

# ICICE STUDY DIABETES GUIDELINES May 2001

## GENERAL GUIDELINES

Outpatient records: Abstract all information as indicated in the abstraction tool questions. You may use information **recorded** in the outpatient record that **refers** to occurrences during an inpatient stay (i.e., information recorded by the outpatient provider describing an inpatient event/diagnosis, etc.).

Inpatient records: Do not abstract **any** information from inpatient documentation (e.g., admission summary, exam results, progress notes, discharge summary) that may be included in the outpatient record.

Records from other outpatient facilities:

If the outpatient record contains copies of records from other **outpatient** facilities where the patient has received care, abstract that information as you would other portions of that record.

### ***When was a history or a diagnosis of Diabetes Mellitus FIRST noted between 5/1/1998 and 8/31/2000?***

Enter any date on which it was indicated that the patient had diabetes (e.g., a history of diabetes, a visit or an admission for diabetes noted in the outpatient record, a diagnosis of diabetes). The date of initial diagnosis does not have to be during the study period.

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history when not contradicted by provider
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.

Do **not** accept:

- ◆ A rule-out (RO), possible, probable or "suggestive of" diagnosis
- ◆ A medication as evidence of a diagnosis
- ◆ A diagnosis written as a result of a test or exam
- ◆ A diagnosis or code of diagnosis from an inpatient or outpatient facesheet

Accept for Diabetes Mellitus:

- AODM - Adult onset DM
- IDDM - Insulin-dependent DM
- Juvenile diabetes
- Juvenile onset type diabetes
- Ketosis-prone diabetes
- MOD - Maturity onset diabetes
- MODM - Maturity onset diabetes mellitus
- MODY - Maturity onset diabetes of youth
- NIDDM - Non-insulin dependent diabetes mellitus
- Nonketosis-prone diabetes
- Type I DM, type 1 diabetes
- Type II DM, type 2 diabetes
- Diabetes – diet controlled, or controlled by oral hypoglycemics

Do **NOT** accept (for either Type I or Type II):

- ◆ Secondary diabetes mellitus or Borderline diabetes
- ◆ Impaired fasting glucose (IFG) or Impaired glucose tolerance (IGT)

- ◆ Gestational diabetes mellitus (GDM)

## MEDICATIONS:

***Enter the start dates, stop (discontinue) dates, continuation dates, patient refusal and medication allergy dates between 5/1/1998 and 8/31/1999 for all medications listed that are prescribed at least daily.***

Enter each medication on the drop-down medication list that was either started (prescribed) stopped (discontinued), continued, refused or noted to be a medication allergy. Enter the date (or date unknown), select the medication (if on the list) and select the status. Note: enter the dose, units and frequency for those medications for which they are indicated.

### GENERAL INFORMATION

- Enter the medication as noted in the record (i.e., generic or brand), including medications administered during a procedure or surgery.
- If a classification (e.g., ACE Inhibitor) is noted rather than the specific drug, select the classification from the medication list.
- A medication may be listed in more than one way (e.g., Metoprolol Succinate, Metoprolol Tartrate, Metoprolol Tartrate/Hydrochlorothiazide. If the record states, for example, "metoprolol" and does not specify the form (e.g., succinate vs tartrate), select the first on the list that is NOT a combination drug (i.e., metoprolol in combination with another drug). In this example you would pick metoprolol succinate. Note that "metoprolol tartrate/Hydrochlorothiazide is a combination drug. The "/" is used to indicate more than one drug in a particular medication.
- Generic combination medications are listed with all components (e.g., aspirin/salicylimide/caffeine). Do not select a combination drug unless all components of the drug are listed as a single drug in the chart.
- The order of the medications in a combination medication as listed in the drop-down medication list may differ from the order listed in the record. Follow the following procedure when entered a combination medication.
  - Type in the first 3 letters of the first medication of the combination medication as listed in the record and look for the same combination medication on the drop-down list.
  - If you find the same combination, but in a different order, select it. For example, you may find "aspirin/caffeine/salicylimide."
  - If you don't find the same combination, type in the second medication of the combination medication as listed in the record.
  - If you find the same combination, but in a different order, select it.
  - Continue to do this for all medications listed in the combination medication until you have either found the combination medication on the drop-down list or searched for each component medication unsuccessfully.
  - NOTE: HCTZ is the same as hydrochlorothiazide. In combination medications on the drop-down list HCTZ is listed as hydrochlorothiazide. Therefore when you have a combination medication with HCTZ you assume that it is hydrochlorothiazide.
- If the date on which the medication was started, stopped, continued or refused is unclear or cannot be calculated (e.g., patient stopped medication – no date or time period indicated) check "Date Unavailable."
- Medication lists such as from pharmacy data or medication summaries: Include medications that are not found in the progress notes (i.e., do not duplicate entries). Include both the initial prescription and the "last filled" dates.
  - ◆ Do **not** code the initial prescription as "Start" unless you are certain that it is the very first time the drug is being prescribed for the patient (i.e., "Initial prescription" on a summary may be the first prescription ever or may just be a new prescription for a drug the patient has been on.)
- Include orders or prescription written on lab reports. You must see the actual name of the drug. Do not make assumptions. Use the date of the note if available. Otherwise use the date of the lab report.

