Primary Care and Chronic Illness, Spring 2020 Cycle: CDP Report

DRAFT REPORT FOR COMMENT
AUGUST 5, 2020

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NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
Executive Summary

Primary care providers serve as the most common contact point for many people within the United States healthcare system. As such, primary care has a central role in improving the health of people and populations. Primary care practitioners work with each patient to manage the health of that individual. In the primary care setting, the diagnosis and treatment of the patient focuses on the health of the entire patient and not a single disease.

Chronic illnesses are long-lasting or persistent health conditions or diseases that patients and providers must manage on an ongoing basis. The incidence, impact, and cost of chronic disease is increasing in the United States. For example, more than 30 million Americans (9.4 percent) are living with diabetes, and in 2017, the U.S. spent $237 billion on diabetes care, making it one of the most expensive health conditions.\textsuperscript{1,2} In addition, studies have estimated the yearly costs for glaucoma, rheumatoid arthritis, and hepatitis C at $5.8 billion, $19.3 billion, and $6.5 billion, respectively.\textsuperscript{3-5} The net economic burden for medication nonadherence—a common issue with primary care patients—has been estimated at nearly $300 billion per year.\textsuperscript{6}

The review and evaluation of measures impacting primary care and dealing with chronic illness has long been a priority of the National Quality Forum (NQF), with endorsement for such measures going back to its inception. At present, there are 48 NQF-endorsed primary care and chronic illness measures. The background and description of NQF’s most recent Primary Care and Chronic Illness (PCCI) Standing Committee meeting as well as previous meetings are available on NQF’s project webpage. This Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of primary care services.

For this project, the Standing Committee evaluated three newly submitted measures against NQF’s standard evaluation criteria. The Committee did not recommend one measure for endorsement and did not reach consensus on two measures.

The Committee did not reach consensus on the following measures:

- 3569e Prediabetes: Screening for Abnormal Blood Glucose (American Medical Association)
- 3571e Retesting of Abnormal Blood Glucose in Patients with Prediabetes (American Medical Association)

The Committee did not recommend the following measure:

- 3570e Intervention for Prediabetes (American Medical Association)

Brief summaries of the measures currently under review are included in the body of the report; detailed summaries of the Committee’s discussion and ratings of the criteria for each measure are in Appendix A.
Introduction

Primary care providers serve as the most common contact point for many people within the U.S. healthcare system. As such, primary care has a central role in improving the health of people and populations.

Over the last 15 years, NQF has endorsed dozens of measures addressing improvements in primary care and chronic illnesses. These measures are used in many national and state-level public reporting and accountability programs, as well as for quality improvement. With the formation of the Primary Care and Chronic Illness Standing Committee in 2017, NQF was able to consolidate and streamline the measure maintenance and endorsement process for a broad set of measures related to primary care and chronic illness.

High-quality performance measurement that captures the complexity of primary care and chronic illnesses is essential to improve diagnosis, treatment, and management of conditions. NQF will review measures in these important healthcare areas under a consolidated measure portfolio that reflects the importance of caring for chronic illness in primary care settings. Measures may focus on nonsurgical eyes or ears, nose, and throat conditions; diabetes care; osteoporosis; HIV; rheumatoid arthritis; gout; back pain; asthma; chronic obstructive pulmonary disease (COPD); and acute bronchitis.

NQF Portfolio of Performance Measures for Primary Care and Chronic Illness Conditions

The Primary Care and Chronic Illness Standing Committee (Appendix C) oversees NQF’s portfolio of Primary Care and Chronic Illness measures (Appendix B) that includes 48 measures: 42 process measures (including one composite measure) and six outcome and resource use measures (see table below).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Process</th>
<th>Outcome</th>
<th>Intermediate Outcome</th>
<th>Composite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine</td>
<td>10</td>
<td>–</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>9</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>5</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Ears, Nose, Throat (ENT)</td>
<td>10</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Infectious Diseases (ID)</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>–</td>
</tr>
<tr>
<td>Total</td>
<td>42</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

Other measures related to primary care and chronic illness have been assigned to other portfolios. These include functional status measures (Patient Experience and Function), opioid use measures (Patient Safety and Behavioral Health and Substance Abuse), diabetes-related admission rate measures (Prevention and Population Health), and a variety of condition- or population-specific measures (Cardiovascular, Pediatric, Geriatrics and Palliative Care, etc.).
Primary Care and Chronic Illness Measure Evaluation

On June 25, June 26, and July 10, the Primary Care and Chronic Illness Standing Committee evaluated three new measures against NQF’s standard measure evaluation criteria.

Table 2. Primary Care and Chronic Illness Measure Evaluation Summary

<table>
<thead>
<tr>
<th>Maintenance</th>
<th>New</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Measures under consideration</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Measures recommended for endorsement</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Measures where consensus is not yet reached</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Measures not recommended for endorsement</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Reasons for not recommending</td>
<td>Importance – 0</td>
<td>Scientific Acceptability – 1</td>
</tr>
</tbody>
</table>

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on May 1, 2020 and will close on September 3, 2020. As of June 26, no comments were submitted and shared with the Committee prior to the measure evaluation meeting(s) (Appendix F).

Overarching Issue

During the Standing Committee’s discussion of the measures, an overarching issue emerged that was factored into the Committee’s ratings and recommendations for multiple measures and is not repeated in detail with each individual measure.

Accuracy Issues in Data Capture for eCQMs

Each of the measures evaluated this cycle were electronic clinical quality measures (eCQM). NQF requires measure developers to complete a feasibility scorecard for eCQMs that explores the ability of a given electronic health record (EHR) to capture the data fields necessary to calculate the measure according to the measure specifications. NQF has emphasized the need to move toward reducing the burden associated with quality measurement, with electronic measures that use data that occurs as part of documentation of normal care delivery within structured EHR fields as an important alternative to the more cumbersome measures that draw from medical chart abstraction. Nonetheless, many EHRs were not originally designed to serve as data sources for quality measurement and this can be problematic in
calculating eCQMs. Moreover, the structured fields that would be useful to populate a measure are often not present even in more advanced EHRs. This creates tension in the measure evaluation process when eCQMs do not exhibit high accuracy during feasibility scorecard testing. There has been concern that providers could be prospectively held accountable for eCQMs that do not display reliable calculation based on accuracy issues during the feasibility scorecard testing. Developers often address those concerns by citing EHR vendor commitment to the implementation of structured fields for capture of data critical to eCQM calculation if and when those measures are required, for example as part of reporting eCQMs within federal quality programs.

