specific topic; or relationship to conceptually related measures (e.g., scores on process measures to scores on outcome measures). Face validity of the measure score as a quality indicator may be adequate if accomplished through a systematic and transparent process, by identified experts, and explicitly addresses whether performance scores resulting from the measure as specified can be used to distinguish good from poor quality. The degree of consensus and any areas of disagreement must be provided/discussed.

Examples of evidence that an exclusion distorts measure results include, but are not limited to: frequency of occurrence, variability of exclusions across providers, and sensitivity analyses with and without the exclusion.

Patient preference is not a clinical exception to eligibility and can be influenced by provider interventions.

Risk factors that influence outcomes should not be specified as exclusions.

With large enough sample sizes, small differences that are statistically significant may or may not be practically or clinically meaningful. The substantive question may be, for example, whether a statistically significant difference of one percentage point in the percentage of patients who received smoking cessation counseling (e.g., 74 percent v. 75 percent) is clinically meaningful; or whether a statistically significant difference of \$25 in cost for an episode of care (e.g., \$5,000 v. \$5,025) is practically meaningful. Measures with overall less-than-optimal performance may not demonstrate much variability across providers.

Please separate added or updated information from the most recent measure evaluation within each question response in the Scientific Acceptability sections. For example:

**Current Submission:**

Updated testing information here.

**Previous (Year) Submission:**

Testing from the previous submission here.

**2a.01. Select only the data sources for which the measure is tested.**

**[Response Begins]**

**[Response Ends]**

**2a.02. If an existing dataset was used, identify the specific dataset.**

*The dataset used for testing must be consistent with the measure specifications for target population and healthcare entities being measured; e.g., Medicare Part A claims, Medicaid claims, other commercial insurance, nursing home MDS, home health OASIS, clinical registry).*

**[Response Begins]**

**[Response Ends]**

**2a.03. Provide the dates of the data used in testing.**

*Use the following format: "MM-DD-YYYY - MM-DD-YYYY"*

[Response Begins]

[Response Ends]

**2a.04. Select the levels of analysis for which the measure is tested.**

*Testing must be provided for all the levels specified and intended for measure implementation, e.g., individual clinician, hospital, health plan.*

*Please refrain from selecting the following answer option(s). We are in the process of phasing out these answer options and request that you instead select one of the other answer options as they apply to your measure.*

*Please do not select:*

- *Clinician: Clinician*
- *Population: Population*

[Response Begins]

[Response Ends]

**2a.05. List the measured entities included in the testing and analysis (by level of analysis and data source).**

*Identify the number and descriptive characteristics of measured entities included in the analysis (e.g., size, location, type); if a sample was used, describe how entities were selected for inclusion in the sample.*

[Response Begins]

[Response Ends]

**2a.06. Identify the number and descriptive characteristics of patients included in the analysis (e.g., age, sex, race, diagnosis), separated by level of analysis and data source; if a sample was used, describe how patients were selected for inclusion in the sample.**

*If there is a minimum case count used for testing, that minimum must be reflected in the specifications.*

[Response Begins]

[Response Ends]

**2a.07. If there are differences in the data or sample used for different aspects of testing (e.g., reliability, validity, exclusions, risk adjustment), identify how the data or sample are different for each aspect of testing.**

[Response Begins]

[Response Ends]

**2a.08. List the social risk factors that were available and analyzed.**

*For example, patient-reported data (e.g., income, education, language), proxy variables when social risk data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate) which do not have to be a proxy for patient-level data.*

[Response Begins]

[Response Ends]

Note: If accuracy/correctness (validity) of data elements was empirically tested, separate reliability testing of data elements is not required – in 2a.09 check patient or encounter-level data; in 2a.010 enter “see validity testing section of data elements”; and enter “N/A” for 2a.11 and 2a.12.

