

FY2025 Continuum of Care Goal

Diabetes Management Toolkit



Table of Contents

Introduction.....3

Measure Definition 4

How to use the Diabetes Management Toolkit..... 6

Key Strategies for Success7

Champion Role Description 8

Frequently Asked Questions..... 9

Contacts.....12

References13

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. As of January 2023, performance data suggests that almost 15,000 CommonSpirit patients have an opportunity to reduce their risk of diabetes-related complications by achieving better blood glucose control. 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.



Measure Definition

Diabetes Management

Objective

Prevent serious health complications and premature death by effectively managing HbA1c levels in patients with diabetes across CommonSpirit Health

Rationale

Diabetes and diabetes-related health complications can be serious and costly. The seventh leading cause of death in the United States. More than 37 million people in the United States have diabetes, and 1 in 5 of them don't know they have it. In the last 20 years, the number of adults diagnosed with diabetes has more than doubled as the American population has aged and become more overweight or obese. Diabetes is more common among people who are members of some racial and ethnic minority groups and groups with lower socioeconomic status.

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. Blood sugar management can reduce the risk of eye disease, kidney disease, and nerve disease by 40%. Medical costs and lost work and wages for people with diagnosed diabetes total \$327 billion yearly, twice as high as for people who don't have diabetes.

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 within 365 days from the most current clinic encounter 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 1 out of the 2 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, Allscripts or eClinicalWorks electronic health record system

Exclusion Criteria

Coded or documented evidence within the ambulatory electronic health record of the following:

- Patients with secondary diabetes due another condition
- Deceased during the measurement period
- Hospice or palliative care status during the measurement period
- Attributed primary care provider not affiliated with CommonSpirit Health

National Contact: Debra Rockman, RN, MBA, CPHQ, CPHRM, System VP Ambulatory Quality

Kelly Bitonio, BSN, MHA, NEA-BC, CPHQ, System Director Ambulatory Quality,

Physician Champion: Dr. Gary Greensweig, CPE Physician Enterprise

Data Source: CommonSpirit Health instance of Cerner, Epic, Allscripts and eClinicalWorks electronic health records system

How to use the 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

[Link to Diabetes Improvement Resources](#)

Staff & Provider Resources

1. CommonSpirit Identification of Clinic Team Roles for Effective Diabetes Management tool
2. HbA1c Monitoring and Follow-up Guidelines
3. ADA Standards of Care App instructions
4. Deployment of Diabetic Guidelines in the Clinic Setting
5. Sample Point of Care Staff Competency tools

Patient Education Resources

1. Diabetes Patient Education Resource links
2. Spanish Language ADA Resource links
3. CHI and Dignity-Branded Resources (including Spanish, Hmong, Punjabi, and Arabic translations):
 - Exchanges Made Simple
 - Patient Blood Glucose Monitoring Tools
 - Patient Diabetes Goal Setting Toolkit
 - Resources to Help Support You in Managing Diabetes handout

Cultural Integration

Cultural Integration Resource Links

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

- Frequency of HbA1c testing in diabetic patients is established by clinicians in alignment with American Diabetes Association (ADA) standards of care, i.e. guided by the assessment of overall health status, diabetes complications, CV risk, hypoglycemia risk, and therapeutic goals set through shared decision making
- Promote use of EHR registries for patient outreach and follow-up
- Establish a clinic workflow or process to flag diabetes patients and schedule follow-up visits (according to evidence based guidelines) at encounter closing
- Optimize point of care testing processes

4 Engage & Support Patients in Self-Management of Diabetes

- Assess food insecurity, housing insecurity/homelessness, financial barriers, and social capital/social community support to inform treatment decisions, with referral to appropriate local community resources
- Ensure patient assessment processes elicit cultural information that can influence intervention strategies
- Ensure education and resource referrals are provided in the patient's preferred language and sensitive to individual culture and literacy levels
- Support patients with diabetes in self-management skills facilitating behavior change
- Promote patient engagement in self-care and emotional well-being with resources and referrals for support
- Reduce medication adherence barriers

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, and 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, and 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

Frequently Asked Questions

Q Why isn't my clinic's data included in the CommonSpirit Health Clinical Scorecard?