The NQF Primary Care and Chronic Illness Committee noted that the measure developer tested the three eCQMs evaluated this cycle within Epic and Cerner. These are the two largest EHR vendors and widely regarded as among the most advanced. The Committee expressed concern that strong accuracy was not reflected in the feasibility scorecard testing. This was especially true of data elements related to the focus of the measure, for example the capture of fasting blood glucose testing for NQF #3569e Prediabetes: Screening for Abnormal Blood Glucose. The Committee expressed concern that the clinician could order such a test for patients who would fall in the denominator of the measure, such a test could be performed and documented, but not accurately captured by the measure. The Committee considered accuracy issues in feasibility scorecard testing for the eCQMs to be threats to both the validity and feasibility of the measures.

**Summary of Measure Evaluation**

The following brief summaries of the measure evaluation highlight the major issues that the Committee considered. Details of the Committee’s discussion and ratings of the criteria for each measure are included in Appendix A.

**3569e Prediabetes: Screening for Abnormal Blood Glucose (American Medical Association): Consensus Not Reached**

**Description:** Percentage of patients aged 40 years and older with a BMI greater than or equal to 25 who are seen for at least two office visits or at least one preventive visit during the 12-month period who were screened for abnormal blood glucose at least once in the last 3 years; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Outpatient Services; **Data Source:** Electronic Health Records

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on validity—a must-pass criterion. The Committee will revote on the measure on the post-comment web meeting on September 24, 2020.

The Committee indicated support of measures that address prediabetes, acknowledging a gap in NQF-endorsed measures that specifically address the issue. Concerning the evidence criterion, Committee members agreed this is an important area of measurement and determined that the evidence submitted generally supports the measure. The Committee noted that the developer cited guidelines from the American Diabetes Association (ADA) as well as from the United States Preventative Services Task Force (USPSTF). The Committee questioned the reason that the measure does not have an age upper limit, noting the USPSTF guidance related to screening for diabetes for patients with high BMI between 40-70.
The Committee agreed a performance gap exists based on the literature despite the lack of actual data on patient care. During the discussion around reliability, Committee members raised concerns that this measure was only tested in two electronic health record (EHR) systems and was not tested with an EHR system less robust than Epic or Cerner. It was concerned with the eCQM feasibility scorecard for Epic and Cerner, noting that the accuracy results were not clear and that there may be poorer results in smaller EHR systems. The Committee passed the measure on reliability. Regarding validity testing, the Committee raised several concerns. The Committee noted that several of the data elements had accuracy issues and could present challenges with acquiring data across different providers. In particular, the Committee reviewed accuracy issues in the feasibility scorecard for eCQMs for fields related to fasting plasma glucose lab testing, glucose in serum plasma lab testing, and exclusions related to intervention orders for comfort care. It expressed the concern that since the focus of the measure is determining whether or not an appropriate test has been conducted, the measure should be especially accurate in detecting when such a test has occurred for patients in the denominator of the measure. Consensus was not reached on the validity of this measure. The measure was not regarded as feasible by Committee members citing the fact that fasting plasma glucose is not routinely captured during care and the fact that the exclusion of comfort measures is not easily captured in EHR software. The Committee did not express any concerns with use and usability.

3570e Intervention for Prediabetes (American Medical Association): Not Recommended

Description: Percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention; Measure Type: Process; Level of Analysis: Clinician: Group/Practice, Clinician: Individual; Setting of Care: Outpatient Services; Data Source: Electronic Health Records

The Standing Committee did not recommend the measure for initial endorsement. This is a new process measure which assesses the percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention. The Committee noted that overall there was good evidence for this measure and passed on this criterion. The Committee also noted that this measure could be an outcome measure but recognized that providers may not have the processes in place to achieve those outcomes and therefore a process measure is still useful. It had no concerns about performance gap. In terms of reliability, the Committee raised concerns about sampling methodology. It noted that convenience sampling did not necessarily indicate systematic bias. The Committee passed this measure on reliability. The Committee passed the measure on validity, but noted that the measure had concerns associated with the feasibility scorecard in that the accuracy of the data elements was questionable. The Committee did not pass the measure on feasibility, raising concerns that the fields needed to collect this measure are not present in the EHR. It acknowledged that the missing data will most likely be able to be captured in the future but note that currently this measure presents too great of a burden for implementation as manual review would be needed to confirm accuracy. The Committee did not have any concerns on use. For usability, the Committee noted that there are potential issues with lack of discrete fields to document the referral and patient lacking access to a diabetes prevention program because their insurance doesn’t cover it. It passed this measure on usability. The Committee observed that there are no related and competing measures to discuss for this measure.
3571e Retesting of Abnormal Blood Glucose in Patients with Prediabetes (American Medical Association): Consensus Not Reached

**Description:** Percentage of patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the previous year who have a blood glucose test performed in the one-year measurement period; **Measure Type:** Process; **Level of Analysis:** Clinician: Group/Practice, Clinician: Individual; **Setting of Care:** Outpatient Services; **Data Source:** Electronic Health Records

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on evidence and validity—both must-pass criteria. The Committee will revote on the measure on the post-comment web meeting on September 24, 2020.