**2a.09. Select the level of reliability testing conducted.**

*Choose one or both levels.*

**[Response Begins]**

**[Response Ends]**

**2a.10. For each level of reliability testing checked above, describe the method of reliability testing and what it tests.**

*Describe the steps—do not just name a method; what type of error does it test; what statistical analysis was used.*

**[Response Begins]**

**[Response Ends]**

**2a.11. For each level of reliability testing checked above, what were the statistical results from reliability testing?**

*For example, provide the percent agreement and kappa for the critical data elements, or distribution of reliability statistics from a signal-to-noise analysis. For score-level reliability testing, when using a signal-to-noise analysis, more than just one overall statistic should be reported (i.e., to demonstrate variation in reliability across providers). If a particular method yields only one statistic, this should be explained. In addition, reporting of results stratified by sample size is preferred (pg. 18, [NQF Measure Evaluation Criteria](#)).*

**[Response Begins]**

**[Response Ends]**

**2a.12. Interpret the results, in terms of how they demonstrate reliability.**

*(In other words, what do the results mean and what are the norms for the test conducted?)*

**[Response Begins]**

**[Response Ends]**

**2b.01. Select the level of validity testing that was conducted.**

**[Response Begins]**

**[Response Ends]**

**2b.02. For each level of testing checked above, describe the method of validity testing and what it tests.**

*Describe the steps—do not just name a method; what was tested, e.g., accuracy of data elements compared to authoritative source, relationship to another measure as expected; what statistical analysis was used.*

[Response Begins]

[Response Ends]

**2b.03. Provide the statistical results from validity testing.**

*Examples may include correlations or t-test results.*

[Response Begins]

[Response Ends]

**2b.04. Provide your interpretation of the results in terms of demonstrating validity. (i.e., what do the results mean and what are the norms for the test conducted?)**

[Response Begins]

[Response Ends]

**2b.05. Describe the method for determining if statistically significant and clinically/practically meaningful differences in performance measure scores among the measured entities can be identified.**

*Describe the steps—do not just name a method; what statistical analysis was used? Do not just repeat the information provided in Importance to Measure and Report: Gap in Care/Disparities.*

[Response Begins]

[Response Ends]

**2b.06. Describe the statistical results from testing the ability to identify statistically significant and/or clinically/practically meaningful differences in performance measure scores across measured entities.**

*Examples may include number and percentage of entities with scores that were statistically significantly different from mean or some benchmark, different from expected; how was meaningful difference defined.*

[Response Begins]

[Response Ends]

**2b.07. Provide your interpretation of the results in terms of demonstrating the ability to identify statistically significant and/or clinically/practically meaningful differences in performance across measured entities.**

*In other words, what do the results mean in terms of statistical and meaningful differences?*

[Response Begins]

[Response Ends]

**2b.08. Describe the method of testing conducted to identify the extent and distribution of missing data (or non-response) and demonstrate that performance results are not biased due to systematic missing data (or differences between responders and non-responders). Include how the specified handling of missing data minimizes bias.**

*Describe the steps—do not just name a method; what statistical analysis was used.*

[Response Begins]

[Response Ends]

**2b.09. Provide the overall frequency of missing data, the distribution of missing data across providers, and the results from testing related to missing data.**

*For example, provide results of sensitivity analysis of the effect of various rules for missing data/non-response. If no empirical sensitivity analysis was conducted, identify the approaches for handling missing data that were considered and benefits and drawbacks of each).*

[Response Begins]

[Response Ends]

**2b.10. Provide your interpretation of the results, in terms of demonstrating that performance results are not biased due to systematic missing data (or differences between responders and non-responders), and how the specified handling of missing data minimizes bias.**

*In other words, what do the results mean in terms of supporting the selected approach for missing data and what are the norms for the test conducted; if no empirical analysis was conducted, justify the selected approach for missing data.*

[Response Begins]

[Response Ends]

Note: This item is directed to measures that are risk-adjusted (with or without social risk factors) OR to measures with more than one set of specifications/instructions (e.g., one set of specifications for how to identify and compute the measure from medical record abstraction and a different set of specifications for claims or eQMs). It does not apply to measures that use more than one source of data in one set of specifications/instructions (e.g., claims data to identify the denominator and medical record abstraction for the numerator). Comparability is not required when comparing performance scores with and without social risk factors in the risk adjustment model. However, if comparability is not demonstrated for measures with more than one set of specifications/instructions, the different specifications (e.g., for medical records vs. claims) should be submitted as separate measures.

