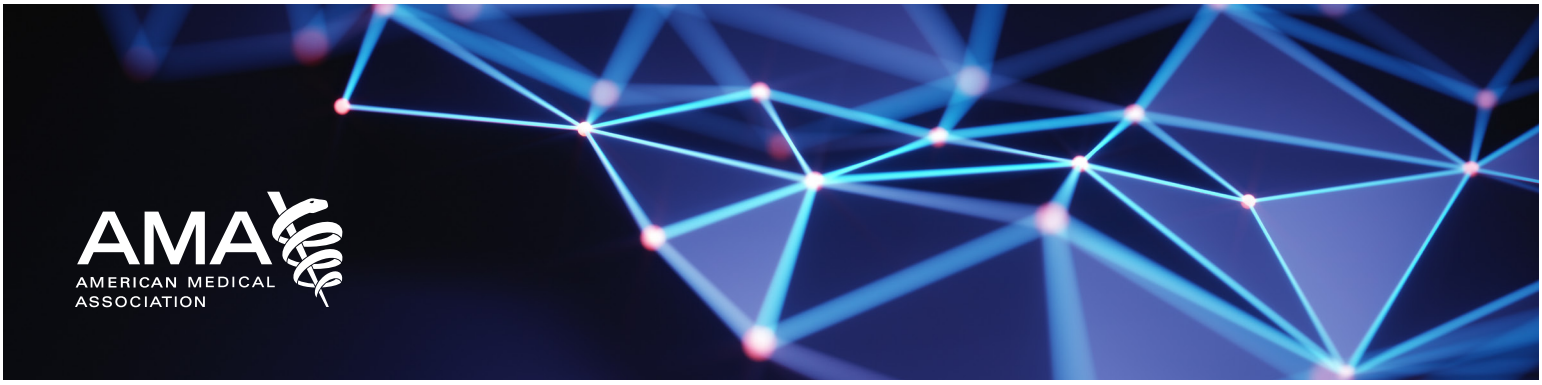

Disease focus: Prediabetes

The American Medical Association offers numerous resources to help your practice improve the quality of care you offer your patients with prediabetes to prevent type 2 diabetes. In fact, your practice's implementation of a performance improvement initiative to prevent type 2 diabetes in your patient population can help you succeed in Medicare's Merit-Based Incentive Payment System (MIPS).

This document outlines the different measures that relate to diabetes prevention in each MIPS performance category, potential MIPS score results, and related AMA resources that can help you improve the health of your patients with prediabetes while checking all your MIPS boxes along the way.

The following measures and resources are for all practice types and practice sizes. Based on your practice size, different scoring may apply. Please see the AMA's Understanding Medicare's Merit-Based Incentive Payment System page for more information about the MIPS program, scoring strategies and bonus point opportunities.

The AMA, through its Improving Health Outcomes group, also offers personalized consulting, technical assistance and support at no cost to your practice to implement a diabetes prevention strategy. The AMA has worked directly with health care organizations and physicians across the nation to successfully identify and manage patients at-risk for type 2 diabetes. For more information, email iho-info@ama-assn.org.

Additionally, most of the tools and resources referenced here can be accessed through the "Prevent Diabetes STAT: Screen, Test, Act – Today™" website (preventdiabetesstat.org).

MIPS performance category: Promoting Interoperability (formerly "Advancing Care Information")

Scoring: 25 percent of the MIPS composite score

Promoting Interoperability (PI) is about using certified electronic health record technology (CEHRT) and the health care information your practice captures in a meaningful way. PI is the new name for the Advancing Care Information (ACI) category. For more information about the PI category and scoring, see the AMA's MIPS Action Plan.

Suggested prediabetes PI MEASURES

- Patient-specific education (PI_PEA_2 or PI_TRANS_PSE_1)
  - The MIPS-eligible clinician must use clinically relevant information from CEHRT to identify patient-specific educational resources and provide access to those materials to at least one unique patient seen by the MIPS-eligible clinician.
- Patient-generated health data (PI_CCTPE_3)
  - Patient-generated health data or data from a non-clinical setting is incorporated into the CEHRT for at least one unique patient seen by the MIPS-eligible clinician during the performance period.

Prevent Diabetes STAT

The AMA has created tools and resources to educate patients and physicians about risk factors and treatments for prediabetes. Below are some of the resources available from the AMA that clinical care teams can integrate into practice and use to successfully meet MIPS ACI measure reporting.

RESOURCES TO USE FOR PATIENT-SPECIFIC EDUCATION (PI_PEA_2 or PI_TRANS_PSE_1)

Are you at risk for prediabetes?
Use this patient handout to increase awareness about screening, testing and referral.

So you have prediabetes ... Now what?
This patient handout provides the patient with concrete information on prediabetes.

Why participate in a diabetes prevention program?
This patient handout educates patients about prediabetes and the benefits of a lifestyle treatment program.

RESOURCES TO USE FOR PATIENT-GENERATED HEALTH DATA (PI_CCTPE_3; please note that this measure is only applicable to practices using 2015 Edition CEHRT)

Do you have prediabetes risk test?
This questionnaire offers patients the opportunity to learn about their risk for prediabetes while helping care teams identify patients at great risk. This can be done using the online risk test screener or through patient portal messaging.