The Committee began the discussion with a review of the evidence. The Committee questioned whether there was evidence to suggest that testing within one year is the correct time frame. The developer noted that the ADA recommended at least an annual retesting. Nonetheless, the Committee noted that there may be unintended consequences associated with testing frequently, namely false positives in testing for diabetes which will increase along with testing frequency. One Committee member noted that this is a process measure with less evidence to support it and expressed concern that the quality measurement enterprise generally has sufficient process measures and not enough outcome measures. When voting on evidence, the Committee did not pass the measure. Since the evidence this measure is based on is expert opinion rather than randomized control trials, the Committee took a vote to grant an exception to evidence. Consensus was not reached on the vote to grant an exception to the evidence provided. It observed the developer’s review of the literature that suggests a gap in care, noting that the United States has 84 million adults with prediabetes, that nine out of 10 patients who have prediabetes are not aware, and that missed opportunities among primary care providers in diagnosing and managing patients with prediabetes represent a gap in care.

In the discussion on validity, the Committee expressed some concern that the measure may not have had all data elements tested and that the eCQM feasibility scorecard assessment suggested that many data elements had issues in the accuracy domain, indicating that these data elements may not be accurately captured. The Committee did not achieve consensus on validity. In the review of the measure’s feasibility, it was also concerned that reporting the measure may be challenging since the accuracy of the data elements was not clear. The Committee did not reach consensus for the measure on feasibility. In the discussion on use, it noted that the measure has not been implemented, but the developer has the intention of submitting the measure to Centers for Medicare & Medicaid Services (CMS) for the Merit-based Incentive Payment System (MIPS) program. During the discussion on usability, the Committee noted that diabetes testing is not completely harmless since going into a primary care provider for regular screening can be burdensome for patients due to peripheral costs and inconvenience. The Committee did not achieve consensus on usability.

**Measures Withdrawn from Consideration**

There were no measures withdrawn from consideration this cycle.
References


### Appendix A: Details of Measure Evaluation

**Rating Scale:** H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable

#### Measures Where Consensus Is Not Yet Reached

<table>
<thead>
<tr>
<th>Measure</th>
<th>Submission</th>
<th>Specifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3569e Prediabetes: Screening for Abnormal Blood Glucose</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Description:</strong> Percentage of patients aged 40 years and older with a BMI greater than or equal to 25 who are seen for at least two office visits or at least one preventive visit during the 12-month period who were screened for abnormal blood glucose at least once in the last 3 years</td>
<td></td>
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</tr>
<tr>
<td><strong>Numerator Statement:</strong> <em>Screening for abnormal blood glucose may include using a fasting plasma glucose, 2-h plasma glucose during a 75g oral glucose tolerance test, or A1C.</em></td>
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</tr>
<tr>
<td><strong>Denominator Statement:</strong> All patients aged 43 years and older with a BMI greater than or equal to 25 seen for at least two office visits or at least one preventive visit during the 12-month measurement period</td>
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</tr>
<tr>
<td><strong>Exclusions:</strong> &quot;Patient is Pregnant at Encounter&quot; or &quot;Patient Has Active Diabetes Diagnosis at Encounter&quot; or &quot;Hospice During Measurement Period&quot; or &quot;Palliative Care During Measurement Period&quot; or &quot;Comfort Measures During Measurement Period&quot;</td>
<td></td>
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</tr>
<tr>
<td><strong>Adjustment/Stratification:</strong> No risk adjustment or risk stratification</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Level of Analysis:</strong> Clinician: Group/Practice, Clinician: Individual</td>
<td></td>
<td></td>
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<tr>
<td><strong>Setting of Care:</strong> Outpatient Services</td>
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<td></td>
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<tr>
<td><strong>Type of Measure:</strong> Process</td>
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<td></td>
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<tr>
<td><strong>Data Source:</strong> Electronic Health Records</td>
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<tr>
<td><strong>Measure Steward:</strong> American Medical Association</td>
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</table>

**STANDING COMMITTEE MEETING 06/25/2020**

1. **Importance to Measure and Report: The measure meets the importance criteria**
   (1a. Evidence, 1b. Performance Gap)
   1a. Evidence: H-4; M-17; L-1; I-0; 1b. Performance Gap: H-5; M-17; L-0; I-0

**Rationale:**
- Developer cites evidence found in guidelines from the United States Preventive Services Task Force (USPSTF) and from the American Diabetes Association (ADA).
  - The focus of the recommendations is lifestyle change.
  - USPSTF incorporated this evidence into the updated recommendation regarding screening for abnormal glucose and type 2 diabetes.
  - The grade B recommendation states that physicians should screen individuals for abnormal glucose if they are between the ages of 40 and 70 and are overweight or obese, or younger if they have additional risk factors.
  - The ADA recommends screening patients who are overweight or obese with one risk factor, regardless of age. Additionally, those who have no risk factors should start screening at age 45.
  - Developer notes that the risk factors included in this measure bring together both the USPSTF and ADA risk factors.
  - Testing for prediabetes and risk for future diabetes in asymptomatic people should be considered in adults of any age who are overweight or obese (BMI ≥25kg/m² or ≥23kg/m² in Asian Americans) and who have one or more additional risk factors for diabetes. (ADA, 2018) (B Recommendation)
Grade B recommendation means: “The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.”

- The Committee questioned the fact that the measure does not have an age upper limit, noting the USPSTF guidance related to screening for diabetes for patients with high BMI ages between 40-70.
- Developer provided a summary of the literature related to gaps in care. Developer states that their review of the literature suggests that the uninsured are less likely to be screened; Hispanics and black people are also more likely to be screened than white people.
- The Committee agreed that a performance gap exists based on the evidence in the literature, though the developer did not present their own data and analyses.

