2011 Revised Best Practice Addendum: Required Key Measures and Suggested Ways to Measure

Please Note: for all data collection methods, ensure that your program is following guidelines for protecting personal health information and HIPAA guidelines[1].

The following table lists the 2011 Diabetes Best Practices, required key measures and examples of ways to obtain the measures. Use this document as a reference for your Best Practice. We have included a brief glossary of terms.

Glossary of Commonly Used Terms

American Association of Diabetes Educators (AADE)

Assessment of Chronic Illness Care (ACIC)

Baby Friendly Hospital Initiative (BFHI)

Blood Pressure (BP)

Body Mass Index (BMI)

Cardiovascular disease (CVD)

Chronic Kidney Disease (CKD)

Contract Health Service (CHS)

Diabetes Self-Management Education (DSME)

Division of Diabetes Treatment and Prevention (DDTP)

Electronic Health Record (EHR)

Gestational Diabetes (GDM)

Hypertension (HTN)

Joslin Vision Network (JVN)

Medical Nutrition Therapy (MNT)

Physical Activity (PA)

Query Manager (Q-MAN)

Rapid Assessment of Physical Activity (RAPA)

Registered Dietitian (RD)

Required Key Measure (RKM)

Resource and Patient Management System (RPMS)

Visit – General (V-GEN)

[1] http://www.hhs.gov/ocr/privacy/

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Systems of Care RKM #3 is exempt for Data Grant programs ONLY. DDTP notified programs involved. Optional additional measures suggested due to anticipated changes to A1C & HTN national standards	1. *Percent of patients at goal using the most recent value in the past twelve months: • A1C<7.0 • BP<130/80 • LDL<100	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet. Consider tracking the following additional measures: • participants with A1C at their own individualized targets • participants with A1C >9.5 • participants with Blood Pressure readings of <140/90
	2. *Percent of patients at goal using the most recent value in the past twelve months for all of three site-selected *Diabetes Care and Outcomes Audit* measures.	2. RPMS Diabetes Care and Outcomes Audit – See RKM #1 above.
	3. *Total score on the Assessment of Chronic Illness Care 3.5 tool, assessed at six month intervals, in the past twelve months.	3. ACIC score[2] and hand tally and maintain records.

[2] http://www.improvingchroniccare.org/index.php?p=Survey_Instruments&s=165

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Physical Activity for Diabetes Prevention and Care Collecting group goals are also acceptable.	1. *Percent of individuals in the target population who have had their level of physical activity assessed and documented in the past twelve months.	1. RPMS Q-MAN (for target group) and search for physical activity health factors (INACTIVE, SOME ACTIVITY, ACTIVE, VERY ACTIVE). See RPMS Health Factor and Exam Code Manual for definitions. OR Local tracking, e.g. Excel spreadsheet. OR Local tracking with a standard tool such as the Rapid Assessment for Physical Activity (RAPA)[3] to assess Physical Activity (PA).
	2. *Percent of individuals enrolled in a fitness intervention who showed improvement in their fitness levels in the past twelve months.	2. Local tracking e.g. Excel spreadsheet or paper and pencil of people who had PA assessed **AND** PA documented.
	3. * Percent of individuals in the target population who met one or more of their physical activity behavioral goals in the past twelve months.	3. Local tracking (RAPA, Access database, Excel spreadsheet, paper and pencil) of people who met one or more of their PA behavioral goals.
	4. *Number of policies implemented by the organization's leadership for the promotion and expansion of opportunities for physical activity.	4. Local tracking, e.g. Excel spreadsheet.

[3] http://depts.washington.edu/hprc/rapa

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Diabetes Self-Management Education (DSME) and Support Clinical and Self-Management Support RKM are now optional	**Educational** 1. *Percent of individuals with documented diabetes self-management education (DSME) services in the past 12 months. **Behavioral** 2. *Percent of individuals with documented diabetes self-management education (DSME) who achieved one or more patient identified behavioral goals in the past 12 months. **Clinical** 3. Percent of individuals with documented diabetes self-management education (DSME) who achieved one or more patient identified clinical goals in the past twelve months. **Self-Management Support** 4. Percent of individuals with documented diabetes self-management education (DSME) who were referred to clinic.	1. RPMS template for target group using updated diabetes education taxonomies. OR RPMS IHS Diabetes Care and Outcomes Audit Report diabetes education code with an end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet. 2. Use RPMS and enter “Goals set” and “Goals met” under Patient Education. OR Local tracking, e.g. Excel spreadsheet.

