CommonSpirit

FY2021
Continuum of Care Goal

Diabetes Management Toolkit

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Introduction

Background

As the seventh leading cause of death in the U.S., diabetes kills approximately 79,500 people a year. People with diabetes are at increased risk of serious health complications including vision loss, heart disease, stroke, kidney failure, amputation of toes, feet or legs, and premature death. Improving management of diabetes demonstrates CommonSpirit's commitment to "Advance a coordinated, systematic, and customizable approach to serving those with acute, chronic and complex conditions," one of the five transformational strategies for our organization. We believe alignment and collaboration amongst providers across the continuum of care in adopting best practices to manage diabetes will enable us to achieve the best care for our patients.

Measure Definition
Diabetes Management

Objective
Prevent serious health complications and premature death by effectively managing HbA1c levels in our diabetic patient populations

Rationale
About one in every ten people (over 34 million) have diabetes in the United States; placing them at 60 percent higher risk for early death than those without diabetes. This one-year measure is to reduce the percentage of adult patients with a diagnosis of diabetes for whom HbA1c level is not adequately controlled i.e., greater than 9 percent.

Diabetes is a significant contributing factor to hospital admissions and healthcare costs. The Centers for Disease Control and Prevention (CDC) estimates medical costs for people with diabetes is more than twice as high as those without the disease. Reducing hemoglobin A1c blood level results by just 1 percentage point (i.e., from 8.0 percent to 7.0 percent) helps reduce the risk of microvascular complications (eye, kidney and nerve diseases) by as much as 40 percent.

Currently, approximately 22 percent of CommonSpirit patients with a diagnosis of diabetes do not have their hemoglobin A1c levels under control. This represents an opportunity for approximately 19,000 patients to reduce their risk for premature death and serious health conditions such as vision loss, heart and kidney disease, and amputation of lower extremities by achieving better control of their diabetes. This measure is included in Centers for Medicare and Medicaid Services (CMS) pay-for-performance programs including various Accountable Care Organization (ACO) agreements and the Merit-based Incentive Payment System (MIPS) for eligible Medicare providers.

Metric
Percentage of patients 18-75 years who had diagnosis and/or active problem of diabetes and whose hemoglobin A1c was poorly controlled (>9%) during measurement period (Inverse measure-lower is better)

Numerator
Patients whose hemoglobin A1c at the most recent visit is poorly controlled (>9%) or whose hemoglobin A1c was not performed during the measurement year

Denominator
Patients 18-75 years with diagnosis or active problem of diabetes who had an encounter during the performance period (E/M CPT codes)

Inclusion/Exclusion Criteria
Inclusion Criteria:

- Patients with an ambulatory encounter during the measurement period that meet one out of the two criteria listed below:
  - Have diabetes type 1 or 2 active on their problem list during the measurement period
  - Have a diagnosis of diabetes type 1 or 2 on a posted encounter during the measurement period
- Ambulatory patients seen by a provider employed or contracted within clinics that are affiliated with CommonSpirit Health that utilizes a CommonSpirit Health instance of Cerner, Epic, Allscript or eClinicalWorks EHR.

Exclusion Criteria:

- Patients with secondary diabetes due to another condition
- Deceased during the measurement period
- Hospice status during the measurement period
- Attribution to a provider identified as an out of network provider

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Physician Champion: Dr. Gary Greensweig, CPE Physician Enterprise

Data Source: CommonSpirit Health instance of Cerner, Epic, Allscript or eClinicalWorks electronic health records system

How to Use Diabetes Management Toolkit

Improving diabetes management will require an expanded effort and improved focus from ambulatory leaders, providers and clinic staff across CommonSpirit Health. This toolkit has been developed to support implementation of evidenced-based, best practices to address challenges in diabetes management within the clinic setting.

Clinic leadership is asked to share this resource and deploy referenced tools to advance efforts in diabetes care, with a focus on the following areas for improvement:

1. Establish Diabetes Management as a Practice Priority
2. Optimize Diabetes Management Practices
3. Improve Diabetes Screening, Diagnosis and Monitoring
4. Engage & Support Patients in Self-Management of Diabetes

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Key Strategies for Success

1 Establish Diabetes Management as a Practice Priority

- Designate a Diabetes Management Champion
- Increase visibility and transparency of diabetes management performance data

2 Optimize Diabetes Management Practices

- Build an accountable diabetes team
- Adopt standing orders or protocols to reduce variation and enhance care
- Encourage provider integration of evidence-based guidelines into treatment planning

3 Improve Diabetes Screening, Diagnosis and Monitoring

- Align HbA1c testing frequency with American Diabetes Association (ADA) standards of care & patient treatment goals
- Promote use of EHR registries for patient outreach and follow up
- Optimize point of care (POC) testing processes

4 Engage & Support Patients in Self-Management of Diabetes

- Offer resources and referrals to facilitate self-awareness and self-care
- Integrate emotional & behavioral support strategies
- Address medication adherence barriers

Diabetes Management Gap Analysis Tool

What is this tool?