### 2. Scientific Acceptability of Measure Properties: The measure did not achieve consensus on the scientific acceptability criteria

**Reliability:** H-1; M-16; L-5; I-0

**Validity:** H-0; M-11; L-8; I-3

**Rationale:**

- Developer used same testing for both data element reliability and validity.
- Developer performed data element reliability/validity testing at two facilities on two common EHR systems, Epic and Cerner.
  - **Test Site #1:** An ambulatory facility in South Carolina, part of a larger health system comprised of eight inpatient hospitals and more than 100 outpatient facilities. This facility uses Epic EHR.
  - **Test Site #2:** An ambulatory facility in South Carolina, part of a larger system comprised of a 1,600+ bed comprehensive integrated health system, serving 1 million patients. This facility uses Cerner EHR.
- The feasibility assessment indicated the following data elements had issues in the accuracy domain indicating that these data elements may not be correct:
  - "Laboratory Test, Performed: Fasting Plasma Glucose Lab Test Mass Per Volume" (in Cerner and Epic) (measure developer noted that Fasting status of glucose testing is not captured in discrete fields in either EHR, however capturing A1C testing is feasible. To test for prediabetes, fasting plasma glucose, 2-h plasma glucose during 75-g oral glucose tolerance test, and A1C are equally appropriate)
  - "Intervention Order: Comfort Measures" (in Cerner) (measure developer noted that Comfort Care as an exclusion is standard in in NQF endocrine registry measures and it is expected that EMR developers to create a distinct field to collect this data in the future)
  - "Laboratory Test, Not Performed: Fasting glucose [Moles/volume] in Serum or Plasma" (in Cerner and Epic)
  - "Laboratory Test, Not Performed: Fasting Plasma Glucose Lab Test Mass Per Volume" (in Cerner and Epic)
  - "Laboratory Test, Not Performed: Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO" (in Cerner)
  - "Laboratory Test, Not Performed: Glucose [Moles/volume] in Serum or Plasma --2 hours post 75 g glucose PO" (in Cerner)
  - "Laboratory Test, Performed: Fasting glucose [Moles/volume] in Serum or Plasma" (in Cerner and Epic)
- Data element reliability/validity testing was conducted utilizing Parallel Forms Reliability Testing methodology to determine if data elements found through electronic data pulls could be confirmed by manual abstraction of the same data elements.
  - Verification of the data elements was obtained through automated data search strategies against a reference strategy (considered the gold standard) for obtaining the data elements.
  - Manual review of the data elements was used as the reference strategy against which automated data search and extraction strategies were evaluated.
  - Interrater reliability (crude agreement and Cohen’s Kappa) was used to assess the reliability of the measure based on results from two independent reviewers trained in the same way reviewing the same patient record.
Committee members raised concerns that this measure was only tested in two EHR systems and was not tested with an EHR system less robust than Epic or Cerner.

- The Committee noted that the accuracy results were not clear and that there may be poorer results in smaller EHR systems.
- The Committee noted that several of the data elements had accuracy issues and could present challenges with acquiring data across different providers.

3. Feasibility: H-0; M-5; L-14; I-1

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:
- During the discussion of feasibility, the Committee raised concerns about the lack of fasting glucose being listed as such in the EMR and the fact that that comfort measures are not necessarily standard.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

Rationale:
- The Committee did not express any concerns with use and usability.

5. Related and Competing Measures

- No related or competing measures noted.


7. Public and Member Comment

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals

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**3571e Retesting of Abnormal Blood Glucose in Patients with Prediabetes**

**Submission | Specifications**

**Description:** Percentage of patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the previous year who have a blood glucose test performed in the one-year measurement period

**Numerator Statement:** Patients who had a blood glucose test performed

*Retesting for abnormal blood glucose may include using a fasting plasma glucose, 2-h plasma glucose during a 75g oral glucose tolerance test, or A1C.

**Denominator Statement:** All patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the year prior to the one-year measurement period

**Abnormal lab result in the range of prediabetes includes a fasting plasma glucose level between 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) OR a 2-hour glucose during a 75g oral glucose tolerance test between 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) OR and A1C between 5.7-6.4% (39-47 mmol/mol).

**Exclusions:**
- Exclude patients who are pregnant.
- Exclude patients who have any existing diagnosis of diabetes (Type 1, Type 2, latent autoimmune diabetes of adults [LADA], monogenic diabetes [MODY]).
- Exclude patients in palliative care/hospice.
**Adjustment/Stratification:** No risk adjustment or risk stratification  
**Level of Analysis:** Clinician: Group/Practice, Clinician: Individual  
**Setting of Care:** Outpatient Services  
**Type of Measure:** Process  
**Data Source:** Electronic Health Records  
**Measure Steward:** American Medical Association

### STANDING COMMITTEE MEETING 06/25/2020

1. **Importance to Measure and Report:** The measure did not achieve consensus on the importance criteria  
   (1a. Evidence, 1b. Performance Gap)  
1a. Evidence: H-0; M-4; L-6; I-7; 1b. Performance Gap: H-1; M-10; L-3; I-3; Evidence Exception: Yes-10; No-7  
**Rationale:**  
- Developer cites evidence found in guidelines from the United States Preventive Services Task Force (USPSTF) and from the American Diabetes Association (ADA).  
  - At least annual monitoring for the development of diabetes in those with prediabetes is suggested. (ADA, 2018) (E Recommendation)  
  - Developer provides evidence of disease prevalence and systematic missing of opportunities to intervene by clinicians.  
  - Developer does not provide studies that offer evidence that annual monitoring is associated with positive outcomes.  
- The Committee noted that there is a lack of evidence to support this measure.  
- The Committee raised the concern that the quality measurement enterprise generally has sufficient process measures and not enough outcome measures.  
- The Committee observed the developer’s review of the literature that suggests a gap in care, noting that the United States has 84 million adults with prediabetes, that nine out of 10 patients who have prediabetes are not aware, and that missed opportunities among primary care providers in diagnosing and managing patients with prediabetes represent a gap in care.

