



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 #: 2800

Corresponding Measures:

De.2. Measure Title: [Metabolic Monitoring for Children and Adolescents on Antipsychotics](#)

Co.1.1. Measure Steward: [National Committee for Quality Assurance](#)

De.3. Brief Description of Measure: The percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.

1b.1. Developer Rationale: This measure addresses metabolic monitoring as one facet of safe and judicious use of antipsychotics in children and adolescents. Although antipsychotic medications offer the potential for effective treatment of psychiatric disorders in children, they can also increase a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Despite the risk of such adverse side effects and clinical guideline recommendation, evidence suggests that children and adolescents do not receive appropriate laboratory monitoring. Thus, this measure encourages metabolic monitoring of children who are on antipsychotic medications.

S.4. Numerator Statement: Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

S.6. Denominator Statement: Children and adolescents 1-17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).

S.8. Denominator Exclusions: Patients in hospice.

De.1. Measure Type: [Process](#)

S.17. Data Source: [Claims](#)

S.20. Level of Analysis: [Health Plan](#)

IF Endorsement Maintenance – Original Endorsement Date: [May 04, 2016](#) Most Recent Endorsement Date: [Jul 31, 2020](#)

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? [N/A](#)

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

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

[APM_Evidence_Form_-2800-.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence.

Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure addresses metabolic monitoring as one facet of safe and judicious use of antipsychotics in children and adolescents. Although antipsychotic medications offer the potential for effective treatment of psychiatric disorders in children, they can also increase a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Despite the risk of such adverse side effects and clinical guideline recommendation, evidence suggests that children and adolescents do not receive appropriate laboratory monitoring. Thus, this measure encourages metabolic monitoring of children who are on antipsychotic medications.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. 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 include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

The following data are extracted from HEDIS data collection and reflect the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by the mean, standard deviation, minimum health plan performance, maximum health plan performance, performance percentiles (10th, 25th, 50th, 75th, and 90th percentile) and the interquartile range. Data is stratified by measurement year, product line (i.e. commercial and Medicaid) at the health plan level.

The following data demonstrate the variation in the rate of children and adolescents who had two or more antipsychotic prescriptions and had metabolic testing.

Metabolic Monitoring for Children and Adolescents on Antipsychotics

N = Number of Health Plans

YEAR = Measurement Year

Commercial

YEAR|N|MEAN|STDEV|MIN|10th|25th|50th|75th|90th|MAX|Interquartile Range

2016|279|34%|10%|8%|22%|27%|33%|39%|47%|80%|12%

2017|272|35%|11%|13%|22%|27%|34%|41%|48%|77%|14%

2018|273|35%|10%|12%|23%|28%|34%|40%|47%|69%|12%

Medicaid

YEAR|N|MEAN|ST DEV|MIN|10th|25th|50th|75th|90th|MAX|Interquartile Range

2016|164|33%|11%|11%|22%|25%|32%|39%|48%|70%|14%

2017|166|35%|13%|12%|22%|26%|32%|41%|51%|83%|15%

2018|169|35%|12%|6%|23%|27%|33%|41%|49%|71%|14%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities*

included.) 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 (4b1) under Usability and Use.

HEDIS data are stratified by type of insurance (e.g. commercial, Medicaid, Medicare), which serves as a proxy for socioeconomic status. While not specified in the measure, this measure can also be stratified by health plans using demographic variables, such as race/ethnicity, gender or other variables, if the plan has sufficient data to support the stratifications. The HEDIS Health Plan Measure Set contains two measures that can assist with stratification to assess health care disparities. The Race/Ethnicity Diversity of Membership and the Language Diversity of Membership measures were designed to promote standardized methods for collecting these data and follow Office of Management and Budget and Institute of Medicine guidelines for collecting and categorizing race/ethnicity and language data. In addition, NCQA’s Multicultural Health Care Distinction Program outlines standards for collecting, storing and using race/ethnicity and language data to assess health care disparities. Based on extensive work by NCQA to understand how to promote culturally and linguistically appropriate services among plans and providers, we have many examples of how health plans have used HEDIS measures to design quality improvement programs to decrease disparities in care.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, 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 1b.4

