CCHCS DIABETES QUALITY OF CARE REVIEW*

Reviewer: _____ **Date of Review:** _____
Patient Name: _____ **CDCR #** _____ **DOB:** _____
PCP: _____ **Date(s) of Visit(s):** _____

1.) Is the overall history/problem list documentation for diabetes adequate? ❑ Yes ❑ No

- Are current complaints documented? Pertinent symptoms reviewed?
- Is a review of medications documented? Is adherence to medications reviewed?
- Is a review of diabetic complications (i.e. retinopathy, neuropathy, hypoglycemia) documented, if applicable?
- Is a review of glycemic control documented (i.e. most recent HbA1c or blood sugar logs)?
- Is a review of vaccinations (Pneumovax, & annual Influenza Vaccine) documented?

2.) Is the overall focused clinical examination for diabetes adequate? ❑ Yes ❑ No

- Are vital signs documented? Weight changes noted? BP on encounter date = ____/___
- Does physical examination include cardiac, lung, extremity exam at a minimum? Does physical examination expand to encompass complaints in history (i.e fundoscopic exam, if visual changes stated, or foot inspection, if neuropathy symptoms mentioned)?
- Is there documentation of a comprehensive foot examination, including observations of skin changes, deformities, peripheral pulses, and presence of neuropathy via pressure sensation or vibratory sensation testing, within the last year?

3.) Is the overall assessment for diabetes adequate? ❑ Yes ❑ No

- Is Diabetes Type 1 or Type 2 indicated?
- Does the assessment address all goals for diabetes management?
  - A. Blood sugar goal achieved (HbA1c < 8%, typically)?
  - B. Blood pressure goal achieved (BP < 140/90, typically)?
  - C. Lipid goal achieved (LDL <100, typically)?
- Does the assessment address microvascular complications, if applicable?
  - A. Retinopathy, Nephropathy, and/or Neuropathy

4.) Is the overall plan for diabetes adequate? ❑ Yes ❑ No

- If blood sugar management not at goal (HbA1c > 8%) is there clear therapeutic recommendations documented (i.e. medication started or dosage increased, second agent started)? If not, is reason given?
  - A. Is Metformin recommended/prescribed as first line medication? If not, was reason given?
  - B. Is sulfonylurea recommended/prescribed as second line medication if HbA1c < 10%? If not, is reason given?
  - C. Is basal insulin recommended/ordered as second line medication if HbA1c > 10%? If not, is reason given?
  - D. Is blood sugar monitoring ordered?
    - i. HbA1c Q 3 months, typically
    - ii. Fingerstick Blood Glucose monitoring, if on insulin therapy?
      - a. Daily fasting if not on multiple insulin injection therapy
      - b. BID or TID pre-prandial if on multiple insulin injection therapy
      - c. Glucometer issued if blood sugars difficult to control or if average fasting blood sugar < 130, but HbA1c > 8%
- If blood pressure management not at goal (BP >140/90) is there clear therapeutic recommendations documented (i.e. medication started or dosage increased)?
  - A. Was ACE-I prescribed if BP not at goal? If not, was reason given?
  - B. Was ARB prescribed, if ACE-I allergy or intolerance documented? If not, was reason given?
  - C. Was blood pressure monitoring ordered, if not at goal? If ordered, was follow-up on blood pressure monitoring appropriate (< 1week, if BP >159/99, <60 days if >139/89)? If not, was reason provided?
- If lipid management not at goal (LDL >100) is there clear therapeutic recommendations documented (i.e. statin started/increased)? If not, is reason given?
- Does the plan appropriately address microvascular disease screening/management?
  - A. Is annual screening ordered for retinopathy, nephropathy, and neuropathy, if indicated and not completed < 1 yr?
    - i. Microalbumin screening is not needed, if patient on ACE-I or ARB
  - A. If urine microalbumin screening +, is patient started on ACE-I or ARB?
  - B. Is specialty referral made, if retinopathy present?
  - C. Is referral made for podiatry, if clinically indicated (i.e. significant deformity)?
- Is appropriate laboratory monitoring ordered?
  - A. HbA1c Q 6 months and LDL Q 6-12 months, if at goal.
  - B. More frequent monitoring, if not at goal.
- Are vaccinations appropriately ordered, if not up to date?
- Is appropriate follow-up ordered, and in accordance with CMDP policy?
  - A. If all goals met over last two encounters, follow-up within 180 days
  - B. If all goals not met, follow-up typically within 90 days or more frequently, if clinically indicated.

5.) Is the overall education and effective communication for diabetes adequate? ❑ Yes ❑ No

- Instructions/counseling on lifestyle modifications: weight loss, dietary changes, exercise, etc.
- Medication issues: adherence, side effects, etc.
- Diabetic complication avoidance and risk reduction.
- Is there documentation of effective communication, including identification of disability† & accommodations‡ employed to ensure effective communication, of applicable?

RECOMMENDATIONS/COMMENTS:

*All elements in the each domain are suggestions for good documentation, not requirements. Use clinical judgment when reviewing the documentation.
Patient disease severity and corresponding management should be clear to the reviewer, in all documentation.
Please consider the elements in this review tool when completing Access Measure Audit Tool.