2. **Scientific Acceptability of Measure Properties:** The measure did not achieve consensus on the scientific acceptability criteria  
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)  
2a. Reliability: H-0; M-12; L-5; I-0; 2b. Validity: H-0; M-9; L-7; I-1  
**Rationale:**  
- Developer used same testing for both data element reliability and validity.  
- Developer performed data element reliability/validity testing at two facilities on two common EHR systems.  
  - Test Site #1: An ambulatory facility in South Carolina, part of a larger health system comprised of eight inpatient hospitals and more than 100 outpatient facilities. This facility uses Epic EHR.  
  - Test Site #2: An ambulatory facility in South Carolina, part of a larger system comprised of a 1,600+ bed comprehensive integrated health system, serving 1 million patients. This facility uses Cerner EHR.  
- Submission includes simulated data set results demonstrating unit testing covering 100% of the measure logic.  
- The feasibility assessment indicated the following data elements had issues in the accuracy domain, indicating that these data elements may not be correct:  
  - Laboratory Test, Performed: Fasting Plasma Glucose Lab Test Mass Per Volume" (measure developer noted that fasting status of glucose testing is not captured in discrete fields in either EHR, however capturing A1C testing is feasible. To test for prediabetes, fasting plasma glucose, 2-h plasma glucose during 75-g oral glucose tolerance test, and A1C are equally appropriate. (in Cerner and Epic)  
  - "Laboratory Test, Performed: Fasting glucose [Moles/volume] in Serum or Plasma" (in Cerner and Epic)
"Laboratory Test, Not Performed: Fasting glucose [Moles/volume] in Serum or Plasma" (in Cerner and Epic)
"Laboratory Test, Not Performed: Glucose [Moles/volume] in Serum or Plasma --2 hours post 75 g glucose PO" (in Cerner)
"Laboratory Test, Not Performed: Fasting Plasma Glucose Lab Test Mass Per Volume" (in Cerner and Epic)
"Laboratory Test, Not Performed: Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO" (in Cerner)
"Intervention, Order: Comfort Measures" using "Comfort Measures (2.16.840.1.113883.17.4077.3.2030)" (measure developer noted that Comfort Care as an exclusion is standard in NQF endocrine registry measures and it is expected that EMR developers to create a distinct field to collect this data in the future) (in Cerner)

Data element reliability/validity testing was conducted utilizing Parallel Forms Reliability Testing methodology to determine if data elements found through electronic data pulls could be confirmed by manual abstractation of the same data elements.

- Verification of the data elements was obtained through automated data search strategies against a reference strategy (considered the gold standard) for obtaining the data elements.
- Manual review of the data elements was used as the reference strategy against which automated data search and extraction strategies were evaluated.
- Interrater reliability (crude agreement and Cohen's Kappa) was used to assess the reliability of the measure based on results from two independent reviewers trained in the same way reviewing the same patient record.

The Committee passed the measure on validity, but noted that the measure had concerns associated with the feasibility scorecard in that the accuracy of the data elements was questionable.

3. Feasibility: H-0; M-7; L-9; I-0
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)
Rationale:
- In the review of the measure’s feasibility, the Committee was concerned that reporting the measure may be challenging since the accuracy of the data elements was not clear.

4. Use and Usability
4a. Use: Pass-15; No Pass-2 4b. Usability: H-0; M-7; L-6; I-3
Rationale:
- The Committee noted that the measure has not been implemented, but the developer has the intention of submitting the measure to CMS for the MIPS program

5. Related and Competing Measures
- No related or competing measures noted.


7. Public and Member Comment

8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

9. Appeals
## Measure Not Recommended

<table>
<thead>
<tr>
<th>Measure</th>
<th>3570e Intervention for Prediabetes</th>
</tr>
</thead>
</table>

### Submission | Specifications

#### Description: Percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention*

**Numerator Statement:** Patients who were provided an intervention*

*Intervention must include one of the following: referral to a CDC-recognized diabetes prevention program; referral to medical nutrition therapy with a registered dietician; prescription of metformin.

**Denominator Statement:** All patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period

**Abnormal lab result in the range of prediabetes includes a fasting plasma glucose level between 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) OR a 2-hour glucose during a 75g oral glucose tolerance test between 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) OR A1C between 5.7-6.4% (39-47 mmol/mol).**

### Exclusions:

- Exclude patients who are pregnant.
- Exclude patients who have any existing diagnosis of diabetes (Type 1, Type 2, latent autoimmune diabetes of adults [LADA], monogenic diabetes [MODY])

### Adjustment/Stratification:

- No risk adjustment or risk stratification

### Level of Analysis:

- Clinician: Group/Practice, Clinician: Individual

### Setting of Care:

- Outpatient Services

### Type of Measure:

- Process

### Data Source:

- Electronic Health Records

### Measure Steward:

- American Medical Association

---

### STANDING COMMITTEE MEETING 06/25/2020

#### 1. Importance to Measure and Report: The measure meets the importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: H-0; M-16; L-2; I-2; 1b. Performance Gap: H-2; M-16; L-1; I-1

**Rationale:**

- Developer cites evidence primarily found in guidelines from the United States Preventive Services Task Force (USPSTF) and from the American Diabetes Association (ADA).
  - USPSTF grade B recommendation states that adults aged 40 to 70 years of age who are overweight or obese should be screened for abnormal blood glucose as part of cardiovascular risk assessment.
  - Referral of patients with abnormal blood glucose to intensive behavioral counseling interventions is also recommended by the USPSTF (grade B recommendation).
  - The ADA recommends an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program for prediabetes patients (grade A recommendation).
  - The developer cites ADA’s grade A recommendation on metformin therapy for preventing type 2 diabetes in individuals with prediabetes (<60 years, BMI ≥35 kg/m² and women with prior gestational diabetes mellitus).
  - An individualized medical nutrition therapy is recommended by ADA for all with type 1 or type 2 diabetes or gestational diabetes mellitus (grade A recommendation).

- The Committee noted that this measure could be specified as an outcome measure but acknowledged that providers may not yet have the processes in place to achieve outcomes.

