



## 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 #:** 3571e

**Corresponding Measures:**

**De.2. Measure Title:** Retesting of Abnormal Blood Glucose in Patients with Prediabetes

**Co.1.1. Measure Steward:** American Medical Association

**De.3. Brief Description of Measure:** 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

**1b.1. Developer Rationale:** At least annual glucose testing in patients who were previously found to have lab results in the range of prediabetes is an important aspect of care so that patients can be monitored for improvement or potential transition to Type 2 diabetes. While there are no current studies that show patients with prediabetes who do not have follow-up testing completed, the physician-led technical expert panel (TEP) felt that this is a key area in which to have a measure. Preventing the onset of type 2 Diabetes by screening for prediabetes, with the goal of referring for treatment and prevention, will help to reduce the 84 million patients with prediabetes, and the overall number that eventually are diagnosed with type 2 diabetes. Furthermore, cost savings for prevention of type 2 diabetes have the potential to be significant. For every beneficiary, at 15 months, costs savings are at least \$ 2,650.00 per person.

**S.4. 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.

**S.6. 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).

**S.8. 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

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

**S.17. Data Source:** Electronic Health Records

**S.20. Level of Analysis:** Clinician : Group/Practice, Clinician : Individual

**IF Endorsement Maintenance – Original Endorsement Date: Most Recent Endorsement Date:**

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

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

**De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results?**

## 1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all 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

[NQF\\_evidence\\_attachment\\_Retesting\\_of\\_Abnormal\\_Glucose\\_-637233243736906821.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.*

At least annual glucose testing in patients who were previously found to have lab results in the range of prediabetes is an important aspect of care so that patients can be monitored for improvement or potential transition to Type 2 diabetes. While there are no current studies that show patients with prediabetes who do not have follow-up testing completed, the physician-led technical expert panel (TEP) felt that this is a key area in which to have a measure. Preventing the onset of type 2 Diabetes by screening for prediabetes, with the goal of referring for treatment and prevention, will help to reduce the 84 million patients with prediabetes, and the overall number that eventually are diagnosed with type 2 diabetes. Furthermore, cost savings for prevention of type 2 diabetes have the potential to be significant. For every beneficiary, at 15 months, costs savings are at least \$ 2,650.00 per person.

**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.*

This measure has not yet been implemented

**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.**

Strong evidence exists that rates of screening patients for prediabetes and undiagnosed diabetes are suboptimal in clinical care, especially in patients who are at high risk for developing type 2 diabetes. Approximately 1/3 of physicians reported screening patients for prediabetes according to guidelines (ADA and USPSTF).

In a nationally representative sample of patients from the National Health and Nutrition Examination Survey (NHANES) from 2005-2012, only 45% of those who met screening criteria were screened. Furthermore, follow-up screening of this sub-set of patients who are initially screened is even less prevalent.

**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.*

This measure has not yet been implemented

**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 are no published studies to address this disparity at one year follow-up, but we would point to the studies that address the lack of screening for prediabetes as a initial reason why this measure is critical.

## 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):

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

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

**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 an eMeasure Attachment: [RetestGlucose\\_v5\\_8\\_Artifacts\\_20200106.zip](#)

**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: [Copy\\_of\\_Retest\\_Abnormal\\_Blood\\_Glucose\\_Value\\_Sets\\_20200106.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.

**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.

**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).

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.

**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).

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

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

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).

**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).

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

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

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

**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.)

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

**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.)

n/a

**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.)

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

**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.

Electronic Health Records

**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.

Measure data elements will be collected through health care organization electronic health record query, electronic health data queries.

**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)

Clinician : Group/Practice, Clinician : Individual

**S.21. Care Setting** (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

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**

NQF\_testing\_attachment\_Retesting\_of\_Glucose\_for\_Prediabetes.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.

## 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.*

## 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.*

## 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)

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 health records (EHRs)

**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).

**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:** [Copy\\_of\\_NQF\\_Feasibility\\_Scorecard\\_-\\_AMA\\_Retesting\\_For\\_Abnormal\\_Glucose.xlsx](#), [Bonnie\\_Report\\_-\\_Retesting\\_of\\_Abnormal\\_BG.pdf](#)

### 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.

N/A

**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).**

None

## 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)

**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

This measure has not yet been implemented

**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?)

There are several discussions underway for this measure to be adopted and implemented in public programs, and we describe the plan and expected timeframes below in 4a 1.3

**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.)

Plans for this measure to be adopted and implemented in public programs are underway. The AMA's goal is for this measure to be included in the MIPS QPP to complement the prediabetes IAs, so we will be submitting to the CMS MUC list call for measures in 2020. Furthermore, CMS CMMI has reached out to the AMA to adopt this measure for the Maryland Primary Care Program's public reporting program for 2021. Ongoing discussions are currently underway and there is a plan in place for this measure to be implemented into this program. Additionally, CMS has already met with the AMA to discuss this measure being included (as part of the set) in a Prediabetes MIPS Value Pathway (MVP) for the 2021 performance period.

