DIABETES MEASURES GROUP OVERVIEW

2016 PQRS OPTIONS FOR MEASURES GROUPS:

2016 PQRS MEASURES IN DIABETES MEASURES GROUP:
#1 Diabetes: Hemoglobin A1c Poor Control
#110 Preventive Care and Screening: Influenza Immunization
#117 Diabetes: Eye Exam
#119 Diabetes: Medical Attention for Nephropathy
#126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

INSTRUCTIONS FOR REPORTING:

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

  G8485: I intend to report the Diabetes Measures Group

- Report the patient sample method:

  20 Patient Sample Method via registries: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2016).

- Patient sample criteria for the Diabetes Measures Group are patients aged 18 through 75 years with a specific diagnosis of diabetes accompanied by a specific patient encounter:

  The following diagnosis codes indicating diabetes:

  Accompanied by:

  One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99349, 99350, G0402, G0438, G0439

- To satisfactorily report the Diabetes Measures Group requires reporting a numerator option on all applicable measures, for each patient within the eligible professional’s patient sample, a minimum of once during the reporting period.

- Measure #110 only needs to be reported a minimum of once during the reporting period when the patient’s visit included in the patient sample population is between January and March for the 2015-2016 influenza season.
season OR between October and December for the 2016-2017 influenza season. When the patient’s office visit is between April and September, Measure #110 is not applicable and will not affect the eligible provider’s reporting or performance rate.

- Measure #126 is not reported (does not apply) when the clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer’s, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation.

- Instructions for qualifying numerator option reporting for each of the measures within the Diabetes Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

**Composite QDC G8494:** All quality actions for the applicable measures in the Diabetes Measures Group have been performed for this patient.

- This measures group contains one or more inverse measures. An inverse measure is a measure that represents a poor clinical quality action as meeting performance for the measure. For these measures, a lower performance rate indicates a higher quality of clinical care. Composite codes for measures groups that contain inverse measures are only utilized when the appropriate quality clinical care is given.

The composite code for this measures group may be reported when codes in the summary table below are applicable for reporting of each measure within the measures group.

### Table 2 - QDC Options

<table>
<thead>
<tr>
<th>Measure #</th>
<th>QDC options for acceptable use of the composite QDC</th>
<th>#1*</th>
<th>#110</th>
<th>#117</th>
<th>#119</th>
<th>#126</th>
<th>#226</th>
</tr>
</thead>
<tbody>
<tr>
<td>QDC options for acceptable use of the composite QDC</td>
<td>3044F or 3045F</td>
<td>G8482</td>
<td>2022F or 2024F or 2026F or 3072F</td>
<td>3060F or 3061F or 3062F or 3066F or G8506</td>
<td>G8404</td>
<td>4004F or 1036F</td>
<td></td>
</tr>
</tbody>
</table>

*Indicates an inverse measure

- **Measure Group Reporting Calculations:**

Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each applicable measure within the measures group reported by the eligible professional.

Performance exclusion QDCs are not counted in the performance denominator. If the eligible professional submits all performance exclusion QDCs, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening for Osteoporosis for Women Aged 65-85 Years of Age would not be applicable to male patients.
according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 (null) and would be considered satisfactorily reporting.

When a lower rate indicates better performance, such as Measure #1, a 0% performance rate will be counted as satisfactorily reporting (100% performance rate would not be considered satisfactorily reporting).

• **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.
Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control -- National Quality Strategy
Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions:
INVERSE MEASURE - A lower calculated performance rate for this measure indicates better clinical care or control. The “Performance Not Met” numerator option for this measure is the representation of the better clinical quality or control. Reporting that numerator option will produce a performance rate that trends closer to 0%, as quality increases. For inverse measures a rate of 100% means all of the denominator eligible patients did not receive the appropriate care or were not in proper control, and therefore an inverse measure at 100% does not qualify for reporting purposes, however any reporting rate less than 100% does qualify.

Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.