### 2. Scientific Acceptability of Measure Properties: The measure meets the scientific acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: H-0; M-16; L-3; I-0; 2b. Validity: H-0; M-13; L-3; I-3

**Rationale:**

- Developer used same testing for both data element reliability and validity.
• Developer performed data element reliability/validity testing at two facilities on two common EHR systems.
  o Test Site #1: An ambulatory facility in South Carolina, part of a larger health system comprised of eight inpatient hospitals and more than 100 outpatient facilities. This facility uses Epic EHR.
  o Test Site #2: An ambulatory facility in South Carolina, part of a larger system comprised of a 1,600+ bed comprehensive integrated health system, serving 1 million patients. This facility uses Cerner EHR.
• Submission includes simulated data set results demonstrating unit testing covering 100% of the measure logic.
• The feasibility assessment indicated the following data elements had issues in the accuracy domain indicating that these data elements may not be correct:
  o "Laboratory Test, Performed: Glucose [Mass/volume] in Serum or Plasma --2 hours post 75 g glucose PO" Measure developer noted that fasting status of glucose testing is not captured in discrete fields in either EHR, however capturing A1C testing is feasible. To test for pre-diabetes, fasting plasma glucose, 2-h plasma glucose during 75-g oral glucose tolerance test, and A1C are equally appropriate (in Cerner and Epic)
  o "Laboratory Test, Performed: Fasting glucose [Moles/volume] in Serum or Plasma" (in Cerner and Epic)
  o "Intervention, Performed: Referral to Dietitian" (measure developer noted that it is expected that EMR developers to create a distinct field to collect this data in the future.) (in Cerner and Epic)
  o "Intervention, Performed: Referral to Diabetes Prevention Program" (measure developer noted that it is expected that EMR developers to create a distinct field to collect this data in the future) (in Cerner and Epic)
  o "Intervention, Not Performed: Referral to Diabetes Prevention Program" (in Cerner and Epic)
  o "Intervention, Not Performed: Referral to Dietitian" (in Cerner and Epic)
  o "Medication, Not Ordered: Metformin" (in Cerner)
  o "Diagnosis: Limited Life Expectancy" (in Cerner)
  o "Encounter, Performed: Nursing Facility Visit" (in Cerner)
• Data element reliability/validity testing was conducted utilizing Parallel Forms Reliability Testing methodology to determine if data elements found through electronic data pulls could be confirmed by manual abstraction of the same data elements.
  o Verification of the data elements was obtained through automated data search strategies against a reference strategy (considered the gold standard) for obtaining the data elements.
  o Manual review of the data elements was used as the reference strategy against which automated data search and extraction strategies were evaluated.
  o Interrater reliability (crude agreement and Cohen’s Kappa) was used to assess the reliability of the measure based on results from two independent reviewers trained in the same way reviewing the same patient record.
• In terms of reliability, the Committee raised concerns around the sampling methodology. It noted that convenience sampling did not necessarily indicate systematic bias.
• The Committee expressed concern that the measure may not have had all data elements tested and that the eCQM feasibility scorecard assessment indicated the many data elements had issues in the accuracy domain, indicating that these data elements may not be accurately captured.

3. Feasibility: H-0; M-5; L-15; I-1
(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/unintended consequences identified 3d. Data collection strategy can be implemented)
Rationale:
• The Committee raised concerns that the fields needed to collect this measure are not present in the EHR.

4. Use and Usability
<table>
<thead>
<tr>
<th>4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>4a. Use: Pass-18; No Pass-0 4b. Usability: H-0; M-10; L-6; I-2</td>
</tr>
<tr>
<td>Rationale:</td>
</tr>
<tr>
<td>• For usability, the Committee noted that there are potential issues due to a lack of discrete fields to document the referral and due to patients lacking access to a diabetes prevention program because their insurance doesn’t cover the services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Related and Competing Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No related or competing measures noted.</td>
</tr>
</tbody>
</table>

| 6. Standing Committee Recommendation for Endorsement: Yes-5; No-13 |

| 7. Public and Member Comment |

| 8. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X |

| 9. Appeals |
### Appendix B: Primary Care and Chronic Illness Portfolio—Use in Federal Programs

<table>
<thead>
<tr>
<th>NQF #</th>
<th>Title</th>
<th>Federal Programs: Implemented or Finalized as of February 22, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>0046</td>
<td>Screening for Osteoporosis for Women 65-85 Years of Age</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0047</td>
<td>Asthma: Pharmacologic Therapy for Persistent Asthma</td>
<td>None</td>
</tr>
<tr>
<td>0053</td>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized), Medicare Part C Star Rating (Implemented)</td>
</tr>
<tr>
<td>0054</td>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)</td>
<td>None</td>
</tr>
<tr>
<td>0055</td>
<td>Comprehensive Diabetes Care: Eye Exam (retinal) performed</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0056</td>
<td>Comprehensive Diabetes Care: Foot Exam</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0057</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing</td>
<td>Medicaid (Implemented), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0058</td>
<td>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)</td>
<td>Medicare Physician Quality Reporting System, Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0059</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (&gt;9.0%)</td>
<td>Medicaid (Implemented), Medicare Shared Savings Program (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0061</td>
<td>Comprehensive Diabetes Care: Blood Pressure Control (&lt;140/90 mm Hg)</td>
<td>None</td>
</tr>
<tr>
<td>0062</td>
<td>Comprehensive Diabetes Care: Medical Attention for Nephropathy</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized), Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0086</td>
<td>Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0087</td>
<td>Age-Related Macular Degeneration: Dilated Macular Examination</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0088</td>
<td>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</td>
<td>None</td>
</tr>
<tr>
<td>0089</td>
<td>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
</tbody>
</table>

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* Per CMS Measures Inventory Tool as of 07/09/2020

