Domain 1 Patient Engagement Data Request

Suffolk Care Collaborative 3ci Diabetes Project

Request: Please return the attached SCC excel template via BOX by January 11, 2019
For BOX questions or access related inquiries, please contact Janine Muccio, Janine.Muccio@stonybrookmedicine.edu

Patient Grouper: **Medicaid Patient Data (Medicaid may be Primary, Secondary or Tertiary Insurance)**
Time Period: **January 1, 2018– December 31, 2018**

Project 3ci: Diabetes Wellness & Self-Management Program

Patient Engagement Definition: As per the definition of actively engaged, patient engagement refers to the number of participating patients with **at least one hemoglobin A1c test within the four most recent quarters** who have diabetes or are at risk for diabetes. Duplicate counts of patients are not allowed within 1 DSRIP measurement year. Counts are not additive across DSRIP years.

The target population as defined below should receive a hemoglobin A1c test within the time period above.

Age Range: **18 years old and older**

1) Who have diabetes based on a principal or secondary ICD-9 diagnosis code of 250.00-250.93 or ICD-10 diagnosis code of E08.___ or E09.___E10.___or E11.___ or E13.___(inclusive of all 4th, 5th, 6th, 7th digits)

   OR

2) A1C ≥ 6.5 (**NOTE:** A1c of ≥ 6.5 defines the target population and still requires a subsequent A1c during the time period above to satisfy the actively engaged definition)

   OR

3) Are "at-risk" for diabetes based on Table 2 of the ADA's Diabetes Care website indicating the criteria for testing for diabetes or pre-diabetes in asymptomatic adults. It should be noted that to be considered a patient "at-risk" the individual would have to demonstrate sufficient risk factors or clear cut symptoms prior to official diagnosis as outlined in Table 2. (http://clinical.diabetesjournals.org/content/diaclin/36/1/14.full.pdf)

1. Testing should be considered in overweight or obese (BMI ≥25 kg/m² or ≥23 kg/m² in Asian Americans) adults who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - History of CVD
   - Hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
   - Women with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
2. Patients with prediabetes (A1C ≥5.7% [39 mmol/mol], IGT, or IFG) should be tested yearly.
3. Women who were diagnosed with GDM should have lifelong testing at least every 3 years.
4. For all other patients, testing should begin at age 45 years.
5. If results are normal, testing should be repeated at a minimum of 3-year intervals, with consideration of more frequent testing depending on initial results and risk status.

Please note the patient engagement metrics and definitions are subject to change by NYS DOH.

The following LOINC codes and CPT II codes may be used to identify completed hemoglobin A1c tests:

- *17856-6*
- *4548-4*
- *4549-2*
- *3044F*
- *3045F*
- *3046F*

Please see excel template for formatting specifications.

Requested Data Elements:

1. CIN #
2. Patient Last Name
3. Patient First Name
4. DOB
5. Patient Resident Zip Code
6. Location/Site Name
7. Service Site Zip Code
8. Provider Name
9. Provider NPI Number
10. Arrival Date
11. Discharge Date
12. Visit Date **(Practice Only)**
13. Primary Payor Name
14. Primary Payor Patient ID Number
15. Secondary Payor Name
16. Secondary Payor Patient ID Number
17. Tertiary Payor Name
18. Tertiary Payor Patient ID Number
19. Diabetes ICD9 Diagnosis Code (if applicable)
20. Diabetes ICD10 Diagnosis Code (if applicable)
21. **Date of most recent Hemoglobin A1c Test**
22. Hemoglobin A1c test result $\geq$ 6.5 (Y/N)
23. Criteria as defined in Table 2.2 (Y/N)

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