**2b.11. Indicate whether there is more than one set of specifications for this measure.**

[Response Begins]

[Response Ends]

**2b.12. Describe the method of testing conducted to compare performance scores for the same entities across the different data sources/specifications.**

*Describe the steps—do not just name a method. Indicate what statistical analysis was used.*

[Response Begins]



[Response Ends]

**2b.13. Provide the statistical results from testing comparability of performance scores for the same entities when using different data sources/specifications.**

*Examples may include correlation, and/or rank order.*

[Response Begins]

[Response Ends]

**2b.14. Provide your interpretation of the results in terms of the differences in performance measure scores for the same entities across the different data sources/specifications.**

*In other words, what do the results mean and what are the norms for the test conducted.*

[Response Begins]

[Response Ends]

**2b.15. Indicate whether the measure uses exclusions.**

[Response Begins]

[Response Ends]

**2b.16. Describe the method of testing exclusions and what was tested.**

*Describe the steps—do not just name a method; what was tested, e.g., whether exclusions affect overall performance scores; what statistical analysis was used?*

[Response Begins]

[Response Ends]

**2b.17. Provide the statistical results from testing exclusions.**

*Include overall number and percentage of individuals excluded, frequency distribution of exclusions across measured entities, and impact on performance measure scores.*

[Response Begins]

[Response Ends]

**2b.18. Provide your interpretation of the results, in terms of demonstrating that exclusions are needed to prevent unfair distortion of performance results.**

*In other words, the value outweighs the burden of increased data collection and analysis. Note: If patient preference is an exclusion, the measure must be specified so that the effect on the performance score is transparent, e.g., scores with and without exclusion.*

[Response Begins]

[Response Ends]

**2b.19. Check all methods used to address risk factors.**

[Response Begins]

[Response Ends]

**2b.20. If using statistical risk models, provide detailed risk model specifications, including the risk model method, risk factors, risk factor data sources, coefficients, equations, codes with descriptors, and definitions.**

[Response Begins]

[Response Ends]

**2b.21. If an outcome or resource use measure is not risk-adjusted or stratified, provide rationale and analyses to demonstrate that controlling for differences in patient characteristics (i.e., case mix) is not needed to achieve fair comparisons across measured entities.**

[Response Begins]

[Response Ends]

**2b.22. Select all applicable resources and methods used to develop the conceptual model of how social risk impacts this outcome.**

[Response Begins]

[Response Ends]

**2b.23. Describe the conceptual and statistical methods and criteria used to test and select patient-level risk factors (e.g., clinical factors, social risk factors) used in the statistical risk model or for stratification by risk.**

*Please be sure to address the following: potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of  $p < 0.10$  or other statistical tests; correlation of  $x$  or higher. Patient factors should be present at the start of care, if applicable. Also discuss any "ordering" of risk factor inclusion; note whether social risk factors are added after all clinical factors. Discuss any considerations regarding data sources (e.g., availability, specificity).*

[Response Begins]

[Response Ends]

**2b.24. Detail the statistical results of the analyses used to test and select risk factors for inclusion in or exclusion from the risk model/stratification.**

[Response Begins]

[Response Ends]

**2b.25. Describe the analyses and interpretation resulting in the decision to select or not select social risk factors.**

*Examples may include prevalence of the factor across measured entities, availability of the data source, empirical association with the outcome, contribution of unique variation in the outcome, or assessment of between-unit effects and within-unit effects. Also describe the impact of adjusting for risk (or making no adjustment) on providers at high or low extremes of risk.*

[Response Begins]

[Response Ends]