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**NATIONAL QUALITY FORUM**

NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>0091</td>
<td>COPD: Spirometry Evaluation</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0405</td>
<td>HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0409</td>
<td>HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0416</td>
<td>Diabetic Foot &amp; Ankle Care, Ulcer Prevention – Evaluation of Footwear</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0417</td>
<td>Diabetic Foot &amp; Ankle Care, Peripheral Neuropathy – Neurological Evaluation</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0541</td>
<td>Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category</td>
<td>Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0563</td>
<td>Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0566</td>
<td>Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement</td>
<td>None</td>
</tr>
<tr>
<td>0575</td>
<td>Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (&lt;8.0%)</td>
<td>Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented)</td>
</tr>
<tr>
<td>0577</td>
<td>Use of Spirometry Testing in the Assessment and Diagnosis of COPD</td>
<td>None</td>
</tr>
<tr>
<td>0653</td>
<td>Acute Otitis Externa: Topical Therapy</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0654</td>
<td>Acute Otitis Externa: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>0655</td>
<td>Otitis Media with Effusion: Antihistamines or decongestants – Avoidance of inappropriate use</td>
<td>None</td>
</tr>
<tr>
<td>0657</td>
<td>Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Implemented)</td>
</tr>
<tr>
<td>0729</td>
<td>Optimal Diabetes Care</td>
<td>None</td>
</tr>
<tr>
<td>1800</td>
<td>Asthma Medication Ratio</td>
<td>Medicaid (Implemented)</td>
</tr>
<tr>
<td>2079</td>
<td>HIV medical visit frequency</td>
<td>Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
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<tr>
<td>2080</td>
<td>Gap in HIV medical visits</td>
<td>None</td>
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<tr>
<td>2082</td>
<td>HIV viral load suppression</td>
<td>Medicaid (Implemented), Merit-Based Incentive Payment System (MIPS) Program (Finalized)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Value</td>
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<tr>
<td>-------</td>
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<td>-------</td>
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<tr>
<td>2083</td>
<td>Prescription of HIV Antiretroviral Therapy</td>
<td>None</td>
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<tr>
<td>2522e</td>
<td>Rheumatoid Arthritis: Tuberculosis Screening</td>
<td>None</td>
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<tr>
<td>2523e</td>
<td>Rheumatoid Arthritis: Assessment of Disease Activity</td>
<td>None</td>
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<tr>
<td>2524e</td>
<td>Rheumatoid Arthritis: Functional Status Assessment</td>
<td>None</td>
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<tr>
<td>2525e</td>
<td>Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy</td>
<td>None</td>
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<tr>
<td>2549e</td>
<td>Gout: Serum Urate Target</td>
<td>None</td>
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<tr>
<td>2550e</td>
<td>Gout: ULT Therapy (Recommended for eMeasure Trial Approval)</td>
<td>None</td>
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<tr>
<td>2811e</td>
<td>Acute Otitis Media - Appropriate First-Line Antibiotics</td>
<td>None</td>
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<tr>
<td>2856</td>
<td>Pharmacotherapy Management of COPD Exacerbation</td>
<td>None</td>
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<td>3086</td>
<td>Population Level HIV Viral Load Suppression</td>
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<td>3209e</td>
<td>HIV medical visit frequency</td>
<td>None</td>
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<tr>
<td>3210e</td>
<td>HIV viral load suppression</td>
<td>None</td>
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<tr>
<td>3211e</td>
<td>Prescription of HIV Antiretroviral Therapy</td>
<td>None</td>
</tr>
<tr>
<td>3569e</td>
<td>Prediabetes: Screening for Abnormal Blood Glucose</td>
<td>None</td>
</tr>
<tr>
<td>3570e</td>
<td>Intervention for Prediabetes</td>
<td>None</td>
</tr>
<tr>
<td>3571e</td>
<td>Retesting of Abnormal Blood Glucose in Patients with Prediabetes</td>
<td>None</td>
</tr>
</tbody>
</table>
Appendix C: Primary Care and Chronic Illness Standing Committee and NQF Staff

STANDING COMMITTEE

Dale Bratzler, DO, MPH (Co-Chair)
University of Oklahoma Health Sciences Center-College of Public Health
Oklahoma City, OK

Adam Thompson, BA (Co-Chair)
Kennedy Health Alliance
Berlin, NJ

Robert A. Bailey, MD
Janssen Scientific Affairs, LLC
Titusville, NJ

Lindsay Botsford, MD, MBA, MBA/FAAFP
Physicians at Sugar Creek
Sugar Land, TX

Kathleen Brady, MD, MSCE
Philadelphia Department of Public Health
Philadelphia, PA

Roger Chou, MD
Oregon Health & Science University
Cochrane Back and Neck Group
Portland, OR

James M. Daniels, MD, MPH, RMSK, FAAFP, FACOEM, FACP
Illinois University
Quincy, Illinois

Kim Elliott, PhD
Health Services Advisory Group, Inc.
Phoenix, AZ

Donald Goldmann, MD
Institute for Healthcare Improvement
Boston, Massachusetts

V. Katherine Gray, PhD
Sage Health Management Solutions, Inc.
Minneapolis, Minnesota

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
Faith Green, MSN, RN, CPHQ, CPC-A  
Humana  
Louisville, Kentucky

Daniel Greninger, MD  
The Permanente Medical Group  
Antioch, California

Stephen Grossbart, PhD  
Health Catalyst  
Salt Lake City, UT

James Michell Harris  
Children’s Hospital Association  
Washington, DC

Starlin Haydon-Greatting, MS, BS, Pharm, FAPhA  
Illinois Pharmacists Association  
Springfield, Illinois

Ann Kearns, MD, PhD  
Mayo Clinic  
Rochester, MN

Grace Lee, MD  
Virginia Mason Medical Center  
Seattle, WA

Jason Matuszak, MD, FAAFP  
The Sports Concussion Center  
Excelsior Orthopaedics  
Amherst, NY

Anna McCollister  
Galileo Analytics  
Washington, DC

Janice Miller, DNP, CRNP, AGPCNP-BC, CDE  
Thomas Jefferson University  
Philadelphia, PA

Crystal Riley, PharmD, MHA, MBA, CPHQ, CHPIT  
Baxter Healthcare Corporation  
Washington, DC

Rishi Singh, MD  
Cleveland Clinic  
Cleveland, Ohio

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
Appendix D: Measure Specifications

3569e Prediabetes: Screening for Abnormal Blood Glucose

STEWARD
American Medical Association

DESCRIPTION
Percentage of patients aged 40 years and older with a BMI greater than or equal to 25 who are seen for at least two office visits or at least one preventive visit during the 12-month period who were screened for abnormal blood glucose at least once in the last 3 years

TYPE
Process

DATA SOURCE
Electronic Health Records Measure data elements will be collected through health care organization electronic health record query, electronic health data queries

LEVEL
Clinician : Group/Practice, Clinician : Individual

SETTING
Outpatient Services

NUMERATOR STATEMENT
*Screening for abnormal blood glucose may include using a fasting plasma glucose, 2-h plasma glucose during a 75g oral glucose tolerance test, or A1C.