There is little research on potential disparities in metabolic monitoring for children and adolescents prescribed antipsychotics. One study found that race/ethnicity was not associated with glucose or lipid screening rates (Morrato et al., 2010). As part of the HEDIS measure’s field testing, we assessed differences in metabolic screening and monitoring in Medicaid children by race/ethnicity. Our results indicate that Hispanic children had better (i.e. higher) rates of baseline metabolic screening (10.3 percent) compared to white non-Hispanic children (5.7 percent) and black non-Hispanic children (6.1 percent). We also found that Hispanic children also had better (i.e. higher) rates of ongoing metabolic monitoring (24.8 percent) compared to white non-Hispanic children (19.1 percent) and black non-Hispanic children (19.4 percent).

Among youth receiving antipsychotics on Medicaid, there is a marked disparity in metabolic monitoring by foster care status. A 2011 study found that 28 percent of Medicaid foster children received metabolic monitoring during the year, while only 18 percent of Medicaid non-foster children received metabolic monitoring during the year (Crystal et al., 2016).

Centers for Disease Control and Prevention. 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, 2011.

Crystal S, Mackie T, Fenton MC, et al. (2016). Rapid Growth of Antipsychotic Prescriptions for Children Who Are Publicly Insured Has Ceased, but Concerns Remain. *Health Affairs*. 2016;35(6):974-82.

Morrato E, Nicol G, Maahs D, Druss B, Hartung D, Valuck R et al. (2010). Metabolic screening in children receiving antipsychotic drug treatment. *Arch Pediatr Adolesc Med*, 164, 344-351.

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 sub criteria 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):

Behavioral Health

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

Safety, Safety : Medication, Screening

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Children, Populations at Risk

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.)

N/A

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: 2800_APM_Value_Sets_Fall_2019.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

There have been minor changes to the measure. NCQA combined the 1-5 and 6-11 year age stratifications. Separate evaluation of children 1-5 years of age is limited as utilization of antipsychotics among this age group is low. Additionally, NCQA added two rates to evaluate glucose testing and cholesterol testing independently. The total rate reflecting both glucose and cholesterol testing remains unchanged. Expert and stakeholder feedback indicate that glucose testing among children on antipsychotics is more common than cholesterol testing. Evaluation of each metabolic test type separately provides additional information to support safe and coordinated management of children on antipsychotics.

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) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Children and adolescents 1-17 years of age on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

S.5. 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, 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 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 (S.14).

Three numerators are reported using administrative data:

1. Children and adolescents 1-17 years of age on antipsychotics who received blood glucose testing during the measurement year.

2. Children and adolescents 1-17 years of age on antipsychotics who received cholesterol testing during the measurement year.
3. Children and adolescents on antipsychotics who received blood glucose and cholesterol testing during the measurement year.

Blood Glucose Testing: one test for blood glucose (Glucose Lab Test Value Set; Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set; HbA1c Test Result or Finding Value Set) during the measurement year.

Cholesterol Testing: one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set) during the measurement year.

Blood Glucose and Cholesterol Testing: both of the following during the measurement year on the same or different dates of service.

- At least one test for blood glucose (Glucose Lab Test Value Set, Glucose Test Result or Finding Value Set) or HbA1c (HbA1c Lab Test Value Set, HbA1c Test Result or Finding Value Set).
- At least one test for LDL-C (LDL-C Lab Test Value Set; LDL-C Test Result or Finding Value Set) or cholesterol (Cholesterol Lab Test Value Set; Cholesterol Test Result or Finding Value Set).

See attachment for all value sets referenced above.

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

Children and adolescents 1-17 years of age who had ongoing use of antipsychotic medications (at least two prescriptions).