**2b.26. Describe the method of testing/analysis used to develop and validate the adequacy of the statistical model or stratification approach (describe the steps—do not just name a method; what statistical analysis was used). Provide the statistical results from testing the approach to control for differences in patient characteristics (i.e., case mix) below. If stratified ONLY, enter “N/A” for questions about the statistical risk model discrimination and calibration statistics.**

*Validation testing should be conducted in a data set that is separate from the one used to develop the model.*

[Response Begins]

[Response Ends]

**2b.27. Provide risk model discrimination statistics.**

*For example, provide c-statistics or R-squared values.*

[Response Begins]

[Response Ends]

**2b.28. Provide the statistical risk model calibration statistics (e.g., Hosmer-Lemeshow statistic).**

[Response Begins]

[Response Ends]

**2b.29. Provide the risk decile plots or calibration curves used in calibrating the statistical risk model.**

*The preferred file format is .png, but most image formats are acceptable.*

[Response Begins]

[Response Ends]

**2b.30. Provide the results of the risk stratification analysis.**

[Response Begins]

[Response Ends]

**2b.31. Provide your interpretation of the results, in terms of demonstrating adequacy of controlling for differences in patient characteristics (i.e., case mix).**

*In other words, what do the results mean and what are the norms for the test conducted?*

[Response Begins]

[Response Ends]

**2b.32. Describe any additional testing conducted to justify the risk adjustment approach used in specifying the measure.**

*Not required but would provide additional support of adequacy of the risk model, e.g., testing of risk model in another data set; sensitivity analysis for missing data; other methods that were assessed.*

**[Response Begins]**

**[Response Ends]**

### 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.

---

**3.01. Check all methods below that are used to generate the data elements needed to compute the measure score.**

**[Response Begins]**

Coded by someone other than person obtaining original information (e.g., DRG, ICD-10 codes on claims)

**[Response Ends]**

**3.02. Detail to what extent the specified data elements are available electronically in defined fields.**

*In other words, indicate whether data elements that are needed to compute the performance measure score are in defined, computer-readable fields.*

**[Response Begins]**

ALL data elements are in defined fields in electronic claims

**[Response Ends]**

**3.03. 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 data elements not from electronic sources.**

**[Response Begins]**

**[Response Ends]**

**3.04. Describe any efforts to develop an eCQM.**

**[Response Begins]**

**[Response Ends]**

**3.06. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.**

**[Response Begins]**

**[Response Ends]**

Consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

**3.07. Detail 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),**

**Attach the fee schedule here, if applicable.**

**[Response Begins]**

#1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using  
Antipsychotic Medications (SSD), Submission Last Updated: Oct 18, 2022

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.

**[Response Ends]**

## 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.

---

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.

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 demonstrating performance improvement.

### 4a.01. Check all current uses. For each current use checked, please provide:

Name of program and sponsor

URL

Purpose

Geographic area and number and percentage of accountable entities and patients included

Level of measurement and setting

[Response Begins]

Public Reporting

Regulatory and Accreditation Programs

Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

[Response Ends]

### 4a.02. Check all planned uses.

[Response Begins]

Public reporting

[Response Ends]

### 4a.03. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing), explain why the measure is not in use.

*For example, do policies or actions of the developer/steward or accountable entities restrict access to performance results or block implementation?*

[Response Begins]

N/A

[Response Ends]

### 4a.04. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes: used in any accountability application within 3 years, and publicly reported within 6 years of initial endorsement.

*A 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.*

**[Response Begins]**

N/A

**[Response Ends]**

**4a.05. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.**

*Detail how many and which types of measured entities and/or others were included. If only a sample of measured entities were included, describe the full population and how the sample was selected.*

**[Response Begins]**

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

**[Response Ends]**

**4a.06. Describe the process for providing measure results, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.**

**[Response Begins]**

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System.

