BlueCross BlueShield of New Mexico

IMPROVING HEALTH CARE QUALITY

Comprehensive Diabetes Care

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) 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 75 with diabetes (type 1 or type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- Retinal eye exam
- Medical attention for nephropathy
- Blood pressure control (<140/90 mm Hg)

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 comorbidities, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death. Proper diabetes management is essential to control blood glucose, reduce risks for complications and prolong life. With support from health care providers, patients can manage their diabetes by taking medications as instructed, eating a healthy diet, being physically active and quitting tobacco products. Learn more from **NCQA**.

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Eligible Population

Members ages 18 to 75 during the measurement year with either type 1 or 2 diabetes are included in this measure.

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

- Received palliative care or used hospice services 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 any office visit. Testing includes basic urinalysis by dip stick or tablet reagent.
- Document medication adherence to angiotensin-converting enzyme (ACE) inhibitors and angiotensin II receptor blockers (ARB) when applicable.
- 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.
- Encourage members with diabetes to have annual retinal eye exams by an eye care specialist.
- Communicate with members and other treating providers to ensure all tests are completed and results are documented in the medical record.

How to Document

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

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

Questions?

Contact your BCBSNM Network Representative.