S.7. Denominator Details *(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 S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Children and adolescents age 1-17 years as of December 31 of the measurement year who had at least two antipsychotic medication dispensing events (Table APM-A) of the same or different medications, on different dates of service during the measurement year, with no more than one gap in enrollment of up to 45 days during the measurement year.

TABLE APM-A: ANTIPSYCHOTIC MEDICATIONS

DESCRIPTION / PRESCRIPTION

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; Thioridazine; Trifluoperazine
 Thioxanthenes / Thiothixene
 Long-acting injections / Aripiprazole; Fluphenazine decanoate; Haloperidol decanoate; Olanzapine; Paliperidone palmitate; Risperidone
 Psychotherapeutics combinations / Fluoxetine-olanzapine; Perphenazine-amitriptyline
 Phenothiazine antipsychotics / Prochlorperazine

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Patients in hospice.

S.9. Denominator Exclusion Details *(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 S.2b.)*

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

See corresponding Excel file for value sets referenced above.

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including 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 with at S.2b.)*

Report two age stratifications and a total rate:

- Children and adolescents 1-11 years of age as of December 31 of the measurement year.
- Children and adolescents 12-17 years of age as of December 31 of the measurement year.
- Total (the sum of the age stratifications).

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. 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.14. Calculation Algorithm/Measure Logic *(Diagram or 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; time period for data, aggregating data; risk adjustment; etc.)*

STEP 1: Determine the eligible population. To do so, identify patients who meet all the specified criteria.

- AGES: Children and adolescents 1-17 years of age as of December 31 of the measurement year.
- EVENT/DIAGNOSIS: Identify patients who had at least two antipsychotic medication dispensing events of the same or different medications, on different dates of service during the measurement year. SEE S.7 for the list of antipsychotic medications.

STEP 2: Determine the numerator by identifying the number of patients in the eligible population who received blood glucose testing, cholesterol testing, or blood glucose testing and cholesterol testing.

STEP 3: Calculate the rate by dividing the numerator by the denominator.

S.15. Sampling *(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)*

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data *(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)*

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source *(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).*

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument *(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

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

S.19. Data Source or Collection Instrument *(available at measure-specific Web page URL identified in S.1 OR in attached appendix at*

A.1)
No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)
Health Plan

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)
Emergency Department and Services, Outpatient Services
If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)
N/A

2. Validity – See attached Measure Testing Submission Form
APM_Testing_Form_-2800-_updated_11.14.19.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

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

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

ALL data elements are in defined fields in electronic claims

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. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

N/A

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. Please also complete and attach the NQF Feasibility Score Card.

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. Required for maintenance of endorsement. 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.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the MCO's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) Information practices and control procedures
- 2) Sampling methods and procedures
- 3) Data integrity
- 4) Compliance with HEDIS specifications
- 5) Analytic file production
- 6) Reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds immediately to questions and identifies possible errors or inconsistencies in the implementation of the measures. This system is vital to the regular re-evaluation of the NCQA measures.

Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the scientific soundness and feasibility of the measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

N/A

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.

Specific Plan for Use	Current Use (for current use provide URL)
	<p>Public Reporting Health Plan Rating https://www.ncqa.org/hedis/reports-and-research/ratings-2019/ Annual State of Health Care Quality: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/ Health Plan Rating https://www.ncqa.org/hedis/reports-and-research/ratings-2019/ Annual State of Health Care Quality: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/</p> <p>Regulatory and Accreditation Programs Health Plan Accreditation https://www.ncqa.org/hedis/reports-and-research/ratings-2019/</p> <p>Quality Improvement (external benchmarking to organizations) Quality Compass https://www.ncqa.org/programs/data-and-information-technology/data-purchase-and-licensing/quality-compass/ Annual State of Health Care Quality: https://www.ncqa.org/hedis/measures/metabolic-monitoring-for-children-and-adolescents-on-antipsychotics/</p>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

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

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2018, the report included results from calendar year 2017 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

HEALTH PLAN RATING/REPORT CARDS: This measure is used to calculate health plan ratings which are reported in Consumer Reports and on the NCQA website. These ratings are based on performance on HEDIS measures among other factors. In 2019, a total of 538 Medicare Advantage health plans, 544 commercial health plans and 268 Medicaid health plans across 50 states were included in the ratings.

