BlueCross BlueShield of New Mexico

IMPROVING HEALTH CARE QUALITY

Comprehensive Diabetes Care — Nephropathy

Blue Cross and Blue Shield of New Mexico (BCBSNM) collects quality data from our providers to measure and improve the quality of care our members receive. Comprehensive Diabetes Care (CDC) – Nephropathy is one aspect of care we measure in our quality programs. Quality measures evaluate a prior calendar year performance.

What We Measure

We capture the percentage of members ages 18 to 85 with type 1 and type 2 diabetes who had medical attention for nephropathy.

CDC is a Healthcare Effectiveness Data and Information Set (HEDIS®) measure. See the **National Committee for Quality Assurance (NCQA) website** for more details.

Why It Matters

If left unmanaged, diabetes can lead to serious complications, including kidney disease. Diabetic kidney disease may be asymptomatic. Regular tests can detect issues, and early treatment may help delay disease progression. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life. With support from providers, members can help manage their diabetes by taking medications as instructed, eating a healthy diet, being physically active and quitting tobacco products. Learn more from **NCQA**.

Eligible Population

This measure includes members ages 18 to 75 during the measurement year with either type 1 or 2 diabetes.

Exclusions: Members are excluded from the measure who meet any of the following criteria:

- Received hospice care during the measurement year
- Were dispensed dementia medication
- Were ages 66 and older during the measurement year with both frailty and advanced illness
- Were Medicare members ages 66 and older and enrolled in an Institutional Special Needs Plan or living long-term in an institution during the measurement year

- Were diagnosed with polycystic ovarian syndrome, gestational diabetes or steroid-induced diabetes during the measurement year or year prior but did not have a diagnosis of diabetes

Tips to Consider

- Identify care gaps and schedule lab testing before office visits to review results and adjust treatment plans if needed.
- Complete urine protein testing for attention to nephropathy at an office visit. Testing includes basic urinalysis by dip stick or tablet reagent.
- Repeat abnormal lab tests later in the year to document improvement.
- Monitor blood pressure status at each visit and adjust medications as needed for control.
- Retake the member's blood pressure during an office visit if the initial readings are high.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.
- Review lists of members who have missed an appointment or missed the nephropathy measurement.

How to Document

Quality data for this measure is collected from claims and chart review.

Document annual evaluation for nephropathy with one of the following:

- Nephropathy screening or monitoring test
- Visit to a nephrologist
- Treatment with angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARB): Document either a written or filled prescription or that member took medication
- Medical attention for any of the following (no restriction on provider type): diabetic nephropathy, end-stage renal disease, chronic renal failure, chronic kidney disease, renal insufficiency, proteinuria, albuminuria, renal dysfunction, acute renal failure, dialysis, hemodialysis, peritoneal dialysis
- Documentation of renal transplant

Documentation must include a note with the date a urine test was performed and the result or finding:

- 24-hour urine test for albumin or total protein
- Urine for albumin/creatinine or protein/creatinine ratio
- Spot urine for albumin or protein such as dipstick or test strip
- Timed urine for albumin or protein

For more information, see **NCQA's HEDIS Measures and Technical Resources**.

Questions?

Contact your BCBSNM Network Representative.