MIPS performance category: Improvement Activities

Scoring: 15 percent of total MIPS composite score

The "Improvement Activities" category is a new area of reporting that incentivizes practices to delve more deeply to find opportunities to improve care delivery, access and patient engagement. For more information on improvement activities and MIPS scoring, see the AMA's MIPS Action Plan.

Suggested prediabetes IA

- Chronic care and preventative care management for empaneled patients (IA_PM_13)
  - Proactively manage chronic and preventive care for empaneled patients that could include one or more of the following:
    - Provide patients annually with an opportunity for development and/or adjustment of an individualized plan of care as appropriate to age and health status, including health risk appraisal; gender, age and condition-specific preventive care services; and plan of care for chronic conditions
    - Use condition-specific pathways for care of chronic conditions (e.g., hypertension, diabetes, depression, asthma and heart failure) with evidence-based protocols to guide treatment to target, such as a CDC-recognized diabetes prevention program
    - Use pre-visit planning to optimize preventive care and team management of patients with chronic conditions
    - Use panel support tools (registry functionality) to identify services due
    - Use predictive analytical models to predict risk, onset and progression of chronic diseases
    - Use reminders and outreach (e.g., phone calls, emails, postcards, patient portals and community health workers where available) to alert and educate patients about services due, and/or routine medication reconciliation
- Glycemic screening services (IA_PM_19)
  - Use systematic preventive approaches to screen Medicare patients for abnormal blood glucose according to current clinical guidelines.
- Glycemic referring services (IA_PM_20)
  - Use systematic preventive approaches to refer at-risk Medicare patients to CDC-recognized diabetes prevention programs.
- Practice improvements that engage community resources to support patient health goals (IA_CC_14)
  - Develop pathways to neighborhood/community-based resources to support patient health goals.
- Participation in MOC Part IV (IA_PSPA_2)
  - Participation in Maintenance of Certification (MOC) Part IV.

- Completion of the AMA STEPS Forward program (IA_PSPA_9)
  - Completion of the AMA STEPS Forward™ program.
- Implementation of condition-specific chronic disease self-management support programs (IA_BE_20)
  - Provide condition-specific chronic disease self-management support programs or coaching, or link patients to those programs in the community.

Prevent Diabetes STAT

The AMA has tools and resources that can be used for prediabetes patient identification, management and referral, as well as physician education around prediabetes. Below are some of the resources available through Prevent Diabetes STAT that will help achieve success in the IA category.

RESOURCES TO USE FOR EACH RELEVANT IA

- Chronic care and preventative care management for empaneled patients (IA_PM_13)
  - *Prediabetes identification and management protocol*
    This algorithm assists practices in identifying and managing patients with prediabetes. To access this resource, email iho-info@ama-assn.org
  - *M.A.P. to diabetes prevention for your practice*
    Offers a roadmap to diabetes prevention identification and referral in practice.
  - *Sample patient letter/email and phone script*
    This letter/email template enables physician practices to conduct efficient follow-up and referral with patients who have prediabetes and for whom referral to a diabetes prevention program is an option.
- Glycemic screening services (IA_PM_19)
  - *Prediabetes identification and management protocol*
    This algorithm assists practices in identifying and managing patients with prediabetes. To access this resource, email iho-info@ama-assn.org.
- Glycemic referring services (IA_PM_20)
  - *Prediabetes identification and management protocol*
    This algorithm assists practices in identifying and managing patients with prediabetes. To access this resource, email iho-info@ama-assn.org.
  - *Sample patient referral form*
    Makes the referral process easier for practices, and helps engage the patient and prepares diabetes prevention program providers to engage with the patient as well.
- Participate in MOC Part IV (IA_PSPA_2)
  - *Prediabetes performance improvement CME*
    Physician MOC Part IV module to increase prediabetes screening and treatment.
- Completion of AMA STEPS Forward program (IA_PSPA_9)
  - *Preventing type 2 diabetes in at-risk patients*
    CME module on how to prevent type 2 diabetes in your patients through education, screening and referral.
- Implementation of condition-specific chronic disease self-management support programs (IA_BE_20)
  - *Sample patient referral form*
    Makes the referral process easier for practices, and helps engage the patient and prepares diabetes prevention program providers to engage with the patient as well.

Other notes

- IA_PM_19 is applicable if group implements systematic prevention approach (60 percent for 2018 performance period) to screen patients for abnormal blood glucose per USPSTF or ADA guidelines
- IA_PM_20 is applicable if group implements systematic prevention approach (60 percent for 2018 performance period) to refer patients with prediabetes to a CDC-recognized diabetes prevention program
- IA_CC_14 is applicable if maintaining a formal link to a diabetes prevention program with the potential for bi-directional information flow

MIPS performance category: Quality

Scoring: 50 percent of total MIPS composite score

The MIPS performance category for "Quality" focuses on your performance on certain quality measures—i.e., you choose to report on six quality measure relevant to your practice and patient population. The Quality category replaces PQRS. There are currently no relevant quality measures for 2018 MIPS for Prediabetes. For more information about the Quality category and MIPS scoring, see the AMA's MIPS Action Plan.

MIPS performance category: Cost

Scoring: 10 percent of total MIPS composite score

The "Cost" performance category uses your Medicare claims data to collect Medicare payment information for the care you gave to beneficiaries during a specific period of time. You don't have to submit any data; CMS will calculate the "Cost" performance category score. For more information, see the AMA's Cost FAQ.