**[Response Ends]**

**4a.07. Summarize the feedback on measure performance and implementation from the measured entities and others. Describe how feedback was obtained.**

**[Response Begins]**

NCQA measures are evaluated regularly. During this "reevaluation" process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure's adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

**[Response Ends]**

**4a.08. Summarize the feedback obtained from those being measured.**

**[Response Begins]**

In general, health plans have not reported significant barriers to implementing this measure, as it uses the administrative data collection method. Questions have generally centered around minor clarification of the



specifications, such as benefit requirements to report the measure and approved medications to identify the eligible population. NCQA responded to all questions to ensure consistent implementation of the specifications.

**[Response Ends]**

**4a.09. Summarize the feedback obtained from other users.**

**[Response Begins]**

This measure has been deemed a priority measure by NCQA and other entities, like the Medicaid Adult Core Set.

**[Response Ends]**

**4a.10. Describe how the feedback described has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.**

**[Response Begins]**

Feedback has not required modification to this measure.

**[Response Ends]**

**4b.01. You may refer to data provided in Importance to Measure and Report: Gap in Care/Disparities, but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included). If no improvement was demonstrated, provide an explanation. 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.**

**[Response Begins]**

From 2015 to 2017, performance rates for this measure have been generally stable or shown slight improvement. In 2017, Medicaid plans had an average performance rate of 81 percent. There continues to be significant variation between the 10th and 90th percentiles, suggesting room for improvement. In 2017, Medicaid plans in the 10th percentile had a rate of 74 percent, compared to 87 percent among plans in the 90th percentile.

This measure was first introduced in HEDIS 2013. Rates for Medicaid were 78.0 percent. In the last 5 years, we have seen improvement of three percent.

**[Response Ends]**

**4b.02. Explain any unexpected findings (positive or negative) during implementation of this measure, including unintended impacts on patients.**

**[Response Begins]**

There were no identified unintended consequences for this measure during testing or since implementation.

**[Response Ends]**

**4b.03. Explain any unexpected benefits realized from implementation of this measure.**

**[Response Begins]**

There were no identified unintended consequences for this measure during testing or since implementation.

**[Response Ends]**



## 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.

---

If you are updating a maintenance measure submission for the first time in MIMS, please note that the previous related and competing data appearing in question 5.03 may need to be entered in to 5.01 and 5.02, if the measures are NQF endorsed. Please review and update questions 5.01, 5.02, and 5.03 accordingly.

### 5.01. Search and select all NQF-endorsed related measures (conceptually, either same measure focus or target population).

*(Can search and select measures.)*

[Response Begins]

[Response Ends]

### 5.02. Search and select all NQF-endorsed competing measures (conceptually, the measures have both the same measure focus or target population).

*(Can search and select measures.)*

[Response Begins]

[Response Ends]

### 5.03. If there are related or competing measures to this measure, but they are not NQF-endorsed, please indicate the measure title and steward.

[Response Begins]

N/A

[Response Ends]

### 5.04. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s), indicate whether the measure specifications are harmonized to the extent possible.

[Response Begins]

Yes

[Response Ends]

### 5.05. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

[Response Begins]

N/A

[Response Ends]

### 5.06. Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality). Alternatively, justify endorsing an additional measure.

*Provide analyses when possible.*

**[Response Begins]**

N/A

**[Response Ends]**

## Appendix

**Supplemental materials may be provided in an appendix.:**

No appendix

## Contact Information

**Measure Steward (Intellectual Property Owner):** National Committee for Quality Assurance

**Measure Steward Point of Contact:** Rehm, Bob, [nqf@ncqa.org](mailto:nqf@ncqa.org)

**Measure Developer if different from Measure Steward:** National Committee for Quality Assurance

**Measure Developer Point(s) of Contact:** Swift, Kristen, [swift@ncqa.org](mailto:swift@ncqa.org)

## Additional Information

**1. Provide any supplemental materials, if needed, as an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be collated one file with a table of contents or bookmarks. If material pertains to a specific criterion, that should be indicated.**

**[Response Begins]**

No appendix

**[Response Ends]**

**2. List the workgroup/panel members' names and organizations.**

*Describe the members' role in measure development.*

**[Response Begins]**

The Technical Advisory Group advised Mathematica Policy Research, Inc. and the National Committee for Quality Assurance during measure development. The TAG was responsible for providing feedback on measure concepts, specifications, results from field and data testing. The TAG consisted of a multistakeholder group of experts with knowledge in behavioral health and quality measurement.