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Foot Care RKM #3 is optional.	1. *Percent of diabetes patients with documented foot exams in the past twelve months.	RPMS RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR RPMS EHR Q-MAN Search (DIABETIC FOOT EXAM, COMPLETE or EX code 28) OR V-GEN or iCare OR Local tracking, e.g. Excel spreadsheet
	2. *Percent of diabetes patients with documented risk-appropriate foot care education in the past twelve months.	2. If using RPMS EHR, you will need to enter the "Diabetes Foot Exam, Compete" in the exams section of the wellness tab, and need to enter the diabetes education under the education tab. For patients with an abnormal exam (high risk), use the Diabetes – Foot care and Exam education module. For patients with normal exams (low risk), any DM education is appropriated. With this data entered, you can use V-GEN or RPMS to generated reports of your patients on the RPMS DM registry that list "Diabetes Foot Exam, Complete" Abnormal, and Education Topic "Diabetes – Foot care and Exam" "Diabetes Foot Exam, Complete" Normal, and any education topic. If **not** using RPMS EHR, you will need to do a chart review.
	3. Percent of diabetes patients with foot ulcers who received treatment in the last twelve months.	

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Adult Weight and Cardiometabolic Risk Management and Diabetes Guidelines	1. *Percent of diabetes patients with a documented assessment for overweight or obesity in the past twelve months	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet.
	2. *Percent of diabetes patients with documented nutrition and physical activity education by a Registered Dietitian or other provider in the past twelve months.	2. RPMS IHS Diabetes Care and Outcomes and Audit with end date that captures time period appropriate for your grant timeline - "Diabetes-Related Education" (Diet instruction by any provider and Exercise instruction). OR Local tracking, e.g. Excel spreadsheet.
	3. *Percent of all participants who achieve both their nutrition goal(s) and physical activity goal(s) in the past twelve months.	3. RPMS EHR National Nutrition Template and local tracking of people with diabetes who achieved nutrition *AND* PA goal. Use provider codes and education codes. • For all providers (including RDs): DM-EX, DM-N, OBS-N OBS-EX, CAD-N, and CAD-EX. • For use by RDs only: DM-MNT OBS-MNT, and CAD-MNT. OR Local tracking, e.g. Excel spreadsheet.
	4. *Percent of all participants who achieve their weight loss goal in the past twelve months.	4. Local tracking, e,g, Excel spreadsheet.

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Cardiovascular Health and Diabetes RKM #3 is now optional	1. *Percent of diabetes patients with documented smoking status in the past twelve months.	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet.
	2. *Percent of diabetes patients who smoke who received tobacco cessation intervention(s) in the past twelve months.	2. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR RPMS Q-MAN to search for Active DM patients who use tobacco (search appropriate Health Factors). Use this list for tracking cessation interventions. OR Local tracking of people with diabetes who smoke AND received tobacco cessation program.
	3. Percent of diabetes patients who smoke who quit smoking in the past twelve months.	
	4. *Percent of diabetes patients who had most recent blood pressure in the past twelve months at target.	4. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet. **NOTE:** Please consider tracking additional measures: • for participants with Blood Pressure readings of <140/90
	5. *Percent of diabetes patients with documented cardiovascular disease (CVD) or hypertension education in the past twelve months.	5. RPMS Patient Education codes such as DM-C, DM-DP, HTN-DP, CAD-DP and use Q-MAN or PGEN to run a report for these specific education codes. OR Local tracking, e.g. Excel spreadsheet.?