The purpose of the gap analysis is to provide clinic improvement teams with a mechanism to:

- Compare the evidence-based "must have" improvement strategies with the processes currently in place within the clinic.
- Determine the "gaps" between current clinic practices and identified best practices.
- Provide a structured approach to documenting action plans to address identified "gaps".
- Provide a reference of available resources to support improvement efforts.

Who should use this tool?

The Diabetes Management Champion or designee will facilitate completion of the gap analysis with participation from providers and clinic team members. Clinics should establish improvement teams or workgroups to develop action plans to address identified gaps and successfully deploy improvement strategies.

How can the tool help you?

Upon completion of the gap analysis, goal improvement team members will have:

- An understanding of the differences between current clinic practices and evidence-based, best practices related to diabetes management within the clinic setting.
- An assessment of the barriers that need to be addressed before successful implementation of best practices.
- An awareness of available resources to support improvement efforts.

Instructions

1. Please review each of the improvement strategy elements in Column 2. Answer Yes or No questions in Column 3 by checking the appropriate box.
2. If the recommended improvement strategy or associated elements are not able to be deployed or supported within your clinic, provide a brief description of reason under the Comments column.
3. Planned improvement strategies to address identified practice gaps should be documented on the Action Planning Document.

Completed gap analysis and Action Planning document should be returned no later than August 31, 2020 to the respective measure Leads identified in the Resource Guide. Measure Leads are also available to answer questions and/or offer assistance with this evaluation. Please note that moving forward the gap analysis will be available electronically for your ongoing updates as identified gaps are filled.

THANK YOU!

Diabetes Management Gap Analysis

Division _____ Clinic _____ Date of Completion _____

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Establish Diabetes Management as a Practice Priority	**A Diabetes Management Champion has been designated and is a clinician or other member of the healthcare team who oversees diabetes improvement activities within one or multiple clinics**	☐ **YES** ☐ **NO** *(If No, document action plan and move to next section)*		CommonSpirit Health *Diabetes Management Champion Role Description*
	The Diabetes Management Champion collaborates with providers and clinic managers to facilitate completion of this gap analysis of current diabetes management practices within assigned clinic(s) and Oversees establishment of an improvement team or workgroup • Schedules regular team meetings (weekly recommended) to monitor gap action plan progress and outcome data • Establishes a clinic workflow for accurate capture of HgA1c values for inclusion within data cohort • Increases visibility and transparency of Diabetes Management performance data • Celebrates successes	☐ **YES** ☐ **NO**		
	If role is fulfilled by a non-clinician, the Diabetes Management Champion partners with a supporting provider.	☐ **YES** ☐ **NO** ☐ **N/A**		

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
Optimize Diabetes Management Practices	**An accountable clinic team is in place for diabetes care, education and outreach**	☐ YES ☐ NO *(If No, document action plan and move to next section)*		*Work Sheet: Team Roles for Effective Diabetes Management*

	• Clinical Team roles and responsibilities have been defined and consider the following:
	  • Pre-visit chart prep, verification of completed labs, review of existing orders
	  • Registration capture of accurate PCP information
	  • Rooming process elements
	  • Care provided is aligned with ADA standards of care for diabetic patients
	  • Patient education and support resources are addressed prior to clinic exit
	  • Follow-up visits are scheduled prior to clinic exit
	  • Outreach is conducted on a regular basis for patients overdue for A1c or visit, i.e. phone calls, text messaging, letters
		☐ YES ☐ NO		

	Clinic workflow incorporates strategies to reduce variation and optimize care for diabetic patients	☐ YES ☐ NO *(If No, document action plan and move to next section)*		Sample *Diabetes Health Maintenance Standing Orders/ Protocol Template and Hemoglobin A1c Standing Orders/Protocol Template*