NUMERATOR DETAILS
exists "A1c Test Performed Within Past 3 Years"
or exists "Fasting Plasma Glucose Test Performed Within Past 3 Years"
or exists "Two Hour Plasma Glucose During 75 Gram Oral Glucose Tolerance Test Performed Within Past 3 Years"
See additional code sets and materials in attachments

DENOMINATOR STATEMENT
All patients aged 43 years and older with a BMI greater than or equal to 25 seen for at least two office visits or at least one preventive visit during the 12-month measurement period

DENOMINATOR DETAILS
Denominator
"Initial Population"
and exists ( ["Patient Characteristic Birthdate": "Birth date"] BirthDate
where Global."CalendarAgeInYearsAt" ( BirthDate.birthDatetime, start of "Measurement Period" ) >= 43

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
)  
and "Highest BMI Documented During Measurement Period is Greater Than or Equal to 25"
See attachment in human readable file in S.2a

EXCLUSIONS

Denominator Exclusions
"Patient is Pregnant at Encounter"
  or "Patient Has Active Diabetes Diagnosis at Encounter"
  or "Hospice During Measurement Period"
  or "Palliative Care During Measurement Period"
  or "Comfort Measures During Measurement Period"

EXCLUSION DETAILS

See attachment in human readable file in S.2a

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

See attachment in human readable file in S.2a 151659

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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. The AMA disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.


3570e Intervention for Prediabetes

STEWARD

American Medical Association

NATIONAL QUALITY FORUM

NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
DESCRIPTION
Percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention*

TYPE
Process

DATA SOURCE
Electronic Health Records Measure data elements will be collected through health care organization electronic health record query, electronic health data queries

LEVEL
Clinician : Group/Practice, Clinician : Individual

SETTING
Outpatient Services

NUMERATOR STATEMENT
Patients who were provided an intervention*
*Intervention must include one of the following: referral to a CDC-recognized diabetes prevention program; referral to medical nutrition therapy with a registered dietician; prescription of metformin.

NUMERATOR DETAILS
Please see attachment in S.2a for all information required to calculate numerator

DENOMINATOR STATEMENT
All patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period
**Abnormal lab result in the range of prediabetes includes a fasting plasma glucose level between 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) OR a 2-hour glucose during a 75g oral glucose tolerance test between 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) OR and A1C between 5.7-6.4% (39-47 mmol/mol).

DENOMINATOR DETAILS
Please see attachment in S.2a for all information required to calculate denominator

EXCLUSIONS
Denominator Exclusions:
Exclude patients who are pregnant.
Exclude patients who have any existing diagnosis of diabetes (Type 1, Type 2, latent autoimmune diabetes of adults [LADA], monogenic diabetes [MODY])

EXCLUSION DETAILS
Please see attachment in S.2a for all information required to calculate denominator exclusions

RISK ADJUSTMENT
No risk adjustment or risk stratification

NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
3571e Retesting of Abnormal Blood Glucose in Patients with Prediabetes

STEWARD
American Medical Association

DESCRIPTION
Percentage of patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the previous year who have a blood glucose test performed in the one-year measurement period

TYPE
Process

DATA SOURCE
Electronic Health Records Measure data elements will be collected through health care organization electronic health record query, electronic health data queries.

LEVEL
Clinician : Group/Practice, Clinician : Individual

SETTING
Outpatient Services
NUMERATOR STATEMENT
Patients who had a blood glucose test performed
*Retesting for abnormal blood glucose may include using a fasting plasma glucose, 2-h plasma glucose during a 75g oral glucose tolerance test, or A1C.

NUMERATOR DETAILS
See attached file in S.2a and S.2b for information to calculate the numerator

DENOMINATOR STATEMENT
All patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the year prior to the one-year measurement period
**Abnormal lab result in the range of prediabetes includes a fasting plasma glucose level between 100 mg/dL (5.6 mmol/L) to 125 mg/dL (6.9 mmol/L) OR a 2-hour glucose during a 75g oral glucose tolerance test between 140 mg/dL (7.8 mmol/L) to 199 mg/dL (11.0 mmol/L) OR and A1C between 5.7-6.4% (39-47 mmol/mol).

DENOMINATOR DETAILS
See attached file in S.2a and S.2b for information to calculate the denominator

EXCLUSIONS
Denominator Exclusions:
Exclude patients who are pregnant.
Exclude patients who have any existing diagnosis of diabetes (Type 1, Type 2, latent autoimmune diabetes of adults [LADA], monogenic diabetes [MODY]).
Exclude patients in palliative care/hospice

EXCLUSION DETAILS
See attached file in S.2a and S.2b for information to calculate the exclusions

RISK ADJUSTMENT
No risk adjustment or risk stratification

STRATIFICATION
n/a

TYPE SCORE
Rate/proportion better quality = higher score

ALGORITHM
See attached file in S.2a for information to calculate the measure logic 151659

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NATIONAL QUALITY FORUM
NQF REVIEW DRAFT—Comments due by September 3, 2020 by 6:00 PM ET.
Appendix E: Related and Competing Measures

There are no related or competing measures.
Appendix F: Pre-Evaluation Comments

No comments were received as of June 26, 2020.