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

4a1.2. 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

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

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.

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.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual Health Care Quality Congress, 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, as described in Section 3c.1.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

NCQA measures are evaluated regularly using a consensus-based process to consider input from multiple stakeholders, including but not limited to entities being measured. 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.

4a2.2.2. Summarize the feedback obtained from those being measured.

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 confirmation that information in claims meets the measure intent and questions about the supporting guidelines for the measure.

4a2.2.3. Summarize the feedback obtained from other users

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the Annual State of Healthcare Quality and the Health Plan Rating.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

We have provided minor clarifications about the measure during the annual update process in order to address questions received through the Policy Clarification Support System.

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.

4b1. Refer to data provided in 1b 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, 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.

Performance on this measure has improved slightly for Medicaid and commercial health plans (see section 1b.2 for summary of data for commercial and Medicaid health plans). The largest improvement in performance scores is seen in the Medicaid product line. In 2019, a total of 273 commercial health plans and 169 Medicaid health plans across 50 states reported calendar year 2018 data on this measure. These data are nationally representative.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

There were no identified unexpected findings during testing or since implementation of this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

There were no identified unexpected findings during testing or since implementation of this measure.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

Yes

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

1932 : Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

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

N/A

5a. Harmonization of Related Measures

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 harmonized to the extent possible?

No

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

The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure assesses metabolic monitoring during the measurement year among children and adolescents who are prescribed antipsychotics. This measure is related to measure #1932 but addresses a different target population and measure focus. Measure #1932 assesses whether adults with schizophrenia or

bipolar disorder who were prescribed antipsychotics are screened for diabetes. Similar to the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure, this measure is specified for the health plan level and uses administrative claims as the data source. The measures have different target populations but a similar measure focus. Measure #1932 focuses on adults 18 to 64 years of age who have schizophrenia or bipolar disorder and who are prescribed antipsychotics. The Metabolic Monitoring for Children and Adolescents on Antipsychotics measure includes all children and adolescents up to 17 years of age who are prescribed antipsychotics and does not focus on any specific conditions. Measure #1932 is focused on diabetes screening by receipt of a glucose test. While the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure also includes assessing whether a glucose test was received, it additionally assesses whether a cholesterol test was received since the focus is not just diabetes screening. The two measures are aligned in the way glucose testing is identified and measured.

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.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-3500-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

Co.4 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-3500-

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.

NCQA BEHAVIORAL HEALTH MEASUREMENT ADVISORY PANEL

Katharine Bradley, MD, MPH, Kaiser Permanente Washington Health Research Institute

Christopher Dennis, MD, MBA, FAPA, Landmark Health

Ben Druss, MD, MPH, Emory University

Frank A. Ghinassi, PhD, ABPP, Rutgers University Behavioral Health Care

Connie Horgan, ScD, Brandeis University

Laura Jacobus-Kantor, PhD, SAMSA, HHS

Jeffrey Meyerhof, MD, Optum Behavioral Health

Harold Pincus, MD, Columbia University

Michael Schoenbaum, PhD, National Institute of Mental Health

John H. Straus, MD, Beacon Health Options

COMMITTEE ON PERFORMANCE MEASUREMENT

Andrew Baskin, MD, Aetna

Andrea Gelzer, MD, MS, FACP, AmeriHealth Caritas

Kate Goodrich, MD, MHS, Centers for Medicare & Medicaid Services
David Grossman, MD, MPH, Washington Permanente Medical Group
Christine Hunter, (Co-Chair), MD, WPS Health Solutions
David Kelley, MD, MPA, Pennsylvania Department of Human Services
Jeffrey Kelman, MMSc, MD, Department of Health and Human Services
Nancy Lane, PhD, Independent Consultant
Bernadette Loftus, MD, The Permanente Medical Group
Adrienne Mims, MD, MPH, AGSF, FAAFP, Alliant Health Solutions
Amanda Parsons, MD, MBA, Montefiore Medical Center
Wayne Rawlins, MD, MBA, ConnectiCare
Rudy Saenz, MD, MMM, FACOG, Riverside Medical Clinic
Marcus Thygeson, (Co-Chair), MD, MPH, Blind ON-Demand
JoAnn Volk, MA, Georgetown University
Lina Walker, PhD, AARP