	• Standing orders or protocols are in place to guide diagnostic testing and management of diabetic patient visits
	Consider for inclusion:
	  • HgA1c (or POC)
	  • Lipid Panel
	  • Nephropathy evaluation
	  • Microalbumin
	  • Dilated Retinal Eye Exam
	  • Foot exam up to date
	  • Immunizations/vaccinations
	  – Influenza immunization
	  – Pneumonia vaccination
	  – Zoster vaccination
	  – Tdap.Td vaccination
	  – Hep B
		☐ YES ☐ NO		

	• Care team members' role in standing orders/protocol deployment is clearly defined	☐ YES ☐ NO		
	• A process exists to monitor utilization of standing orders/ protocols, i.e. medical record audits	☐ YES ☐ NO		

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources

	Providers integrate evidence-based guidelines into individualized treatment planning for diabetic patients
	• Promote use of ADA Standards application as a treatment guide, or if other algorithm is used, the following components are addressed:
	  • Individualized glycemic management; HbA1c target
	  • Lifestyle management
	  • Medication therapy
	  • Assessment of cardiovascular risk
	  • Referral to educators, endocrinologists, diabetic specialists
	• A process exists to monitor utilization of evidence-based guidelines, i.e. medical record audits
		☐ YES ☐ NO *(If No, document action plan and move to next section)*
		☐ YES ☐ NO
		
		☐ YES ☐ NO
				ADA Standards of Care App Provider Memo https://professional.diabetes.org/content-page/standards-care-app-1

Improve Screening, Diagnosis and Monitoring of Diabetes	**Frequency of HbA1c testing in diabetic patients is established by clinicians in alignment with American Diabetes Association (ADA) standards of care, i.e. every 3 - 6 mos. based on individualized treatment goals** **A process exists to identify diabetic patients not at goal for outreach and follow up, i.e. use of registries or pursuit lists** • Outreach is conducted for diabetic patients not at goal to provide support and schedule follow up office visits • Pre-visit planning is conducted using standing orders/ protocols for diagnostic testing	☐ YES ☐ NO ☐ YES ☐ NO *(If No, document action plan and move to next section)* ☐ YES ☐ NO ☐ YES ☐ NO		*HbA1C Monitoring, Refill Management & Follow-up Guidelines* Sample *Diabetes Health Maintenance Standing Orders/ Protocol Template and Hemoglobin A1c Standing Orders/Protocol Template* Tip sheets available for electronic health record systems *ADA Standards of Care App Provider Memo* https://professional.diabetes.org/content-page/standards-care-app-1

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
	Clinic workflow supports process to flag patients for follow up visits and testing (in accordance with evidenced-based recommendations) at encounter closing	☐ YES ☐ NO		
	Process exists to support effective use of HbA1c point of care (POC) testing methodology *(Applicable to clinics with HbA1c POC testing capability)*	☐ YES ☐ NO *(If No, document action plan and move to next section)*		*HbA1c Point of Care Testing Staff Competency Validation tool samples*
	• The following are in place to assure effective use of HbA1c POC testing	☐ YES ☐ NO		Tip sheets available for EHR documentation of HbA1c point of care test results
	• Criteria for POC testing use defined in protocol/ standing order	☐ YES ☐ NO		
	• A process exists to validate competency of direct care staff conducting POC testing at time of hire and annually	☐ YES ☐ NO		
	• Standardized process exists for documentation of POC test results in discreet EHR fields	☐ YES ☐ NO		
	Additional Strategies for Consideration: *(Optional only)*			
	A process exists to identify diabetes in asymptomatic adults at risk for type 2 diabetes	☐ YES ☐ NO		
	• Criteria for screening is defined in protocol/standing order and is aligned with ADA standards of care: • All patients 45 years and older, with repeat testing every 3 years if results are normal, every year for patients with pre-diabetes • Testing considered for adults < 45 years who are overweight (BMI > 25, or > 23 in Asian Americans) and have other risk factors			ADA Screening App https://professional.diabetes.org/content-page/standards-care-app-1

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources
	A process exists to identify adult patients that are undiagnosed with Diabetes but have an HbA1c >6.5% i.e. use of registries or pursuit lists	☐ YES ☐ NO *(If No, document action plan and move to next section)*		Tip sheets available for EHR generation of patient registry and pursuit lists
	• Outreach is conducted for potentially undiagnosed patients to schedule office visits	☐ YES ☐ NO		Sample *Diabetes Health Maintenance Standing Orders/ Protocol Template and Hemoglobin A1c Standing Orders/Protocol Template*
	• Pre-visit planning is conducted using standing orders/ protocols for diagnostic testing	☐ YES ☐ NO		
Support Patients in Self-Management of Diabetes	**Strategies exist to promote patient self-management skills facilitating behavior change**	☐ YES ☐ NO *(If No, document action plan and move to next section)*		

