Quality Measure Highlight
Comprehensive Diabetes Care (CDC)
Medical Attention for Nephropathy

MEASURE DESCRIPTION

Denominator: The number of continuously enrolled Medi-Cal members 18 - 75 years of age (DOB between January 1, 1944 and December 31, 2002) with diabetes identified as of December 31, 2019.

There are two ways to identify members with diabetes: by pharmacy data and by claim or encounter data. PHC will use both methods to identify the eligible population, but a member only needs to be identified by one method to be included in the measure. PHC may count services that occur during the measurement year or the year prior, e.g., January 1, 2018 - December 31, 2019.

Claim / Encounter Data: Members who met any of the following criteria during the measurement year or the year prior to the measurement year (count services that occur over both years, January 1, 2018 - December 31, 2019).

At least two outpatient visits, observation visits, ED visits, or non-acute inpatient encounters, on different dates of service, with a diagnosis of diabetes. The visit type need not be the same for the two visits.

At least one acute inpatient encounter with a diagnosis of diabetes.

Pharmacy Data: Members who were dispensed insulin or hypoglycemics/antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year.

Numerator: The number of members from the denominator who had a nephropathy screening or monitoring test during the measurement year ***or*** evidence of nephropathy during the measurement year.

Measure Type: Hybrid (medical record/claims/encounter/lab data/pharmacy data)

Intent / Importance: Attention to diabetes nephropathy care is important for members to maintain healthy kidney function. The presence of albumin in the urine and/or reduced estimated glomerular filtration rate (eGFR) are signs of kidney disease.

PCP QIP 2019	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Adult Medicine	10 points 10 points	93.43%	90th
Half Points	Family Adult Medicine	5 points 5 points	92.05%	75th
Relative Improvement Threshold	Family Adult Medicine	10 points 10 points	90.51%	50th

Notes for eReports and PQD:

- All CDC measures will have the same denominator because they share the same eligible population.

For additional information regarding the specifications for this measure feel free to email us: QIP@partnershiphp.org

References: National Committee on Quality Assurance (NCQA) HEDIS® 2019 Vol 2 Technical Specifications for Health Plans; NCQA HEDIS 2018 Vol 1 Narrative. HEDIS® is a registered trademark of NCQA.

Numerator Compliant Documentation:

A nephropathy screening or monitoring test (e.g., urine test[s], ACE/ARB therapy) ***or*** evidence of nephropathy during the measurement year, as documented through either administrative data or medical record review.

1. Any of the following meet criteria for a nephropathy screening or monitoring test or evidence of nephropathy.
   - A urine test for albumin or protein. At a minimum, documentation must include a note indicating the date when a urine test was performed and the result or finding. Any of the following meet the criteria:
     - 24-hour urine for albumin or protein
     - Timed urine for albumin or protein
     - Spot urine (e.g., urine dipstick or test strip) for albumin or protein
     - Urine for albumin/creatinine ratio
     - 24-hour urine for total protein
     - Random urine for protein/creatinine ratio
   - Documentation of a visit to a nephrologist
   - Documentation of a renal transplant
   - Documentation of medical attention for any of the following (with no restriction on provider type):
     - Diabetic nephropathy
     - End Stage Renal Disease (ESRD)
     - Chronic renal failure (CRF)
     - Chronic kidney disease (CKD)
     - Renal insufficiency
     - Proteinuria
     - Albuminuria
     - Renal dysfunction
     - Acute renal failure (ARF)
     - Dialysis, hemodialysis or peritoneal dialysis
2. Evidence of ACE inhibitor / ARB therapy. Documentation in the medical record must include evidence that the member received ACE inhibitor / ARB therapy during the measurement year. See the ACE / ARB medication list below as a resource. Any of the following that are documented during the measurement year meet criteria:
   - Documentation that a prescription for an ACE inhibitor/ARB
   - Documentation that a prescription for an ACE inhibitor/ARB was filled
   - Documentation that the member took an ACE inhibitor/ARB

ACE Inhibitor/ARB Medications (for your reference)

Description	Prescription				
Angiotensin converting enzyme inhibitors	• Benazepril • Captopril	• Enalapril • Fosinopril	• Lisinopril • Moexipril	• Perindopril • Quinapril	• Ramipril • Trandolapril
Angiotensin II inhibitors	• Azilsartan • Candesartan	• Eprosartan • Irbesartan	• Losartan • Olmesartan	• Telmisartan • Valsartan	

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Description	Prescription		
Antihypertensive combinations	• Amlodipine-benazepril • Amlodipine-hydrochlorothiazide-valsartan • Amlodipine-hydrochlorothiazide-olmesartan • Amlodipine-olmesartan • Amlodipine-perindopril • Amlodipine-telmisartan	• Amlodipine-valsartan • Azilsartan-chlorthalidone • Benazepril-hydrochlorothiazide • Candesartan-hydrochlorothiazide • Captopril-hydrochlorothiazide • Enalapril-hydrochlorothiazide • Fosinopril-hydrochlorothiazide • Hydrochlorothiazide-irbesartan	• Hydrochlorothiazide-lisinopril • Hydrochlorothiazide-losartan • Hydrochlorothiazide-moexipril • Hydrochlorothiazide-olmesartan • Hydrochlorothiazide-quinapril • Hydrochlorothiazide-telmisartan • Hydrochlorothiazide-valsartan • Sacubitril-valsartan • Trandolapril-verapamil

Exclusions:

- Members who do not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior to the measurement year ***and*** who had a diagnosis of gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or the year prior to the measurement year
- Members in hospice are excluded from the eligible population (**Mandatory**)

Strategies to Consider That May Lead to an Increase in CDC - Nephropathy Performance:

- Nephropathy screening at the diagnosis of diabetes and at least once per year (specifically, for diagnosis five years or longer)
- On-site urine testing
- Treatment for persistent albuminuria
- Perform / order screening / monitoring (if due) regardless of the reason for the office visit
- Hard stop diabetic assessment question at registration to trigger screening form for provider (e.g., recommended screening test(s), due date and results)
- Establish and maintain a tracking system for diabetic members to identify lab appointments (e.g., due, results, follow-up communication), specialty referrals (nephrologist), medication reconciliation for ACE / ARB therapy
- Designate a team member to outreach to members due for screening / monitoring (e.g., phone call, post card, letter signed by provider, text)
- If appointment missed, phone call to member within one week to reschedule
- Reinforce the importance of testing and self-management / accountability
- Reassess member's knowledge of screening / monitoring, assess barriers to screening / monitoring (e.g., cultural, financial, social support, health beliefs)
- Ensure member is informed of screening / monitoring results and next step(s)
- Provide timely claims to help ensure accurate data collection

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