- Summarizing medications: You may summarize orders for Coumadin (warfarin) that are written on lab reports or in the progress notes on a weekly basis (i.e one entry every 7 days). No other medications are to be summarized.
- It is not necessary to enter more than one type of insulin per visit. (See list of insulins below.)

**Insulins:**

Humalog Insulin	Insulin
Humalog Mix	Insulin 70/30
Humulin 50/50	Insulin Lente Pork
Humulin 70/30	Insulin Pork Mix
Humulin L	Insulin Purified NPH Pork
Humulin N	Insulin Purified Regular Pork
Humulin R	Lispro Insulin
Humulin U	Novolin
Iletin II Lente Pork	Novolin 70/30
Iletin II NPH Pork	Novolin L
Iletin II Regular Pork	Novolin N
Iletin Insulin	Novolin R
Iletin Lente	NPH Insulin
Iletin NPH	Regular Insulin
Iletin Regular	Velosulin BR

Do **not** enter:

- ◆ Medications that are **administered** during an outpatient or Emergency Room visit.
- ◆ Medications ordered or administered **during** hospitalization or noted on an inpatient Discharge Summary.
- ◆ Medications ordered on a PRN basis (e.g., enter ASA 325 mg qd; do not enter ASA 325 mg prn for pain).
- ◆ Medications that the patient has tried in the past (e.g., previous trial of an ACE Inhibitor) unless the date is specified.
- ◆ Medications ordered to be started or taken **if** a particular situation arises (e.g., if symptoms persist more than 5 days) and it is unknown whether that situation did arise.
- ◆ Medications that are part of a study in which the patient is participating and the drug given to the patient is unknown (e.g., Altolomet vs. placebo).
- ◆ Medications listed on an ECG report/request.

Outpatient, Emergency Room, Telephone and Letter medications:

- Enter all medications prescribed, listed as continued, stopped (discontinued), or refused on the visit/contact date.
- If the date on which a medication is to be initiated is different from the date of the prescription, enter the date the medication is to be initiated.

Long-term care facility

- Summarize on the monthly visit date as indicated in the "Visit" guidelines below.

Medication Status:

- Select **Start** when:
  - The medication is the initial prescription for a medication (i.e., the patient did not have a prescription for the medication prior to that date).
  - The medication had been discontinued previously and is now being resumed (e.g., Lasix was discontinued on 4/4/99 and was started again on 6/6/00).
- Select **Continued** when:

- A medication that the patient had been taking prior to that date is continued on that date.
- A medication is listed as a current medication on that date and is not discontinued on that date.
- Select **Stopped** when:
  - A medication is discontinued by the provider.
- Do **not** accept for "stopped":
  - ◆ Medication temporarily stopped when patient has surgery (i.e., the drug is to be stopped for a few days and then resumed after surgery).
  - ◆ Patient refusal to begin taking medication when it is initially prescribed.
  - ◆ Patient noncompliance (i.e., not taking medication as prescribed or has stopped taking the medication).
- Select **Refused** when:
  - The patient refuses to start taking a medication when it is first prescribed.
  - A medication that the patient had been taking was discontinued by the patient for any reason (e.g., ran out of drug, noncompliance, forgot to take it).
- Select **Allergic** when:
  - The medication is listed or noted to be an allergy for this patient either on an allergy list/problem list (with or without a date)
- Select **"Other/No data"** when:
  - Some other status was indicated
  - The status is unclear

