VISUAL FIELD TESTS FOR GLAUCOMA PATIENTS EVERY 2 YEARS

Disease State: Glaucoma

Strength of Recommendation: B

Quality of Evidence: III

Physician Specialties: Primary: Ophthalmology, Mixed Specialty

Disease Burden
- Glaucoma is the leading cause of irreversible blindness in the world. The Eye Disease Prevalence Research Group estimated that in the year 2000, glaucoma affected 2.22 million people in the United States. This number is projected to increase to 3.36 million by 2020.[1-3]

Reason for Indicated Intervention or Treatment
- Screening for evidence of poor control or disease progression and adjusting therapy as needed may protect against further damage to the optic nerve head.[4-8]

Evidence supporting Intervention or Treatment
- While increasing the frequency of visual field testing shortens the time to detection of a statistically significant change in vision, no well designed trials have specifically evaluated if routine visual field testing alone is associated with slower disease progression.[5, 6, 9-13]
- Several trials have demonstrated that lowering intraocular pressure reduces the risk of visual loss in patients with primary open angle glaucoma.[14-19]

Clinical Recommendations
- A recent evidence-based guideline recommended annual visual field testing for patients with glaucoma.[4]
- The American Academy of Ophthalmology recommends that patients with primary open-angle glaucoma who have achieved the target intraocular pressure, have no progression of damage, and have more than 6 months of control, receive visual field evaluations every 6 to 24 months.[20]

Comparative Baseline Data
Health Benchmark's 2004 average plan rate across all existing clients was 66%.

Denominator
Continuously enrolled members with a primary diagnosis of glaucoma by an ophthalmologist, optometrist, or mixed specialty group during the year prior to the reporting period.

Denominator Exclusion
None

Numerator
Members who had at least one visual field test during the reporting period or year prior to the reporting period.

Interpretation of Score
High score implies better performance
Physician Attribution

Score all physicians (in the selected specialties) who saw the member during the reporting year.

References


1 *Indicator Category* (Adapted from Health Plan Employer Data Information Set (HEDIS®) technical specifications and U.S. Preventive Services Task Force (USPSTF) Methodology)
Effectiveness

Primary Prevention Measures: Those that are applicable to individuals who are asymptomatic and are designed to prevent the onset of the targeted condition (e.g. immunizations);

Secondary Prevention Measures: Those that are applicable to asymptomatic patients who have risk factors or pre-clinical disease but in whom the condition has not become clinically apparent (e.g. pap smears, screening for elevated blood pressure);

Tertiary Prevention Measures: Those that are applicable to individuals who are diagnosed with a condition and are part of the treatment or management of patients with that condition (e.g. cholesterol reduction in patients with diabetes).

Strength of Recommendation (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

A  It is strongly recommended that clinicians provide the service to eligible patients. There is good evidence that the service improves important health outcomes and that benefits substantially outweigh harms.

B  It is recommended that clinicians provide the service to eligible patients. There is at least fair evidence that the service improves important health outcomes and that benefits outweigh harms.

C  Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

D  It is recommended that clinicians DO NOT routinely provide the service to eligible patients. There is at least fair evidence that the service is ineffective or that harms outweigh benefits.

I  The evidence is insufficient to recommend for or against routinely providing the service. Evidence that the service is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.

Quality of Evidence (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

Good: Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair: Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor: Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Quality of Evidence (Based on U.S. Preventive Services Task Force (USPSTF), 3rd Edition Criteria)

I: Evidence obtained from at least one properly randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3: Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III: Opinions of respected authorities, based on clinical experience descriptive studies and case reports or reports of expert committees.