A The CommonSpirit Clinical Scorecard includes data elements abstracted from electronic medical records (EMRs) 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 Clinical Scorecard?

A Although not all markets will be able to compare their measure performance within the CommonSpirit Clinical Scorecard, 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 EMR 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 for the measurement period of July 2023–June 2024.

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

A Yes, the rate would be cumulative, showing “Out of Control/In Control” status for each patient landing 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 (in-clinic and virtual) 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 or outside laboratory, be included in the measure cohort?

A HbA1c results that are documented in the discrete EMR field will be included in the measure, regardless of result source. Therefore, it is important to establish standard workflows for transcribing results from outside sources into the designated EMR field if no interface exists.

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

A The most recent HbA1c reading in the EMR 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

Q What is the HbA1c result period for a diabetic patient with a visit encounter during the measurement period (July 1, 2023 - June 30, 2024)?

A The most recent HbA1c result documented within 365 days of a clinic encounter occurring during the measurement period will qualify for numerator inclusion.

Scenario #1: DM patient seen in July 2023 with a HbA1c done in June 2023 (outside of the measurement period, but within the 365 day look-back period.) The HbA1c value in June 2022 would be included in numerator criteria (> 9% in poor control, ≤ 9% in good control.)

Scenario #2: DM patient seen in March 2024 with most recent HbA1c done in January 2023 (outside of the measurement period.) The January 2023 HbA1c result exceeded the 365 day look-back period. If the HbA1c is not repeated within the measurement period, this patient would be categorized as in "poor control" due to lack of HbA1c result within the look-back and measurement periods.

Q What patients are excluded from the Diabetes measure?

A The following patients are excluded from the diabetes measure if there is coded or documented evidence within the ambulatory electronic health record:

- Patients with secondary diabetes due another condition
- Patients that are deceased during the measurement period
- Patients that are placed in Hospice or palliative care status during the measurement period
- Patients who are attributed to primary care provider who is not not affiliated with CommonSpirit Health

Q Why isn't frailty included as one of the measure exclusions for Diabetes?

A The analytic team conducted an in-depth analysis related to application of frailty denominator exclusions and found no statistically significant impact (0.2%) on overall rates of HbA1c control. Based on these findings, frailty-related exclusion measure specifications have been deferred for FY2024.

Q Do patient reported HbA1c results meet measure requirements?

A Patient reported or lab values from non-CommonSpirit entities may meet measure requirements if they are transcribed in the appropriate discrete patient reported EMR fields, with minimum documentation of the month and year that the A1c was performed and the source of the report.

Q We have heard that the national team conducts virtual visits with clinic teams requiring assistance with performance or quality improvement support. Can we request a visit?

A Absolutely! Many clinics participating in focused virtual visits with national team members have demonstrated improvement in diabetes performance rates and report the visits as a positive experience for providers and staff. Reach out to Debra Rockman or Kelly Bitonio to discuss options.

Contacts

Debra Rockman RN, MBA, CPHQ, CPHRM

System VP, Ambulatory Quality

Debra.Rockman@commonspirit.org

Kelly Bitonio, BSN, MHA, NEA-BC, CPHQ

System Director, Ambulatory Quality

Kelly.Bitonio@commonspirit.org

Gary Greensweig, MD

System SVP, Chief Physician Executive

Physician Enterprise

Gary.Greensweig@commonspirit.org

References

1. American Diabetes Association. (2023). *ADA Standards of Medical Care in Diabetes*. Diabetes Care Dec, 2022
2. American Diabetes Association. (2020, July 7). *Connected for Life*. Retrieved from Diabetes.org: <https://www.diabetes.org/>
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*.
6. Centers for Disease Control and Prevention. National Diabetes Statistics Report website. <https://www.cdc.gov/diabetes/data/statistics-report/index.html>.
7. CMS Quality ID #1 (NQF 0059): Diabetes: *Hemoglobin A1c (HbA1c) Poor Control (>9%)*.