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Eye Care	1. *Percentage of diabetes patients in the target population with a documented qualifying eye exam in the past twelve months	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet.
	2. *Percentage of diabetes patients in the target population with abnormal retinal screening exam who received appropriate specialty follow up in the past twelve months.	2. Local tracking of Contract Health Service (CHS) referrals of people with diabetes who were evaluated as needing retinal treatment AND received treatment. OR Contact eye care specialists, including Joslin Vision Network (JVN) sites, to determine who received treatment.
Nutrition for Diabetes Prevention and Care	1. *Percent of individuals in the target population with documented nutrition education in the past twelve months.	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline ("Diet instruction by any provider"). OR Local tracking, e.g. Excel spreadsheet
	2. *Percent of individuals in the target population with documented MNT in the past twelve months.	2. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline ("Diet instruction by RD"). OR Local tracking, e.g. Excel spreadsheet.
	3. * Percent of individuals in the target population with documented MNT or individualized nutrition education who met one or more of their nutrition-related behavioral goals in the past twelve months	3. RPMS EHR – National Nutrition Template – Education Nutrition goals and use local tracking of people with documented MNT or nutrition education AND who meet at least 1 nutrition-related behavioral goals. Use the following patient education codes: • For all providers (including RDs): DM-LA, PDM-LA for Lifestyle Adaptation; DM-N, PDM-N for Nutrition Education; DM-P, PDM-P for Prevention. • For use by RDs only: DM-MNT, PDM-MNT for diabetes and pre-diabetes. OR Local tracking, e.g. Excel spreadsheet.
	4. * Percent of individuals in the target population with documented MNT or individualized nutrition education who met one or more of their nutrition-related clinical goals in the past twelve months	4. See RKM #3 above.

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Diabetes/Pre-Diabetes Case Management	1. * Percent of high-risk diabetes patients in the target population with an assigned case manager.	1. Local tracking, e.g. Excel spreadsheet. OR RPMS template or Register for case-managed patients. OR RPMS Q-MAN search for "Case Manager".
	2. *Percent of patients with improvement (positive results) for at least one patient-identified self-management goal.	2. Local tracking, e.g. Excel spreadsheet. OR AADE7[4] to track goal-setting.
Oral Health Care Required Key Measures re-worded.	1. *Percent of diabetes patients who had documented oral health patient education (done by any provider) in the past 12 months.	1. RPMS education code DM-PERIO. OR Local tracking, e.g. Excel spreadsheet.
	2. *Percent of diabetes patients who had a documented dental exam during the in the past 12 months.	2. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet.
Community Diabetes Screening	1. *Percent of individuals in the target population screened for diabetes in the past twelve months.	1. Local tracking, e.g. Excel spreadsheet to track a targeted group at least one community screening event and following up and reporting on the target group.
	2. *Percent of individuals screened for diabetes who received diabetes prevention education at the time of screening in the past twelve months	2. Local tracking, – e.g. Excel spreadsheet, of people who were screened AND received DM prevention education at time of screening for at least one community screening event. **NOTE:** RPMS patient education codes include DM instruction for at least 5 minutes done individually or in a group setting.

[4] http://www.diabeteseducator.org/ProfessionalResources/AADE7/

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Youth & Type 2 Diabetes Prevention and Treatment	1. *Percent of youth in the target population screened for overweight and obesity in the past twelve months. 2. *Percent of youth in the target population with a screening BMI result greater than the 85th percentile tested for pre-diabetes/diabetes in the past twelve months. 3. *Percent of youth in the target population with an increase in both healthy eating and physical activity behaviors in the past twelve months.	1. Local tracking, e.g. Excel spreadsheet of youth registry. OR Use RPMS and run Q-MAN to create template of target group and run BMI report. 2. Use RPMS and generate a Body Mass Index report (BMI) on template to determine target group over 85th percentile and use list for tracking prediabetes/diabetes screening. 3. Local tracking tool of percent of youth with improved healthy eating behaviors AND improved PA behaviors.
Diabetes Prevention	1. *Percentage of all participants who achieve their weight loss goal. 2. *Percentage of all participants who achieve their nutrition goal(s). 3. *Percentage of all participants who achieve their physical activity goal(s).	1. Local tracking, e.g. Excel spreadsheet 2. See RKM #1 above. 3. See RKM #1 above.

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Screening for Chronic Kidney Disease RKM #1 Re-worded. Optional additional measure suggested by due to anticipated changes to HTN national standards	1. *Percent of individuals with diabetes who were screened for CKD in the past twelve months screened by using urine albumin to creatinine ratio (UACR) and creatinine/Glomeluar Filtration Rate (GFR).	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet.
	2. *Percent of individuals with diabetes who had most recent BP at < 130/80 in the past twelve months (or have comorbidities that dictate a higher target).	2. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline. OR Local tracking, e.g. Excel spreadsheet. **C**onsider tracking this additional measure: • participants with Blood Pressure readings of <140/90
	3. *Percent of individuals with diabetes and hypertension who are treated with an angiotensin converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) (or have a documented allergy/intolerance) in the past twelve months.	3. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline and include people with diabetes AND hypertension AND are treated with ACE or ARB. OR Local tracking, e.g. Excel spreadsheet.