## VISITS

***In the table below, enter the date of each outpatient office visit, outpatient ancillary visit, outpatient procedure, urgent care facility visit, emergency room visit, telephone/letter contact and long term care summarized visit and indicate the lowest systolic pressure, the lowest diastolic pressure and indicate the type of provider seen at that visit.***

### GENERAL INFORMATION

- Enter each visit date and associated information as indicated below.
- If the patient sees more than one **TYPE** of provider during a single visit enter the visit twice and select each provider once.
- If there are multiple visits on the same day (e.g., 2 providers, an ER visit and an inpatient admission) enter the date for each visit and indicate the visit type.
- The following visits/situations should be summarized. See General Guidelines and guidelines below for specific instructions.
  - Inpatient stay in long-term care facility (i.e. nursing home, rehabilitation institution TCU-Transitional Care Unit, Sub-Acute Unit)

Do **not** enter any of the following as a separate visit date:

- ◆ Imbedded visits. These are visits with a provider/ER/Radiology that are mentioned within one of the visits listed above (e.g., description of an inpatient visit within an outpatient visit, notation of a prior coronary angiogram within an ER visit, notation of a past mammogram result in an outpatient visit).
- ◆ A visit that is **only** for the **administration** of a medication, an immunization or an allergy injection (i.e., no assessment, plan or other documentation).
- ◆ Any of the following types of visits:
  - Dialysis visits
  - Coumadin visit/clinic (specifically for anticoagulation – INR, coumadin dose)
  - Physical or occupational therapy
  - Orthotics/prosthesis clinic/visit
  - Psychotherapy
  - Cardiac rehab
  - Dental
  - Audiology clinic
  - Ear irrigation
- ◆ A visit to **remove** a Holter monitor as long as no other services (e.g., BP, prescription, assessment, etc.) were provided.
- ◆ Treatment plans, transfer forms that are a summary of care, and on which there is no indication that the patient was seen on that date.
- ◆ The patient leaves the office/clinic before they are seen by a healthcare worker (e.g., signs in with receptionist and leaves before being seen, in the office to pick up copy medical record only).
- ◆ A referral to the provider (e.g., "Pt to see diabetic counselor," " will try to arrange for visit to dietitian"). Referrals are to be entered on the "Referral" tab.

### TYPE OF VISIT

- Outpatient Medical
  - Visit to a provider's office during which the patient is assessed and/or treated. This includes: MD, nurse practitioner (NP), physician's assistant (PA), RN, LPN, medical technician, etc.)
  - Ophthalmologist visit
  - Podiatrist visit
  - Visit to provider's office for blood pressure check
  - Medical consults: enter as a contact date when the consulting provider (see first bullet above) provides a report of a contact with the patient.
    - Enter the date of the consult. If the report is in the form of a letter that does not indicate the actual date of the contact or allow you to estimate the date (e.g., saw

the patient last week), and it is a recent or current consult, then use the date of the letter.

- Outpatient ancillary
  - Visit to or progress note by ancillary providers such as diabetic counselor, registered dietitian (RT), physical therapist, pharmacist.
  - Psychotherapy session/visit (regardless of the reason for the visit) with the following providers: Counselor, ACSW, MC, Marriage Counselor, MSW (Masters in social work)
  - Cardiac rehabilitation center visits
  