**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.**

[This measure has not yet been implemented](#)

**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.**

[This measure has not yet been implemented](#)

**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.**

[This measure has not yet been implemented](#)

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

[This measure has not yet been implemented](#)

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

[This measure has not yet been implemented](#)

**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.**

[This measure has not yet been implemented](#)

#### **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.**

[This measure has not yet been implemented](#)

#### **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.**

[This measure has not yet been implemented](#)

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

[This measure has not yet been implemented](#)

## **5. Comparison to Related or Competing Measures**

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

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

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually



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

No

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

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

**5a. Harmonization 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?**

Yes

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

**5b. Competing Measures**

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

**OR**

Multiple measures are justified.

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

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

There are no competing measures for prediabetes, this the first set of measures in U.S. to address this condition.

**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):** American Medical Association

**Co.2 Point of Contact:** Beth, Tapper, beth.tapper@ama-assn.org, 312-933-6636-

**Co.3 Measure Developer if different from Measure Steward:** American Medical Association

**Co.4 Point of Contact:** Beth, Tapper, beth.tapper@ama-assn.org, 312-933-6636-

**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.**

Ronald T Ackermann, MD, MPH (Co-Chair) Northwestern University  
Senior Associate Dean for Public Health

Director, Institute for Public Health and Medicine (IPHAM) - Center for Community Health  
Director, Center for Diabetes and Metabolism  
Professor of Medicine (General Internal Medicine and Geriatrics), Medical Social Sciences and Medicine (Endocrinology)

William Golden, MD, MACP (Co-Chair)      Professor of Medicine and Public Health  
University of Arkansas for Medical Sciences  
Medical Director  
Arkansas DHS/Medicaid

Mary Carol Greenlee, MD, FACP, FACE      Endocrinologist  
Faculty for TCPi (national faculty and Colorado Practice Transformation Network faculty)

Mary E Krebs, MD  
Family Medicine Physician and Faculty  
HealthSource of Ohio and Soin Family Medicine Residency

Ameldia R. Brown MDiv, BSN, RN  
Director Faith and Community Health  
Henry Ford Health System; Henry Ford Macomb Hospital

Leslie Kolb, RN, BSN, MBA  
Vice President of Science and Practice  
American Association of Diabetes Educators

Jennifer Torres Mosst, PhD, MscPH, MSSW  
Program Manager, Diabetes Prevention and Health System Strategies  
Los Angeles County Department of Public Health

Tannaz Moin, MD, MBA, MSHS  
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Anita Stewart, MD, MPH, JD  
Medical Director for Medicare/Medicaid Programs  
BlueCross BlueShield Illinois

Maria Prince, MD, MPH  
Medical Director  
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Laura Clapper, MD, MPPA, CPE, FAAPL  
Regional Vice President  
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Elizabeth Joy, MD, MPH  
Physician, Medical Director  
Community Health and Food & Nutrition  
Intermountain Healthcare

Stephen Benoit, MD, MPH Medical Epidemiologist  
Centers for Disease Control

James L. Rosenzweig, MD Endocrinologist  
CDC Subject Matter Expert

Ann Albright, PhD, RD

AMA Staff

Kate Kirley, MD, MS

Karen Kmetik, PhD

Koryn Rubin

Beth Tapper, MA

Greg Wozniak, PhD

PCPI Foundation-consultants to this measure development project

Beth Bostrom, MPH

Kerri Fei, MSN, RN

Diedra Gray, MPH

Courtney Hurt, MSW, LCSW

Sam Tierney, MPH

Patrick Yep, MS, MPH

Technical expert panel members played a key role in the evidence review, development of the draft measures through an in-person consensus development process, and refinement and revision of the measures post-public comment. TEP members also helped with final measure revisions and approval of the measures in their current form.

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

**Ad.2 Year the measure was first released:** 2019

**Ad.3 Month and Year of most recent revision:** 12, 2019

**Ad.4 What is your frequency for review/update of this measure?** yearly

**Ad.5 When is the next scheduled review/update for this measure?** 12, 2020

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**Ad.8 Additional Information/Comments:** We believe this measure, as part of the full measure set is necessary to reduce chronic disease burden. An estimated 30 million Americans have diabetes. This epidemic will continue to grow unless clinicians screen patients for prediabetes and manage at risk patients with preventive interventions. This measure addresses important areas that are critical to quality of care, improved outcomes, and lowered costs in the prevention and treatment of chronic disease, specifically:

- Improving patient outcomes by preventing or delaying progression of type 2 diabetes
- Reducing medical expenditures associated with type 2 diabetes and its complications by identifying and addressing prediabetes before progression to type 2 diabetes
- Improving clinical practice burden associated with treating diabetes by referring patients for treatment of their prediabetes

The United States has 84 million adults with prediabetes, putting them at a higher risk for developing type 2 diabetes.