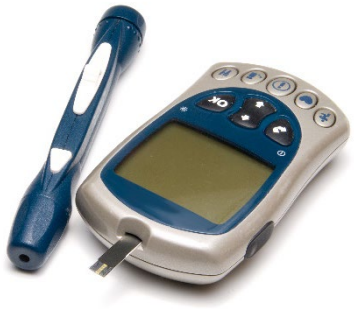
Measure Tip Sheet: Diabetes A1c Poor Control > 9%

Ready to achieve success in Quality Payment Program (QPP) reporting?
Boost your likelihood for success by:

- Understanding variables associated with the QPP 001 measure.
- Identifying improvement opportunities such as accurate (input and output) data and gaps in care processes, both of which can lead to better patient outcomes and quality measure performance.
- Improving your patients' understanding of diabetes prevention and engagement in self-management activities, which are key ingredients for further improvements.



HQIN's collection of tools, resources and key strategies from high-performing practices can help improve your team's performance of this quality measure.

Leverage Preventative Services & Partners in the Community

Annual Wellness Visits (AWV) and Chronic Care Management (CCM) services are two of the best ways to identify, address and manage patients with diabetes or those who are at risk of developing diabetes.

- The AWV is an annual reimbursable service for providers to review and assess many health aspects that contribute to diabetes outcomes. It is an ideal time to refer for follow up and treatment. Use our AWV Revenue Estimation Tool to see how much your practice might be leaving on the table by not maximizing AWV services.
- CCM provides wrap-around services to address multiple chronic conditions through a care team that is available to the patient 24/7. Request our CCM Implementation Toolkit to get started.

Blue Bag Initiative (BBI)

The BBI fosters partnerships among pharmacists, physicians, and other providers to facilitate medication reconciliation and help patients avoid medication errors. Email BBI@hqi.solutions to learn more.

Quick Jump to:

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES
HQIN Health Quality Innovation Network

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Pharmacist Collaboration

- Medication Therapy Management
  - Medication Adherence
  - Medication Synchronization
- Comprehensive Medication Review
- Annual Wellness Visits: Non-Billing Clinician
- Chronic Care Management: Non-Billing Clinician
- Transitional Care Management: Non-Billing Clinician

Patients with the most need of medication-focused care coordination visit the pharmacy more than 35 times annually.

Source: University of Minnesota, College of Pharmacy

Diabetes Prevention and Education

- Diabetes Prevention Programs (DPP) (virtual options may be available)
- Diabetes Self-Management and Education (DSME) Programs (virtual options may be available)
- Other Lifestyle Change Programs offered by community-based organization like local Area Agencies on Aging or YMCA's. Contact your HQIN Quality Improvement Advisor (QIA) for additional information.

Smoking Cessation Counseling

Consider the importance of smoking cessation counseling, especially for your patients with diabetes. According to the CDC:

- Smoking and nicotine can cause cells to stop responding to insulin and increase blood sugar levels.
- Smoking puts people at a 30%-40% higher chance to get type 2 diabetes compared to those who don't smoke.
- As soon as a smoker stops, the body starts healing itself:
  - In 20 minutes, the heart rate and blood pressure drop.
  - In 12 hours, carbon monoxide (a toxic gas from cigarette smoke) in the blood drops to normal.
  - In 2 weeks to 3 months, circulation and lung function improve.
  - In a year, the risk for heart disease is half that of someone who still smokes.

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Data Collection

HQIN Quality Improvement Advisors will help you identify best practices for optimal data collection to improve you A1c reporting performance. Such as:

- Identifying the different ways your patients' A1c data is collected and reported back to the ordering provider.
- Helping to establish a bi-directional HL7 laboratory interface through your electronic health record (EHR).
- HQIN QIAs will help you coordinate with specialist referral providers to determine if they have Health Information Exchange (HIE) or lab data exchange capacity and leverage this if it is available.