NCQA TECHNICAL MEASUREMENT ADVISORY PANEL

Andy Amster, MSPH, Kaiser Permanente
Jennifer Brudnicki, MBA, Inovalon Inc.
Lindsay Cogan, PhD, MS, New York State Department of Health
Kathryn Coltin, MPH, Independent Consultant
Mike Farina, RPh, MBA, Capital District Physicians' Health Plan
Marissa Finn, MBA, CIGNA
Scott Fox, MS, MEd, FAMIA, The MITRE Corporation
Carlos Hernandez, CenCalHealth
Harmon Jordan, ScD, Westat
Virginia Raney, LCSW, Center for Medicaid and CHIP Services
Lynne Rothney-Kozlak, MPH, Rothney-KozlakConsulting, LLC
Laurie Spoll, Aetna

NATIONAL COLLABORATIVE FOR INNOVATION IN QUALITY MEASUREMENT (NCINQ) MEASUREMENT ADVISORY PANEL

Samantha Broderick, Cardinal Catalysts
Cathy Caldwell, MPH, Alabama Department of Public Health
Jim Chase, MHA, Network for Regional Healthcare Improvement
Lindsay Cogan, PhD, MS, New York Department of Health
Kim Elliott, PhD, Health Services Advisory Group
Lynda Gargan, PhD, National Federation of Families for Children's Mental Health
David Harmon, MD, FAAP, Superior Health Plan
Jennifer Havens, MD, NYU Langone Health
Virginia Moyer, MD, MPH, FAAP, The American Board of Pediatrics
Sheree Neese-Todd, MS, Rutgers University, Center for Health Services Research
Rob Penfold, PhD, Kaiser Permanente Washington Health Research Institute
Cheryl J. Roberts, JD, Virginia Department of Medical Assistance Services
Jeff Schiff, MD, MBA, Minnesota Department of Human Services
Julie Sonier, MPA, MN Community Measurement
Craig Thiele, MD, Health Management Associates
Jeb Weisman, PhD, Icahn School of Medicine at Mount Sinai
Judy Zerzan, MD, MPH, WA Health Care Authority

NCINQ CONSUMER PANEL

Joan Alker, MPhil, Georgetown Center for Children and Families
Roni Christopher, MEd, OTR/L, PCMH-CCE, The Greater Cincinnati Health Collaborative
Daniel Coury, MD, Nationwide Children's Hospital
Eileen Forlenza, Colorado Medical Home Initiative, Children and Youth with Special Health Care Needs Unit
Michaelle Gady, JD, Families USA
Janis Guerney, JD, Family Voices

Jocelyn Guyer, MPA, Georgetown Center for Children and Families
 Catherine Hess, MSW, National Academy for State Health Policy
 Carolyn Muller, RN, Montgomery County Health Department
 Cindy Pellegrini, March of Dimes
 Judith Shaw, EdD, MPH, RN, VCHIP
 Stuart Spielman, JD, LLM, Autism Speaks
 Michelle Sternthal, PhD, March of Dimes

