

Category	Recommended Quip Diabetes Measures Based on the IOM Starter-Set	Guideline Recommendations from the American Diabetes Association*** (ADA)
<b>Long-Term Management of Diabetes</b>		
HbA1c management	Percentage of patients with diabetes with one or more HbA1c test(s) conducted during the [prior twelve months*]	<p>Perform the A1c test at least 1 time a year in patients who are meeting treatment goals (and who have stable glycemic control)</p> <p>Perform the A1c test quarterly in patients whose therapy has changed or who are not meeting glycemic goals</p>
Comprehensive Diabetic Eye exam	Percentage of patients with diabetes who received a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) [at least once during the prior twenty-four months*]	<p>Adults and adolescents with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3–5 years after the onset of diabetes. (B)</p> <p>Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B)</p> <p>Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered in the setting of a normal eye exam. Examinations will be required more frequently if retinopathy is progressing. (B)</p>
LDL cholesterol level	Percentage of patients with diabetes with most recent LDL-C <100 mg/dL or <130 mg/dL	<p>In individuals without overt CVD:</p> <ul style="list-style-type: none"> <li>▪ The primary goal is an LDL &lt;100 mg/dl (2.6 mmol/l). (A)</li> <li>▪ For those over the age of 40 years, statin therapy to achieve an LDL reduction of 30–40% regardless of baseline LDL levels is recommended. (A)</li> <li>▪ For those under the age of 40 years but at increased risk due to other cardiovascular risk factors who do not achieve lipid goals with lifestyle modifications alone, the addition of pharmacological therapy is appropriate. (C)</li> </ul> <p>In individuals with overt CVD:</p> <ul style="list-style-type: none"> <li>▪ All patients should be treated with a statin to achieve an LDL reduction of 30–40%. (A)</li> <li>▪ A lower LDL cholesterol goal of &lt;70 mg/dl (1.8 mmol/l), using a high dose of a statin, is an option. (B)</li> <li>▪ Lower triglycerides to &lt;150 mg/dl (1.7 mmol/l) and raise HDL cholesterol to &gt;40 mg/dl (1.15 mmol/l). In women, an HDL goal 10 mg/dl higher (&gt;50 mg/dl) should be considered. (C)</li> </ul> <p>From NCEP on High Blood Cholesterol<sup>†</sup>: The presence of diabetes should modify treatment goals for LDL cholesterol. Persons with type 2 diabetes should be managed as a coronary heart disease (CHD) risk equivalent.</p>

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Kidney disease screening	Percentage of patients with diabetes with one or more kidney screening tests conducted [during the prior twelve months*]	<p>Perform an annual test for the presence of microalbuminuria in type 1 diabetic patients with diabetes duration of <math>\geq 5</math> years and in all type 2 diabetic patients, starting at diagnosis and during pregnancy. (E)</p> <p>Serum creatinine should be measured at least annually for the estimation of glomerular filtration rate (GFR) in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine alone should not be used as a measure of kidney function but instead used to estimate GFR and stage the level of chronic kidney disease (CKD). (E)</p>