- Outpatient procedure
  - Dates on which only an outpatient procedure was performed (i.e., the patient was not admitted to the hospital). Include procedures during which a blood pressure was taken.
  - Includes **but is not limited to**:
    - Arthroscopy Breast biopsy or FNA (fine needle aspiration)
    - Bone Scan
    - Bronchoscopy
    - Cardiac catheterization/angioplasty
    - Cataract extraction
    - Colonoscopy
    - Cystoscopy
    - DEXA Scan
    - Diagnostic D&C
    - Electromyographic testing (EMG)
    - Electrophysiologic study (EPS)
    - Endometrial biopsy
    - Endoscopic retrograde cholangiopancreatography - ERCP
    - Esophagogastroduodenoscopy (EGD), upper endoscopy
    - Herniorrhaphy – hernia repair
    - Hysterectomy, vaginal
    - Laparoscopy (any type)
    - Liver biopsy
    - Lung biopsy
    - Mammogram
    - Mastectomy
    - Prostate biopsy
    - Radiation therapy
    - Radioactive implantation procedure
    - Renal biopsy
    - Sigmoidoscopy (Flex sig)
    - Stress (exercise or pharmacological) testing (e.g., treadmill, ETT, thallium, echo)
    - Transurethral resection of prostate (TURP)
    - Tubal ligation
    - Ultrasound (Doppler)
  
  - Do **not** accept the following outpatient visits, procedures or surgeries as an Outpatient Procedure.
    - Plain x-rays
    - Sleep studies
    - Electrocardiogram (ECG) only
    - Visits for lab test only (e.g., blood drawn, urine sample taken)
    - Outpatient procedure that occurs during an outpatient office visit in which the patient was assessed and/or treated (e.g., chief complaint, assessment, plan, etc.) This should be entered as an Outpatient Medical visit.
  
- Urgent Care Facility/Emergency Room
  - Visits to an urgent care facility.
  - Visits to a walk-in clinic/sick call clinic

- Emergency room/department visits
  - Include all visits whether or not the patient was admitted to the hospital or discharged from the emergency room.
  - Code an Emergency room contact regardless of the length of time the patient is in the E.R. or the fact that the E.R. stay runs over the midnight hour.

Do **not** accept for Urgent Care Facility/Emergency Room

- ◆ A visit when the patient leaves the facility without being seen by the healthcare provider.
- ◆ Urgent/walk-in/drop-in visits to a provider's office

- Telephone/Letter/Email

- Enter the date on which the provider and the patient had phone contact or on which the provider wrote a letter/note/email to the patient.
- Include calls initiated by the patient or the provider. Include calls on which the office either spoke with the patient or family member.
- The contact may or may not refer to the diabetes problem
- Multiple telephone contacts/letters/emails may be summarized into one entry per week. Include all data from all telephone contacts on the date of the first telephone contact of that week.
- Include:
  - Telemonitoring calls
  - Pacemaker checks

Do **not** include for telephone/letter:

- ◆ A note of a phone conversation that is physician-to-physician or office-to-office contact (i.e., not a contact with the patient).
- ◆ A call or letter that is **ONLY** for any (or any combination) of the reasons listed below.
  - Calls to the patient re "no show"
  - Calls/letters to schedule labwork or appointment
  - Calls/letters to get or to give lab/test results
  - Calls that document only a BP taken by the patient
  - Cancellation of appointment
  - Change of phone, address, pharmacy phone
  - Request for copy of medical record
  - Provider office or patient "left message"

- Long-term care facility

- Includes nursing home, rehabilitation institution TCU-Transitional Care Unit, Sub-Acute Unit
- If the patient is a resident of a long-term care facility at the beginning of the study period, enter 5/1/1998 as a visit and summarize all data from the long-term care facility for the month of May 1998 on that visit date.
- If the admission date is within the study period enter the admission date as a visit date and summarize all data for that month on the admission date.
- If the patient remains in the institution more than one month, for all months following the month of admission or the beginning of the study period, enter the first **day** of the month (e.g., 10/01/1999) as the visit date. Then summarize all data for the month on that date. For example, code each visit date (first day of the month) and enter the lowest systolic blood pressure, the lowest diastolic blood pressure and each type of provider for the summarized period. If more than one type of provider was seen during that month, you will have to enter the month once for each provider type. For example:
  - 10/1/99 - 120/78 - "Other MD, ...";
  - 10/1/99 - - "Podiatrist"
  - 10/1/99 - - "Dietitian"

