2022 Quality Measure Highlight

Comprehensive Diabetes Care

Hgb A1c Good Control ≤ **9.0%**

MEASURE DESCRIPTION

The percentage of members 18-75 years of age who had a diagnosis of diabetes with evidence of HgbA1c levels at or below the threshold.

Denominator: The number of continuously enrolled Medi-Cal members 18 - 75 years of age (DOB between January 1, 1947 and December 31, 2004 with diabetes identified as of December 31, 2022.

Numerator: The number of diabetics in the eligible population with evidence of the most recent measurement (during the measurement year) at or below the threshold for HbA1c ≤ 9.0%.

There are two (2) 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, 2021 - December 31, 2022.

Measure Type: Hybrid (Medical record / claims / encounter, lab data)

Intent / Importance: Many complications of diabetes, such as amputation, blindness and kidney failure, can be prevented if detected and addressed in the early stages. HbA1c monitoring can assist members with diabetes maintain control over their blood sugar and minimize the risk of complications.

Notes for eReports and PQD:

- This is the only CDC measure included in the core measure set for PCP QIP 2022 but CDC-Eye Exam performance will remain visible as a monitoring only measure.

Coding

HbA1c CPT: 83036, 83037
CPT II codes 3044F, 3051F, 3052F

*Please refer to Diagnosis Crosswalk in eReports for complete listing of Code Types

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

References: Managed Care Accountability Set (MCAS)

Claims / Encounter Data: Members who met any of the following criteria during the measurement year or the year prior (count services that occur over both years, January 1, 2021 - December 31, 2022).

At least two (2) outpatient visits, observation visits, telephone visits, e-visits or virtual check-ins, 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 (2) visits.
At least one (1) acute inpatient encounter with a diagnosis of diabetes.

PCP QIP 2022	Practice Type	Total Points	Threshold	Percentile
Full Points	Family Medicine Internal Medicine	7 points 12.5 points	61.63%	75th
Partial Points	Family Medicine Internal Medicine	5 points 9 points	56.81%	50th

Relative Improvement

- A site's performance on a measure must meet the 50th percentile target in order to be eligible for RI points on the measure **AND**
- Have an RI score of 10% or higher, ending up thereby achieving performance equal to or exceeding between the 50th percentile and not exceeding the 75th percentile, to earn full points.

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.

Compliant Documentation – HbA1c Good Control (< 9.0%)

- The number of diabetics in the eligible population with evidence of the most recent measurement (during the measurement year) at or below the threshold for HbA1c ≤ 9.0%.
  Codes to identify HbA1c good control: HbA1c Level Less Than or Equal to 9.0 code list.

Non-Compliant Documentation – HbA1c Control > 9%

- If the most recent HbA1c level during the measurement year is > 9.0% or is missing, or if an HbA1c test was not performed during the measurement year.

- Ranges and thresholds (e.g., 8-9%, >12%, 14+) do not meet criteria for these indicators. A distinct numeric result (7.8%, 7.0%) is required for numerator compliance.

Exclusions

- Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or year prior to measurement year, **and** who had a diagnosis of polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes, in any setting, during the measurement year or year prior to measurement year.
- Members in hospice or receiving palliative care during the measurement year are excluded from the eligible population.

Best and Promising Practices

Data and Coding

- Submit claims and encounter data within 90 days of service.
- Exclude members as appropriate and use coding to document reason for exclusion.
- Use CPT-II coding to document HbA1c test results.
- Review lab requisition forms and visit superbills (EHR or paper) to ensure codes align with HEDIS technical specifications

HbA1c Measurement Workflows

- Hard stops / prompts for HbA1c testing at check-in for office visits.
- On-site HbA1c testing or phlebotomy.
- Chart prep and huddles to add HbA1c as an add-on service for any visit.
- Perform / order testing (if due) regardless of the reason for the office visit.
- Standing orders for HbA1C that can be completed by non-provider staff
- Streamline or automate pathways to HbA1c testing; lab order should not require a PCP visit.
- Leverage telehealth for diabetes medication management visits.

Practice Workflows

- Cross departmental coordination of care:
    - Incorporate care team members using standing orders for nursing, pharmacists and registered dieticians.
    - Diabetic panel manager coordinates care for uncontrolled diabetics, including HbA1c testing
- Ensure members are informed of HbA1c results and next step(s).

- Refer/enroll uncontrolled diabetics with PHC Chronic Case Management. Optimize pathways for referrals to Case Management, Health Education, and Clinical Pharmacy teams.
- Point incentive program to encourage self-management (gift card or other rewards).
- Consider using an equity approach to increase screening rates for targeted communities. By looking at controlled diabetic rates by such factors as race, ethnicity, location (i.e.zip code), and preferred language, it is possible to identify barriers that affect specific communities, and plan interventions to address these barriers.

Outreach

- Designate a team member to contact members due for HbA1c testing (e.g., phone call, post card, letter signed by provider, text).
- Call members within a week to reschedule if a lab or provider appointment is missed.

Education

- Assess and address the member's knowledge, gaps and barriers related to self-management (e.g., cultural, financial, literacy/health literacy, social support, health beliefs).
- Provide/encourage the use of virtual tools to support self-management (computer/phone apps and programs for healthy eating, physical activity and medication management).
- Refer for nutrition education, in-house or via telehealth.
- Reinforce the importance of testing and self-management.