Numerator Options:
**Performance Met:**
- Most recent hemoglobin A1c level > 9.0% (3046F)
- Hemoglobin A1c level was not performed during the measurement period (12 months) (3046F with 8P)

**Performance Not Met:**
- Most recent hemoglobin A1c (HbA1c) level < 7.0% (3044F)
- Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0% (3045F)
Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization -- National Quality Strategy Domain: Community/Population Health

**DESCRIPTION:**
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

**NUMERATOR:**
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

**Numerator Instructions:**
- If reporting this measure between January 1, 2016 and March 31, 2016, quality-data code G8482 should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 or January, February, and March of 2016 for the flu season ending March 31, 2016.
- If reporting this measure between October 1, 2016 and December 31, 2016, quality-data code G8482 should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2016 for the flu season ending March 31, 2017.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2015-2016 flu season OR 2016-2017 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, G8482 should be reported.

**Definition:**
**Previous Receipt** - Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

**NUMERATOR NOTE:** The numerator for this measure can be met by reporting either administration of an influenza vaccination or that the patient reported previous receipt of the current season’s influenza immunization. If the performance of the numerator is not met, a clinician can report a valid performance exclusion for having not administered an influenza vaccination. For clinicians reporting a performance exclusion for this measure, there should be a clear rationale and documented reason for not administering an influenza immunization if the patient did not indicate previous receipt, which could include a medical reason (e.g., patient allergy), patient reason (e.g., patient declined), or system reason (e.g., vaccination not available). The system reason should be indicated only for cases of disruption or shortage of influenza vaccination supply.

**Numerator Options:**
**Performance Met:**
Influenza immunization administered or previously received (G8482)

**OR**

**Other Performance Exclusion:**
Influenza immunization was not administered for reasons documented by clinician (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons) (G8483)

**OR**

**Performance Not Met:**
Influenza immunization was not administered, reason not given (G8484)
Measure #117 (NQF 0055): Diabetes: Eye Exam -- National Quality Strategy Domain: Effective Clinical Care

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal or dilated eye exam (no evidence of retinopathy) in the 12 months prior to the measurement period.

NUMERATOR:
Patients with an eye screening for diabetic retinal disease. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional in the measurement period or a negative retinal or dilated exam (no evidence of retinopathy) by an eye care professional in the year prior to the measurement period.

NUMERATOR NOTE: The eye exam must be performed or reviewed by an ophthalmologist or optometrist. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

Numerator Options:
Performance Met: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed (2022F)

OR
Performance Met: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed (2024F)

OR
Performance Met: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed (2026F)

OR
Performance Met: Low risk for retinopathy (no evidence of retinopathy in the prior year) (3072F)*

*NOTE: This code can only be used if the encounter was during the measurement period because it indicates that the patient had “no evidence of retinopathy in the prior year”. This code definition indicates results were negative, therefore a result is not required.

OR
Performance Not Met: Dilated eye exam was not performed, reason not otherwise specified (2022F or 2024F or 2026F with 8P)

**DESCRIPTION:**
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.

**NUMERATOR:**
Patients with a screening for nephropathy or evidence of nephropathy during the measurement period

**Numerator Instructions:** This measure is looking for a nephropathy screening test or evidence of nephropathy.

**Numerator Options:**

- **Performance Met:** Positive microalbuminuria test result documented and reviewed (3060F)
- **OR**
- **Performance Met:** Negative microalbuminuria test result documented and reviewed (3061F)
- **OR**
- **Performance Met:** Positive macroalbuminuria test result documented and reviewed (3062F)
- **OR**
- **Performance Met:** Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist) (3066F)
- **OR**
- **Performance Met:** Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8506)
- **OR**
- **Performance Not Met:** Nephropathy screening was not performed, reason not otherwise specified (3060F or 3061F or 3062F with 8P)
Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

**NUMERATOR:**
Patients who had a lower extremity neurological exam performed at least once within 12 months

**Numerator Instructions:** Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk categorization and follow up treatment plan should be done according to the following table:

**Table 3 - Risk Categorization System:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Profile</th>
<th>Evaluation Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal</td>
<td>Annual</td>
</tr>
<tr>
<td>1</td>
<td>Peripheral Neuropathy (LOPS)</td>
<td>Semi-annual</td>
</tr>
<tr>
<td>2</td>
<td>Neuropathy, deformity, and/or PAD</td>
<td>Quarterly</td>
</tr>
<tr>
<td>3</td>
<td>Previous ulcer or amputation</td>
<td>Monthly to quarterly</td>
</tr>
</tbody>
</table>

This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Definition:**
Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.