- Other/No data
  - Includes Home Health visits
  - A survey or questionnaire completed by the patient and there is no other indication of whether it was completed at a visit or by phone.
  - If there is no way to determine the type of visit, use this selection

#### SYSTOLIC AND DIASTOLIC PRESSURE

- Enter a diastolic and systolic measurement for each contact date.
- If more than one is recorded, enter the lowest measurement for diastolic and the lowest measurement for systolic on that visit date regardless of the position in which it is taken.
- If no there is no BP recorded at an outpatient/urgent care/ER visit, you may enter a patient reported BP taken on the visit date. If date of patient reading is not indicated, assume it is the date of the telephone call
- If you are summarizing visits from a long term care facility, enter the lowest systolic and the lowest diastolic for the month regardless of whether they are on the same date.
- If the visit type is "Telephone/letter" you are not required to enter the SBP or DBP value and you do not need to check the "NA" checkbox.

#### TYPE OF PROVIDER

- Select the type of provider seen
- If the patient sees more than one **TYPE** of provider during a single visit enter the visit twice and select each provider once.
- You may assume the provider is an ophthalmologist if the provider is an MD who addressed only eye problems/issues, the examination was a detailed ophthalmic examination and there is no other indication that the provider was of a specialty other than ophthalmology.
- If the type seen is other than those listed or if you are unable to determine the type of provider, select "Other/No data"
- If you are summarizing visits from a long term care facility, enter a date for each type of provider seen during the month. Summarize all the visits with that type of provider in one visit date (i.e., all "Other MD/NP/PA/DO) visits summarized on the first date during the month that the patient is seen by an MD, NP, PA, or DO).

## COMORBIDITIES

**Indicate whether the patient had a history or diagnosis of any of the following conditions.**

For each of the conditions listed below, indicate whether the patient had a history or diagnosis of that condition (e.g., noted in the past or current history, noted as the reason for a visit or an admission, noted as an impression or a diagnosis of that condition). The date of initial diagnosis does not have to be during the study period.

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history when not contradicted by provider
- Notation on a Problem List or intake form
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.

Do **not** accept:

- ◆ A rule-out (R/O), possible, probable or "suggestive of" diagnosis diagnosis except where noted (i.e., AIDs). If there is a conflict in the chart (R/O versus history of/diagnosis of) assume that the patient has the history/diagnosis on the date indicated.
- ◆ A diagnosis that is preceded by "...symptoms consistent with" (e.g. patient has symptoms consistent with peripheral neuropathy).
- ◆ A medication as evidence of a diagnosis
- ◆ A diagnosis written as a result of a test or exam

### Hypertension (HTN)

- Hypertension (HTN)
- HBP – use only when it is clear that this is being used as a diagnosis (i.e., discussion, treatment, etc) and is **not** just an indication that the patient's BP is elevated at that visit – or visit's.
- accelerated hypertension
- arterial hypertension
- Either systolic or diastolic hypertension
- essential/idiopathic/malignant hypertension
- primary/secondary hypertension
- Stage I, II, III, or IV hypertension
- Borderline hypertension
- Labile hypertension

Do **not** accept

- ◆ Hi normal BP
- ◆ Hypertensive cardiovascular disease
- ◆ Hypertensive heart disease
- ◆ Hypertensive reaction
- ◆ Pregnancy induced hypertension (PIH)
- ◆ Gestational HTN
- ◆ R/O hypertension, "?HTN", etc.

### Coronary Artery Disease (CAD)

Accept:

- Angina – stable, unstable, chronic exertional or unspecified
- Acute myocardial infarction (AMI, MI) (definite or probable)
- Acute Coronary Artery Syndrome
- Atherosclerotic heart disease (ASHD)
- Arteriosclerotic or Atherosclerotic Coronary Vascular Disease (ASCVD)
- Atherosclerotic calcification of the coronary arteries
- Coronary artery disease (CAD)
- Coronary mineralization or calcification
- Coronary vessel disease (e.g., 1-vessel disease, 3-vessel disease)
- IHD: Ischemic heart disease
- Prior history of CABS, PTCA or other revascularization
- Result of stress test notes either moderate or greater risk for CAD
- Stenosis of 50% or greater on 2 or more coronary arteries on a coronary angiogram

