CommonSpirit

FY2024
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. 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

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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. Glycemic Status 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

Gap Analysis Guide

Key Concept	Improvement Strategy	Available Resources
Designated Diabetes Management Champion	**A designated provider or other member of the healthcare team (partnered with a provider) oversees diabetes improvement activities within one or multiple clinics** The Initiative Champion collaborates with providers and clinic managers to facilitate completion of this gap analysis of current diabetes management practices within assigned clinic(s) and • Facilitates clinic approach to support adherence to diabetes management improvement strategies to address gap analysis findings. (For example, establish an improvement team or work group to focus on these efforts.) • Mentors providers, clinic staff, improvement teams to effectively apply improvement methods and tools • Facilitates process for periodic review, monitoring and sharing of performance outcome data reports with providers and staff • Celebrates key milestone achievements If role is fulfilled by a non-clinician, the Diabetes Management Champion partners with a supporting provider.	*Diabetes Champion Role Description*

Optimize Diabetes Management Practices	**An accountable clinic team is in place for diabetes care, education and outreach**
	
	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
	
	Clinic workflow incorporates strategies to reduce variation and optimize care for diabetic patients
	
	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
	• Care team members' role in standing orders/protocol deployment is clearly defined
	• A process exists to monitor utilization of standing orders/protocols, i.e. medical record audits
		Clinic Team Roles for Diabetes Management
		
		Sample CommonSpirit Diabetes Health Maintenance Standing Orders/Protocol Template and Hemoglobin A1c Standing Orders/Protocol Template can be found in the *Best Practice Sharing* folder
		
		Deploying Diabetes Guideline toolkit to guide development of protocol if needed

Key Concept	Improvement Strategy	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
		ADA Standards of Care App Provider Memo
		ADA Standards of Care Flyer with App link

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. guided by the assessment of overall health status, diabetes complications, CV risk, hypoglycemia risk, and therapeutic goals set through shared decision making**
	
	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
	
	Clinic workflow supports process to flag patients for follow up visits and testing (in accordance with evidence-based recommendations) at encounter closing
	
	Process exists to support effective use of HbA1c point of care (POC) testing methodology (*Applicable to clinics with HbA1c POC testing capability)*
	
	• The following are in place to ensure effective use of HbA1c POC testing
	  • Criteria for POC testing use defined in protocol/standing order
	  • A process exists to validate competency of direct care staff
	  • conducting POC testing at time of hire and annually
	  • Standardized process exists for documentation of POC test results in discreet EHR fields
		Glycemic Status Monitoring and Follow-up Guidelines
		
		Sample CommonSpirit Diabetes Health Maintenance Standing Orders/Protocol Template and Hemoglobin A1c Standing Orders/Protocol Template can be found in the *Best Practice Sharing* folder
		
		Tip sheets available for electronic health record systems
		
		EHR Tip Sheets
		
		In Exam Room Scheduling Tip Sheet

Support Patients in Self-Management of Diabetes	**Patient assessment process elicits cultural information that can influence intervention strategies**
	
	• Providers and clinic staff are aware and have access to resources to facilitate understanding of patient-specific cultural values, beliefs, and practices
	
	• The assessment process addresses the following:
	  • What cultural, religious, spiritual, or lifestyle beliefs may impact the kind of health care patient wants to receive
	  • Preference of participants in medical decision-making
	  • Preference of communication: written, pictures
	  • How recommended care plan fits into patient's lifestyle and beliefs
	
	Diabetes education is provided in patient's preferred language and sensitive to individual culture and literacy levels
		Resources to Support Culturally Appropriate Care for clinicians.
		Culture Clues designed to increase awareness about concepts and preferences of patients from the diverse cultures)
		
		Patient Resources folder contains patient facing educational material in English, Spanish, Punjabi, Hmong, and Arabic. Resources include:
		• Patient Goal Setting Toolkit
		• Patient Glucose Monitoring Toolkit
		• Exchanges Made Simple
		• Online and App Support in Managing Diabetes
		• ADA Patient Education Resources (English and Spanish)
		• DM education found in the EMRs

Key Concept	Improvement Strategy	Available Resources

	If English is the patient's second language, or the patient is deaf/hard of hearing or has vision impairment, providers and staff utilize an interpreter or translation services in all of care discussions. Family members are not relied on to translate health information.
	
	Intervention strategies exist to promote diabetic patient engagement in self-management skills facilitating behavior change
	
	• 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
	• 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
	Staff and clinicians have been educated and expectations communicated regarding use of available tools to support patient self-care strategies
	Written and verbal education provided in ALL encounters
	
	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
	
	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
		CommonSpirit *ADA Patient Education Resource links flyer*
		
		CommonSpirit *American Diabetes Association Patient Resources in Spanish* flyer
		
		Diabetes Guide to Foods of African Heritage
		
		CommonSpirit Community Health is available to support in social needs screening and workflow support; send queries to *ccn@dignityhealth.org*
		
		Resources to Help Support You in Managing Diabetes handout (available in Spanish, Punjabi, Hmong, and Arabic translation)
		
		CommonSpirit *CHI Branded* and *Dignity Health*

Sources: Together 2 Goal Campaign Toolkit: An initiative of AMGA Foundation 2016

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, 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

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