NCINQ FOSTER CARE PANEL

Kamala Allen, MHS, Center for Health Care Strategies
 Mary Applegate, MD, Ohio Department of Job and Family Services
 Samantha Jo Broderick, Foster Care Alumni of America
 Mary Greiner, MD, Cincinnati Children's Hospital Medical Center
 David Harmon, MD, FAAP, Superior HealthPlan
 Patricia Hunt, Magellan Health Services
 Audrey LaFrenier, MSW, Parsons Child and Family Center
 Bryan Samuels, MPP, Chapin Hall
 Phil Scribano, DO, MSCE, The Children's Hospital of Philadelphia
 Lesley Siegel, MD, State of Connecticut Department of Children and Families
 Chauncey Strong, MSW, LGSW, Fairfax County Department of Family Services/Foster Care and Adoption
 Janet (Jessie) Sullivan, MD, Hudson Health Plan
 Nora Wells, MS, National Center for Family/Professional Partnerships

NCINQ MENTAL HEALTH PANEL

Francisca Azocar, PhD, Optum Health Behavioral Solutions
 Frank Ghinassi, PhD, Western Psychiatric Institute and Clinic of UPMC Presbyterian Shadyside
 Jennifer Havens, MD, NYU Langone Health
 Danielle Laraque, MD, FAAP, Maimonides Infants and Children's Hospital of Brooklyn

NCINQ STATE PANEL

Mary Applegate, MD, Ohio Department of Job and Family Services
 Susan Castellano, Minnesota Department of Human Services
 Sharon Carte, MHS, State of West Virginia Children's Health Insurance Program
 Catherine Hess, MSW, National Academy for State Health Policy
 Michael Hogan, PhD, New York State office of Mental Health
 Barbara Lantz, MN, RN, State of Washington Department of Social and Health Services, Medicaid Purchasing Administration
 Judy Mohr Peterson, PhD, Oregon Health Authority
 Tracy Plouck, MPA, Ohio Department of Mental Health
 Gina Robinson, Colorado Department of Health Care Policy and Financing
 Janet Stover, Illinois Association of Rehabilitation Facilities
 Eric Trupin, PhD, University of Washington

NCINQ MEASURE DEVELOPMENT PARTNERS

Shahla Amin, MS, Rutgers University
 Scott Bilder, PhD, Center for Health Services Research, Rutgers University
 Stephen Crystal, PhD, Institute for Health, Health Care Policy and Aging Research, Rutgers University
 Molly Finnerty, PhD, NY State Office of Mental Health
 Emily Leckman-Westin, PhD, NY State Office of Mental Health
 Sheree Neese-Todd, MA, Institute for Health, Health Care Policy and Aging Research, Rutgers University

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2014

Ad.3 Month and Year of most recent revision: 07, 2019

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? 06, 2020

Ad.6 Copyright statement: The HEDIS® measures and specifications were developed by and are owned by the National Committee for Quality Assurance (NCQA). The HEDIS measures and specifications are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures or specifications. NCQA holds a copyright in these materials and can rescind or alter these materials at any time. These materials may not be modified by anyone other than NCQA. Anyone desiring to use or reproduce the materials without modification for a non-commercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA.

©2019 NCQA, all rights reserved.

Calculated measure results, based on unadjusted HEDIS specifications, may not be termed “Health Plan HEDIS rates” until they are audited and designated reportable by an NCQA-Certified Auditor. Such unaudited results should be referred to as “Unaudited Health Plan HEDIS Rates.” Accordingly, “Health Plan HEDIS rate” refers to and assumes a result from an unadjusted HEDIS specification that has been audited by an NCQA-Certified HEDIS Auditor.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. NCQA disclaims all liability for use or accuracy of any coding contained in the specifications.

Content reproduced with permission from HEDIS, Volume 2: Technical Specifications for Health Plans. To purchase copies of this publication, including the full measures and specifications, contact NCQA Customer Support at 888-275-7585 or visit www.ncqa.org/publications.

Ad.7 Disclaimers: This HEDIS® performance measure is not a clinical guideline and does not establish a standard of medical care and has not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

Ad.8 Additional Information/Comments: NCQA Notice of Use. Broad public use and dissemination of these measures, without modification, are encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Modifications to, and/or commercial use of, a measure requires the prior written consent of NCQA and is subject to a license at the discretion 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.