Do **not** accept:

- ◆ R/O CAD
- ◆ R/O angina
- ◆ R/O MI
- ◆ Findings of ischemia on an ECG in the absence of a diagnosis
- ◆ History of hyperlipidemia
- ◆ Organic heart disease

### Myocardial Infarction (MI)

- Myocardial infarction (MI)
- Acute MI (AMI)
- Heart attack

Do **not** accept:

- ◆ Silent MI
- ◆ R/O MI that is not ruled in

### Congestive Heart Failure (CHF)

- Congestive heart failure (CHF)
- Heart failure
- Left-sided with right-sided heart failure
- Forward with backward failure
- Left with right ventricular heart failure
- Low output heart failure
- Left-sided heart failure
- Left ventricular heart failure
- Right-sided heart with left-sided heart failure
- Forward failure
- Cardiomyopathy (i.e. ischemic cardiomyopathy, dilated cardiomyopathy, alcoholic cardiomyopathy)

Do **not** accept:

- ◆ Isolated right heart failure (Right-sided heart failure without left-sided heart failure also mentioned)
- ◆ Failure from diastolic dysfunction
- ◆ Notation of left ventricular dysfunction on an echo, radiologic, or other cardiac procedure.
- ◆ Borderline left ventricular hypertrophy
- ◆ R/O heart failure

### Peripheral Vascular Disease (PVD)

- Peripheral vascular disease (PVD)

- Peripheral atherosclerotic disease
- Intermittent claudication
- Arterial insufficiency
- Untreated thoracic or abdominal aneurysm
- Gangrene

Do **not** accept:

- ◆ Deep Vein Thrombosis (DVT)

#### Chronic lung disease

- Asthma
  - Hyperresponsiveness of the airways to a variety of inhaled stimuli
  - Occupational asthma
  - Allergic Asthma
  - Chronic obstructive asthma
  - Extrinsic/intrinsic Asthma
  - Allergic asthma
  - Idiosyncratic asthma
  - Occupational asthma
  - Bronchial asthma
  - Bronchial induced asthma
  - Bronchospasm in a patient with a history of asthma
  - Reactive airway disease (RAD)
  - Reversible hyper-reactive lung disease
  - Reversible airway disease
  - Reversible obstructive airway disease
  - Chronic obstructive asthma
- Chronic Obstructive Pulmonary Disease (COPD)
  - Chronic bronchitis
  - Simple obstructive lung disease
  - GOLD - chronic obstructive lung disease
  - COPD
  - Obstructive airways disease
  - Emphysema
- Asthmatic bronchitis [chronic]
- Chronic bronchitis
- Bronchiectasis
- Chronic pulmonary fibrosis
- Chronic lung disease
- Cystic fibrosis
- Tuberculosis (TB)

#### Connective tissue disease

- Rheumatoid arthritis (RA)
- Infectious arthritis
- Mixed connective tissue disease
- Osteomyelitis
- Lyme disease
- Reiter's syndrome
- Psoriatic arthritis
- Ankylosing spondylitis
- Gout
- Gouty arthritis
- Pseudogout
- Calcium pyrophosphate dihydrate (CPPD)
- Crystal deposition disease
- Relapsing polychondritis (RP)
- Vasculitis
- Lupus Erythematosus – Discoid (DLE) or Systemic (SLE)

- Progressive systemic sclerosis (PSS)
- Scleroderma
- Polymyositis
- Dermatomyositis
- Sclerodermatomyositis
- Inclusion body myositis (IBM)
- Polymyalgia rheumatica
- Temporal arteritis
- Giant cell arteritis
- Cranial arteritis
- Polyarteritis nodosa
- Polyarteritis
- Wegener's granulomatosis
- Mixed connective tissue disease (MCTD)
- Ankylosing Spondylitis (AS)
- Marie-Strumpell disease
- Reiter's syndrome (RS)

Do **not** accept:

- ◆ Osteoarthritis (OA, DJD)
- ◆ Arthritis

#### Ulcer disease

- Peptic ulcer (PUD)
- Duodenal ulcer
- Gastric ulcer
- Channel ulcer
- Postbulbar ulcer
- Marginal ulcer
- Stomal ulcer