**Numerator Options:**

- **Performance Met:** Lower extremity neurological exam performed and documented (G8404)

- **Performance Not Met:** Lower extremity neurological exam not performed (G8405)
Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention -- National Quality Strategy Domain: Community/Population Health

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention report 4004F with 8P.

Numerator Options:
Performance Met: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user (4004F)

OR
Performance Met: Current tobacco non-user (1036F)

OR
Medical Performance Exclusion: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons) (4004F with 1P)

OR
Performance Not Met: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified (4004F with 8P)
DIABETES MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

MEASURE #1 – DIABETES: HEMOGLOBIN A1C POOR CONTROL
RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al., 1995).

CLINICAL RECOMMENDATION STATEMENTS:
American Geriatrics Society (Brown et al. 2003):

For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Quality of Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):

Lowering A1c to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1c goal for non-pregnant adults in general is < 7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of < 7% appears reasonable for many adults for macrovascular risk reduction. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial suggest a small but incremental benefit in microvascular outcomes with A1c values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1c goals than the general goal of < 7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (Level of Evidence: B)

Conversely, less stringent A1c goals than the general goal of < 7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain.
despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (Level of Evidence: C)

**MEASURE #110 – PREVENTIVE CARE AND SCREENING: INFLUENZA IMMUNIZATION**

**RATIONALE:**
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

**CLINICAL RECOMMENDATION STATEMENTS:**
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Routine annual influenza vaccination is recommended for all persons aged >=6 months who do not have contraindications. Vaccination optimally should occur before onset of influenza activity in the community. Health care providers should offer vaccination soon after vaccine becomes available (by October, if possible). Vaccination should be offered as long as influenza viruses are circulating. (CDC/ACIP, 2014)

**MEASURE #117 – DIABETES: EYE EXAM**

**RATIONALE:**
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative) (American Diabetes Association 2009).

**CLINICAL RECOMMENDATION STATEMENTS:**
American Diabetes Association (ADA) (2009):
- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
- Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
- Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
• The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)

MEASURE #119 – DIABETES: MEDICAL ATTENTION FOR NEPHROPATHY
RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body’s inability to correctly produce or utilize the hormone insulin (National Institute of Diabetes and Digestive and Kidney Diseases 2011). It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Diabetes may cause life-threatening, life-ending or life-altering complications, including end-stage kidney disease. Diabetes is the primary cause of kidney failure, accounting for 44 percent of newly diagnosed cases in 2005 (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Clinical guidelines recommend regular testing to evaluate urine albumin excretions and serum creatinine and the estimated glomerular filtration rate derived from serum creatinine, in addition to comparing measurements when screening for chronic kidney disease (American Diabetes Association 2009; American Association of Clinical Endocrinologists 2007).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (2009):
• Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of >= 5 years and in all type 2 diabetic patients, starting at diagnosis. (Level of Evidence E)
• Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (Level of Evidence E)
• In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (Level of Evidence A)

American Association of Clinical Endocrinologists (2007): Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with Type 1 diabetes mellitus (T1DM) and at the time of diagnosis in patients with Type 2 diabetes mellitus (T2DM). Testing includes:
• Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine

The following are diagnostic criteria for chronic kidney disease:
• Estimated glomerular filtration rate < 60 mL/min/1.73 m2 or albumin-to-creatinine ratio >= 30 mg albumin/g creatinine
• Microalbuminuria >= 30 mg albumin/g creatinine
• Macroalbuminuria >= 300 mg albumin/g creatinine (Grade A)
• Prescribe an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker in the antihypertensive regimen in the absence of contraindications. (Grade A)

California Healthcare Foundation/American Geriatrics Society (2003): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes mellitus. After the initial screening and in the absence of previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Level III, Grade A)
MEASURE #126 - DIABETES MELLITUS: DIABETIC FOOT AND ANKLE CARE, PERIPHERAL NEUROPATHY – NEUROLOGICAL EVALUATION

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines).

MEASURE #226 – PREVENTIVE CARE AND SCREENING: TOBACCO USE: SCREENING AND CESSATION INTERVENTION

RATIONALE:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of
effectiveness (ie, pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)