Diabetes Fact Sheet and Roadmap

HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE
A Division of the UCF College of Medicine

Goals

- Increase the use of clinical quality measures to drive improvements in diabetes management, prevention, and overall patient care
- Establish policies to increase implementation of standardized quality improvement procedures to screen patients for diabetes and refer them to appropriate prevention and management interventions
- Maximize electronic health record (EHR) technology through use of trackable and reportable quality measures
- Establish targets and benchmarks (e.g. Merit -based Incentive Payment System (MIPS) Quality Measure Benchmarks) to evaluate improvement efforts and outcomes routinely
- Increase value-based reimbursement through improved performance on quality measures
- Use evidence-based practices to address and reduce health disparities in diabetes

CQMs

- Quality ID #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation
  - Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months
- Quality ID #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear
  - Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing
- *Quality ID #117 (NQF 0055): Diabetes: Eye Exam
  - Percentage of patients 18 - 75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period
- *Quality ID #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)
  - Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
- *Quality ID #119 (NQF 0062): Diabetes: Medical Attention for Nephropathy
  - The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

**Are also Electronic Clinical Quality Measures (eCQMs)*

Documentation

- Use a combination code that includes diabetes and the specific complication
- Additional codes should be used to describe the stage of CKD or diabetic ulcers
- Use a HCPCS code for A1c Levels
- Document diabetic complications using cause and effect language such as “due to,” “in,” or, “associated with”

- Document risk factors such as family history, race, clinical characteristics (i.e. age, weight), and environmental factors
- In addition to documenting A1c results and other labs, social determinants of health should also be documented (i.e. potential food insecurity, housing stability, and financial situation)
- Evaluate for diabetes-related complications and comorbidities
- Document detailed foot exam and eye exam

Optimizing

- Clinical practice workflows
- Organize your practice for efficiency
- Optimize use of your EHR and health IT to meet quality measures threshold (e.g. create templates and/or order sets for abnormal glucose screenings)
- Facilitate team-based care and ensure each member is working to the top of their license
- Empower patients through proactive reminders/outreach, patient education, and patient portal access

Population Health

- Use Clinical Information Systems (e.g. registries) to share patient-specific and population-based support to the care team)
- Assess social context (i.e. food insecurities, housing stability, and financial barriers) and apply that information to treatment decisions
- Adopt a patient-centered communication style that includes patient preferences, assesses health literacy, and addresses cultural barriers to care

Managing Disparities

- Identify or develop community resources to support healthy lifestyles
- Refer patients to local community resources when available
- Develop or offer educational programs and materials in multiple languages
- Utilize health IT (EHR) to outreach to vulnerable populations needing preventative care services

Provider Tips

- Use shared decision-making tools to create a management plan
- Create a management plan to include personal goals, clinical goals, and medication adherence
- Provide patients with self-management support and education
- Increase use of pharmacist-patient care processes that help people with diabetes manage their medications
- Monitor your quality measure dashboard

Coding Considerations

- Use Z codes to capture social determinants of health
- Submit claims with the HCPCS codes for A1c levels and eye exam results

- Include codes from L97.- to describe location and stage of diabetic ulcer
- Use additional code from N18.- to indicate stage of chronic kidney disease
- Use combination codes for diabetes with complications
    - Nephropathy
    - Kidney disease
    - Eye disease
    - Neurological and circulatory complications
    - Skin and periodontal disease

Federal & State Initiatives

- National Diabetes Prevention Program (DPP) – https://www.cdc.gov/diabetes/prevention/index.html
- ADA recognized/AADE accredited Diabetes Self-Management Education and Support (DSMES) Programs – https://www.cdc.gov/diabetes/programs/stateandlocal/resources/self- management-education-support.html
- Centers for Disease Control and Prevention's 6 |18 Initiative: Prevent Type 2 Diabetes – https://www.cdc.gov/sixeighteen/diabetes/index.htm

Resources

- Prevent Diabetes STAT – https://preventdiabetesstat.org/
- NDPP Coverage Toolkit – https://coveragetoolkit.org/
- DSMES Toolkit – https://www.cdc.gov/diabetes/dsmes-toolkit/index.html
- NCQA Diabetes Recognition – https://www.ncqa.org/programs/health-care-providers-practices/diabetes-recognition-program-drp/