Do **not** accept:

- ◆ Erosion
- ◆ Esophageal ulcers

#### Liver Disease

- Jaundice
- Hepatitis
- Cholestasis
- Hepatomegaly
- Portal hypertension
- History of variceal bleeding
- Ascites
- Portal-systemic encephalopathy
- Hepatic encephalopathy
- Hepatic fibrosis
- Cirrhosis
- Primary biliary cirrhosis (PBC)

#### Diabetes; End-organ Disease

- Diabetic retinopathy

Do **not** accept:

- ◆ Retinoschisis

- Diabetic nephropathy
  - Arterionephrosclerosis
  - Azotemia
  - Chronic renal disorder

- Chronic renal insufficiency
  - Renal insufficiency
  - Acute renal failure
  - Diabetic kidney disease
  - Diabetic nephropathy
  - Diffuse diabetic or nodular glomerulosclerosis
  - End stage renal disease (ESRD)
  - Kimmelstiel-Wilson lesion
  - Microalbuminuria (as a diagnosis)
  - Proteinuria, albuminuria (as a diagnosis)
  - Notation by provider that the patient has a positive urine test for proteinuria or microproteinuria, or albuminuria
  - Papillary necrosis
  - Renal dialysis
- Diabetic neuropathy
    - Neuropathic pain
    - Neuropathic symptoms

#### Cerebrovascular Disease (CVD)

- Cerebrovascular Disease
- Cerebral insufficiency
- Arteriovenous malformation (AVM)
- Transient ischemic attack (TIA)
- Cerebrovascular accident (CVA)
- Stroke
- Stroke in evolution
- Cerebral or brainstem infarction/hemorrhage
- Focal hemorrhage in brain
- Hemorrhagic stroke
- Thromboembolic stroke
- Atherothrombotic ischemic stroke
- Embolic or ischemic stroke
- Hemispheric infarct
- Intracerebral hemorrhage (ICH)
- Lacunar infarction
- Ruptured cerebral aneurysm
- Intracerebral/subarachnoid hemorrhage
- Hypertensive encephalopathy

#### Dementia

- Dementia
- Static dementia
- Progressive dementia
- Alzheimer's disease
- Multi-infarct dementia
- AIDS dementia
- Chronic cognitive deficit

#### Hemiplegia

- Permanent paralysis of one side (right or left) of the body

Do **not** accept:

- Temporary hemiplegia (e.g, occurs during a stroke or TIA but resolves or leaves residual weakness.
- Paraplegia

#### Moderate/severe renal disease

- End-stage renal disease (ESRD)

- Patient is on dialysis
- Chronic renal failure (CRF)
- Renal insufficiency
- Uremia
- Kidney transplant recipient
- Glomerulonephritis - acute (AGN)/chronic/membranous (MGN)/membranoproliferative (MPGN)
- Postinfectious glomerulonephritis (PIGN)
- Acute nephritic syndrome
- Rapidly progressive nephritic syndrome
- Rapidly progressive glomerulonephritis (RPGN)
- Crescentic glomerulonephritis
- Nephrotic syndrome (NS)
- Chronic nephritic/proteinuric syndrome
- Slowly progressive glomerular disease
- Nephritis – Acute/Chronic/tubulointerstitial
- Toxic nephropathy
- Pyelonephritis – acute/chronic
- Nephritis

Do **not** accept:

- ◆ Nephrectomy

### Malignant Tumor

- Any primary malignant solid tumor, such as:
  - Hepatocellular carcinoma
  - Hepatoma
  - Adenocarcinoma of the prostate
  - Malignant tumors of the lung, breast, colon

Do **not** enter:

- ◆ Basal cell skin cancer
- ◆ Squamous cell skin cancer
- ◆ Metastatic tumors here. See "Metastatic tumor" below.