	• Diabetic patients are provided educational resources to facilitate self-awareness and self-care. Examples include:
	  • Diabetes basics
	  • HbA1c awareness
	  • Exercise
	  • Foot Care
	  • Nutritional guidance
	  • Sick day management
	  • Prevention of hypoglycemia
	  • Complication awareness
	  • Self-monitoring glucose measurement
		☐ YES ☐ NO		Tip sheets available for EHR access to patient education materials
				
				CommonSpirit Health Patient Blood Glucose Monitoring Tools
				
				CommonSpirit Health Patient Goal Setting Tool Kit

	• Self-management strategies include collaboration with patients in developing their own goals and plan to support life style changes. Patient-specific goal planning includes:
	  • Manageable number; mutually agreed-upon goals
	  • Action and tracking plan
		☐ YES ☐ NO		

	• Staff and clinicians have been educated and expectations communicated regarding use of available tools to support patient self-care strategies	☐ YES ☐ NO		
	• Written and verbal education provided in ALL encounters	☐ YES ☐ NO		

Key Concept	Improvement Strategy	Assessment	Comments	Available Resources

	Process exists to promote patient engagement in self-care and emotional well-being with resources and referrals for support
	• A list of community resources to promote patient engagement in self-care and emotional well-being is provided and includes contact information for the following:
	  • Diabetes self-management education (DSME) programs
	  • Specialists such as nutritionists
	  • Diabetes support groups
	  • Social service or care coordination needs such as transportation, meals, and assisting patient with accessing community resources
	  • Collaborative plan with behavioral health practitioners-depression/ diabetes distress screenings
		☐ YES ☐ NO *(If No, document action plan and move to next section)*
		☐ YES ☐ NO
				Resources to Help Support You in Managing Diabetes handout
				REACH program for selected markets
				Unite Us program for select markets

	A process exists to reduce medication adherence barriers for diabetic patients • Clinic workflow supports provider-approved, automatic medication refill protocol based on HbA1c • Resource information regarding medication financial assistance provided to patients as needed	☐ YES ☐ NO *(If No, document action plan and move to next section)* ☐ YES ☐ NO ☐ YES ☐ NO		*HbA1C Monitoring, Refill Management & Follow-up Guidelines* *Resources to Help Support You in Managing Diabetes* handout

Diabetes Management Gap Analysis Action Plan

Facility/Entity Name: _____

Completed By: _____ Date Initiated _____

Key Concept/ Process	Action Plan	Responsible Person	Estimated Completion Date	Monitoring/ Validation Process (How do you know it's happening?)

Additional Comments:

Diabetes Management Champion Role Description

Recommended Role for Champion:

Provider or Clinic Staff Member with
Provider Partner

Role Summary

In collaboration with the Physician Enterprise Division Quality Leader and market leadership, the Diabetes Management Champion is authorized to serve as a liaison and coordinate implementation of evidence-based practices and strategies to improve care for patients with diabetes within the clinic setting. Although highly recommended to be a clinician, this role may also be fulfilled by other member of the healthcare team if partnered with a supporting clinician.

Desired Skills

1. Knowledgeable and enthusiastic about diabetes management with appropriate expertise and experience
2. Good communication skills and able to work well with others
3. Willing/able to invest time in necessary activities including conducting educational presentations to providers and clinic staff, sharing performance outcome data

Functions and Duties as Goal Champion

1. Actively and enthusiastically promote diabetes management as a practice/clinic improvement priority
2. Collaborate with providers and clinic managers to facilitate a gap analysis of current diabetes management practices within assigned clinic(s) and promote, advocate and implement an improvement plan using evidence-based strategies to address identified gaps
3. Provide input and leadership for implementation, monitoring, and evaluation of deployed improvement strategies
4. Work collaboratively with providers and clinic staff to leverage and optimally utilize clinic infrastructure to:
   - Facilitate clinic approach to support adherence to diabetes management improvement strategies as directed by the Physician Enterprise Division Quality Leadership group and gap analysis findings. (For example, oversee establishment of an improvement team or work group to focus on these efforts.)
   - Mentor providers, clinic staff, improvement teams to effectively apply improvement methods and tools
   - Facilitate process for periodic review, monitoring and sharing of performance outcome data reports
   - Celebrate key milestone achievements

Adapted from "Kaiser Permanente. Cardiovascular Physician Champion Role Description" included as Appendix A. Centers for Disease Control and Prevention. Hypertension Control Change Package for Clinicians. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2015.