Technical Advisory Group Roster:

Alisa Busch, MD, MS  
Enola Proctor, PhD, MSW  
David Shern, PhD  
Wilma Townsend, MSW  
Dan Ford, MD, MPH  
Lorrie Rickman-Jones, PhD  
Eric Hamilton  
Alexander Young, MD, MHS  
Peter Delany, PhD  
Ben Druss, MD, MPH  
Maureen Corcoran, MSN, MBA  
Mike Fitzpatrick, MSW  
Anita Yuskas  
Bob Heinssen, PhD

Consultants:

Lisa Dixon, MD, MPH  
Julie Kreyenbul, PharmD, PhD

COMMITTEE ON PERFORMANCE MEASUREMENT:

Bruce Bagley, MD, FAAFP, Independent Consultant  
Andrew Baskin, MD, Aetna  
Jonathan D. Darer, MD, Siemens Healthineers  
Helen Darling, MA, Strategic Advisor on Health Benefits & Health Care  
Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas  
Kate Goodrich, MD, MHS, Centers for Medicare and Medicaid Services  
David Grossman, MD, MPH, Washington Permanente Medical Group  
Christine Hunter, MD, (Co-Chair) US Office of Personnel Management  
Jeffrey Kelman, MMSc, MD, United States Department of Health and Human Services  
Nancy Lane, PhD, Independent Consultant

#1932 Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using  
Antipsychotic Medications (SSD), Submission Last Updated: Oct 18, 2022

Bernadette Loftus, MD, The Permanente Medical Group  
Adrienne Mims, MD, MPH, Alliant Quality  
Amanda Parsons, MD, MBA, Montefiore Health System  
Wayne Rawlins, MD, MBA, ConnectiCare  
Rodolfo Saenz, MD, MMM, FACOG, Riverside Medical Clinic  
Eric C. Schneider, MD, MSc (Co-Chair), The Commonwealth Fund  
Marcus Thygeson, MD, MPH, Adaptive Health  
JoAnn Volk, MA, Reforms  
Lina Walker, PhD, AARP

Behavioral Health Measurement Advisory Panel:

Katharine Bradley, MD, MPH, Kaiser Permanente Washington Health Research Institute  
Christopher Dennis, MD, MBA, FAPA, Landmark Health, LLC  
Ben Druss, MD, MPH, Emory University  
Frank Ghinassi, PhD, ABPP, Rutgers University Behavioral Health Care  
Connie Horgan, ScD, Brandeis University  
Laura Jacobus-Kantor, PhD, SAMHSA  
Jeffrey Meyerhoff, MD, Optum  
Harold Pincus, MD, College of Physicians and Surgeons, Columbia University, New York Presbyterian Hospital,  
RAND  
Michael Schoenbaum, PhD, National Institute of Mental Health  
John Straus, MD, Massachusetts Behavioral Health Partnership-A Beacon Health Options Company

[Response Ends]

**3. Indicate the year the measure was first released.**

[Response Begins]

[Response Ends]

**4. Indicate the month and year of the most recent revision.**

[Response Begins]

[Response Ends]

**5. Indicate the frequency of review, or an update schedule, for this measure.**

[Response Begins]

Every 3-5 years.

[Response Ends]

**6. Indicate the next scheduled update or review of this measure.**

[Response Begins]

[Response Ends]

**7. Provide a copyright statement, if applicable. Otherwise, indicate "N/A".**

[Response Begins]

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**[Response Ends]**

**8. State any disclaimers, if applicable. Otherwise, indicate “N/A”.**

**[Response Begins]**

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**[Response Ends]**

**9. Provide any additional information or comments, if applicable. Otherwise, indicate “N/A”.**

**[Response Begins]**

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**[Response Ends]**