If the structured data are missing, it will count against your measure performance in the numerator, just as if the patient had a hemoglobin A1c level >9%

Workflow Consistency

- Due to COVID-19, the most common issue with poorer-than-usual performance on this measure has been the difficulty for patients to maintain regular testing. It is important to keep this in mind when treatment planning with your patients with diabetes and/or hypertension.
    - Be sure to review the numerators in your reports to identify patients who have not had an A1c test result in their record for more than 12 months.
    - Reach out to those patients first to engage and encourage testing.
    - The pandemic has also affected lifestyles and behaviors that could exacerbate challenges with good nutrition and exercise, and negatively impact A1c levels.
- Ensure the EHR is configured to provide Clinical Decision Support (CDS) alerts to more easily identify and flag patients who are missing lab results or are due soon.
    - Check with your EHR administrator or vendor support to verify this is set up.
    - All staff who access the clinical patient record should check for these alerts (not just A1c) to assist providers and the clinical team to reconcile.
        - For example, if a patient comes for a sick visit, staff should check to ensure labs are up to date or schedule the patient if labs are due soon.
- Every 90 days, or at least every 12 months, A1c results for all patients with Type 1 or Type 2 diabetes should be obtained and entered into the medical record.
    - It is recommended that labs are completed at least every three months to ensure that the most current values are reflected in the measure performance. These may be covered as a billable service depending on the insurance provider.
- All patients with hypertension should be tested for diabetes.

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- All staff who are involved with A1c data collection should be aware of the correct data collection workflow at your practice. Whether lab results are received electronically or in another format, staff designated to process results should follow the EHR-specific workflow process.
    - Check with your EHR vendor on where to find documented instructions on the required workflow to meet this measure.

Numerator Performance

"Met" Criteria

This is an inverse measure. Closer to 0% performance is better.

"Met" means the patient has out-of-control A1c >9%, or the data are missing. The goal of this measure is to reduce the number of patients in the numerator with missing or out-of-control A1c results.

- Most recent hemoglobin A1c level > 9.0% (3046F) OR
- Hemoglobin A1c level was not performed during the measurement period (12 months) (3046F with 8P)

"Not Met" Criteria

The "Performance Not Met" numerator option for this measure represents better clinical quality or control. Submitting that numerator option will produce a performance rate that trends closer to 0% as quality increases.

- Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F) **OR**
- Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (3051F) **OR**
- Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (3052F)

Measure Exclusions

Be sure to accurately document Denominator Exclusions in the EHR (methods can vary by EHR vendor) See CMS Measure Specification link in the Best Practice Resources & Tools section below.

Manual Sample Auditing

Review 10% of QI/QA measure reports at least quarterly to verify root cause for patients not included in the numerator.

- Identify system issues in calculations.

- Identify workflow training opportunities for staff to reduce variation in the process.
- Identify Quality Improvement (QI) opportunities to maximize scoring.

Coding

Make sure practices/providers are reporting and documenting the appropriate billing CPT/HCPCS and ICD-10 diagnosis codes for this measure. Verify correct EHR coding per the CMS specifications (see resource link below).

MIPS Related Improvement Activities

- **MIPS IA_BMH_1:** Diabetes Screening
- **MIPS IA_BE_3:** Engagement with QIN-QIO to implement self-management training programs
- **MIPS IA_PM_4:** Glycemic Management Services
- **MIPS IA_PM_20:** Glycemic Referring Services
- **MIPS IA_PM_19:** Glycemic Screening Services
- **MIPS IA_BE_19:** Use Group Visits for Common Chronic Conditions

Best Practice Resources & Tools

- 2022 MIPS CQM Specifications
- NAHC-How COVID-19 Has Changed the Ways Health Centers Treat Diabetes and Other Underlying Conditions
- Pharmacologic Approaches to Glycemic Treatment
- ADA-Standards of Medical Care in Diabetes 2021-Web Version
- ADA-Facilitating Behavior Change and Well-being
- ADA-T2 Risk Assessment
- 2022 Diabetes Self Management Standards
- ADA-Free Patient Living with T2 Program
- AMA-Prevent Diabetes 2 in Your Patients Tools for Physicians
- AMA-Prevent Diabetes Bidirectional Feedback Loop
- CDC-National Diabetes Prevention Program
- CDC-National Diabetes Prevention Program Registry
- CDC-Diabetes Information for Professionals
- CDC-Diabetes Prevention Tools and Resources
- CDC-Materials to Engage and Recruit Patients
- CDC-Diabetes Prevention Lifestyle Change Program Flipbook
- CDC-Diabetes Prevention Lifestyle Change Program Reference Card
- CDC-Patient Success with DSMES Through Telehealth
- CDC-DSMES Toolkit
- CDC-Smoking and Diabetes

This material was prepared by Health Quality Innovators (HQI), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. 12SOW/HQI/QIN-QIO-0260-07/06/22