Frequently Asked Questions

Q Why isn't my division's data included in the CommonSpirit Health National Quality Measure Report?

A The National Quality Measure Report includes data elements abstracted from electronic health records of ambulatory patients seen by providers who are either employed or contracted within clinics that are affiliated with CommonSpirit Health and that utilize an owned instance of Cerner, Epic, eClinical Works or Allscripts EHR. Data from these entities have undergone a thorough validation process. By using this validated data, we are able to produce an accurate, reliable snapshot of measure performance. While this year's measurement and data extraction processes will include only employed or contracted providers as above, our goal is to communicate and align efforts for effective diabetes management across all of CommonSpirit Health.

Q What is the expectation for clinics that do not have data in the CommonSpirit Health National Quality Measure Report?

A Although not all markets will be able to compare their measure performance within the National Quality Measure report, control of diabetes is a national initiative. All markets will be expected to monitor ongoing performance through use of locally produced or claims-based reporting systems, participate in national improvement activities, deploy recommended strategies and monitor effectiveness of improvement initiatives.

Q What is the source of the diabetes measure data?

A The measurement data is aggregated from discrete fields within the electronic medical record as well as coded, or claims-based information.

Q How will performance data be reported – year-to-date or rolling 12 months?

A Data will be reported year-to-date.

Q Is this a cumulative report as the measurement period progresses? For example, do December results also include those diabetic patients seen in October and November?

A Yes, the rate would be cumulative, showing "Out of Control/In Control" status for each patient landed in the denominator during the measurement period, and using the MOST RECENT HBA1c result to determine numerator status. (Patients in prior months would be included, because it's cumulative, but each patient is only counted once.)

Q What encounter types are included in the denominator data?

A Outpatient office visits for in-network primary care providers (PCPs) and specialists during the measurement period are included. Visits in emergency rooms and urgent care centers are not included.

Q **Will HbA1c results obtained from outside sources, i.e. another provider's office, outside laboratory, patient-reported, be included in the measure cohort?**

A HbA1c results that are documented in the discreet electronic health record field will be included in the measure, regardless of result source.

Q **Is this only a PCP measure or will HbA1c recorded in a specialist visit satisfy the measure, if it is the most recent visit?**

A The most recent HbA1c reading in the EHR will be used to determine poor control. If this reading is obtained for a patient assigned to an in-network primary care provider during an in-network, specialist office encounter, the HbA1c measurement will be part of the data cohort.

Therefore, it is important to engage in-network specialty providers and clinic staff to:

1. Inform the specialty provider of out of range HbA1c results, i.e. > 6.5%
2. Schedule appointment with patient's PCP or affiliated PCP (if none designated) prior to departure
3. Educate patient on risks of diabetes and importance of keeping scheduled PCP appointment

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Appendix

Patient and Family Resources

1. Resources to Help Support You in Managing Diabetes patient handout
2. Patient-Goal Setting Tool Kit
3. Patient Blood Glucose Monitoring Tools
4. Print on demand patient handouts
    - ADA Desk Moves
    - ADA Starter Walking Plan
    - ADA Weekly Blood Glucose Log
    - ADA Diabetes Standards of Care
    - ADA Managing Your Medicines
    - CDC Tasty Recipes For People with Diabetes and Their Families
    - Diabetes Online Community links
5. Electronic Medical Record Tip Sheets for Accessing Patient Education Resources

Provider and Staff Resources

1. American Diabetes Association Standards of Care App
2. Team Roles for Effective Diabetes Management worksheet and sample
3. HbA1c Monitoring, Refill Management & Follow-up Guidelines reference cards
4. Tools for Success: Deployment of Diabetic Treatment Guidelines in the Clinic Setting
5. Point of Care HbA1c Testing Guidelines and Staff Competency Validation tool samples
6. Electronic Medical Record Tip Sheets for Accessing Patient Education Resources

The resources noted above can be located on Sharepoint.

CHI Sharepoint

Dignity Health SharePoint

References

1. American Diabetes Association. (2018). *ADA Standards of Medical Care in Diabetes.* Diabetes Care 2018 Jan; 41(Supplement 1): S1-S2.
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3. American Medical Group Foundation (AMGF). (2019). *Together 2 Goal® Campaign Toolkit.* Alexandria, VA: AMGA Foundation.
4. Centers for Disease Control and Prevention. (2018). *Diabetes Self-Management Education and Support Toolkit.*
5. Centers for Disease Control and Prevention. (2020). *Diabetes Meal Planning.*