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School Health: Promoting Health Eating and Physical Activity and Managing Diabetes in the School Setting [5]	1. *Percent of students with a BMI calculated within the past twelve months. 2. *Percent of youth with a BMI greater than the 85th percentile who are referred to their health care team within the past twelve months 3. *The school's score on the School Health Index[4] within the past twelve months.	1. Use RPMS to create template of student target group. Use Q-MAN to run a Body Mass Index (BMI) report. OR Local tracking, e.g. Excel spreadsheet. 2. Use RPMS to generate a Body Mass Index (BMI) report on template to list target group over 85th percentile. Use list to track referrals. OR Local tracking, e.g. Excel spreadsheet. 3. Local tracking, e.g. Excel spreadsheet. Consider while tracking: • Plan to collect baseline data at the beginning of the school year, regardless of your grant period
Depression Care	1. *Percentage of diabetes patients in the target population, who were ***screened*** for depression in the past twelve months. 2. *Percentage of diabetes patients in the target population with documented depression that received ***treatment*** for depression in the past twelve months.	1. RPMS IHS Diabetes Care and Outcomes Audit Report with end date that captures time period appropriate for your grant timeline OR Local tracking, e.g. Excel spreadsheet. 2. Use RPMS and run medication list. OR Use RPMS and do Q-MAN for DM Register Active patients with Depression surveillance category to create a list for tracking treatment. OR Local tracking, e.g. Excel spreadsheet.

[5] http://www.cdc.gov/HealthyYouth/SHI/

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Diabetes and Pregnancy	1. *Percent of women diagnosed with diabetes in pregnancy whose care and clinical outcomes are actively tracked in the past twelve months. 2. *Percent of reproductive age women with diabetes who have documented preconception care and counseling in the past twelve months. 3. *Percent of women with diabetes in pregnancy who have documented care and education specific to diabetes and pregnancy in the past twelve months.	1. Local tracking of target population. OR Set up registry in RPMS of target population and use iCARE for tracking. 2. RPMS education codes DMC-PCC, PDM-PCC. OR Local tracking, e.g. Excel spreadsheet. 3. RPMS patient education codes GDM-N, GDM-MNT (MNT for RD use only), GDM-EX, GDM-LA. OR Local tracking, e.g. Excel spreadsheet.
Community Advocacy for Diabetes Prevention and Control	1. *Number of members in your Community Diabetes Advocacy Group which include the following: • who have diabetes • family members of a person with diabetes • representatives from community entities and/or health care facilities outside of your diabetes program. 2. *Number of health-related policies that are impacted or implemented as a result of action by the Community Diabetes Advocacy Group.	1. Local tracking, e.g. Excel spreadsheet. 2. See RKM #1 above.

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Breastfeeding Support Changed "Baby Friendly Steps" to BFHI for better clarity in RKM #1.	1. *The number of Baby Friendly Hospital Initiative[6] steps implemented in hospital/clinic in past twelve months.	1. Local tracking, e.g. Excel spreadsheet.
	2. *Percent of babies with documented breastfeeding choice at birth, two months, four months, six months, and one year in the past twelve months.	2. Local tracking such as delivery Roster/Log orPerinatal Excel Roster.
	3. *Percent of babies exclusively breastfed at birth, and mostly or exclusively breastfed at two months, six months, nine months, and one year in the past twelve months.	3. Local tracking, e.g. Excel spreadsheet.
Pharmaceutical Care	1. *Percent of diabetes patients with documented review of the medication profile by a pharmacist in the past twelve months.	1. Use RPMS codes for review of medication profile by pharmacist.
	2. *Percent of diabetes patients with documented medication education by a pharmacist in the past twelve months.	2. Use RPMS patient education codes for pharmacists only use M-any or any-M education codes.

[6] http://www.babyfriendlyusa.org/eng/index.html