### Leukemia

- Leukemia
- Acute/chronic myelogenous leukemia
- Acute/chronic lymphoblastic leukemia (ALL)
- Acute/chronic myeloid leukemia (AML)
- Acute/chronic myelocytic leukemia
- Acute/chronic lymphocytic leukemia
- Polycythemia vera

### Lymphoma

- Lymphoma
- Lymphosarcoma
- Hodgkin's disease
- Non-Hodgkin's lymphoma (NHL)
- Myeloma
- Burkitt's Lymphoma
- Waldenstrom's macroglobulinemia
- Mycosis Fungoides

### Metastatic tumor or AIDS

- Secondary malignancy that appeared in parts of the body remote from the primary site
- Metastatic carcinoma of unknown primary origin (UPO)
- Metastatic solid tumors (e.g., breast, lung, colon)
- Acquired Immune Deficiency Syndrome (AIDS) – definite **or probable**
- AIDS related complex

## GENERAL MEDICAL HISTORY

***Was a diagnosis or a notation of a history of diabetic nephropathy (e.g., renal insufficiency, renal dialysis, provider diagnosis of proteinuria, etc.) noted between 5/1/1998 and 8/31/2000.***

Indicate whether there is any documentation during the study period that the patient had diabetic nephropathy (e.g., a history of diabetic nephropathy, a visit or an admission for diabetic nephropathy noted in the outpatient record, a diagnosis of diabetic nephropathy). The date of initial diagnosis does not have to be during the study period.

Accept:

- Provider's notation of history or diagnosis
- Patient's report of history when not contradicted by provider
- Provider's notation of a positive urine test for proteinuria, microalbuminuria, albuminuria
- A diagnosis or history of the disease when indicated on a test report as a reason for the test or as a symptom/diagnosis prior to the test.

Do **not** accept:

- ◆ A rule-out (RO), possible, probable or "suggestive of" diagnosis
- ◆ A medication as evidence of a diagnosis
- ◆ A diagnosis written as a result of a test or exam

Accept for diabetic nephropathy:

- Arterionephrosclerosis
- Azotemia
- Chronic renal disorder
- Chronic renal insufficiency
- Renal insufficiency
- Acute renal failure
- Diabetic kidney disease
- Diabetic nephropathy
- Diffuse diabetic or nodular glomerulosclerosis
- End stage renal disease (ESRD)
- Kimmelstiel-Wilson lesion
- Microalbuminuria (as a diagnosis)
- Proteinuria (as a diagnosis)
- Albuminuria (as a diagnosis)
- Papillary necrosis
- Renal dialysis

***When was the earliest documentation that the patient's diabetes was currently being controlled solely by diet?***

Enter the first date during the study period on which there is evidence that the patient was on a diabetic diet (e.g., provider's order/plan, diabetic diet counseling) at the time of the visit and that the patient is **not** taking either an oral hypoglycemic or insulin at that time.

Accept:

- Diet-controlled diabetes

***When was the earliest documentation that the patient's diabetes was currently being treated by oral hypoglycemic(s)?***

Enter the earliest date on which there is any indication that the patient was taking an oral hypoglycemic at the time of the visit with or without concomitant use of insulin (e.g.,

provider's order/plan, current medication, patient comment on compliance). The date may occur prior to the first notation of diagnosis of diabetes in the study period.

**Oral Hypoglycemics:**

Acarbose	Glynase Pres-Tab
Acetohexamide	Glyset
Actos	Metformin Hydrochloride
Amaryl	Micronase
Avandia	Miglitol
Chlorpropamide	Oral Hypoglycemic Agent
DiaBeta	Orinase
Diabinese	Pioglitazone
Dymelor	Prandin
Glimepiride	Precose
Glipizide	Repaglinide
Glucophage	Rezulin
Glucotrol	Rosiglitazone
Glucotrol XL	Tolazamide
Glyburide	Tolbutamide
Glyburide, Micronized	Tolinase
Glycron	Troglitazone

***When was the earliest documentation of current ROUTINE (ongoing) outpatient insulin administration between 5/1/1998 and 8/31/2000? (DO NOT include insulin prescribed SOLELY during an acute illness).***

Enter the earliest date during the study period on which there is any indication that the patient was routinely taking insulin at the time of the visit (e.g., provider's order/plan, current medication, patient comment on compliance). The insulin must have been taken continuously and not administered only when the patient was acutely ill.

**Insulins:**

Humalog Insulin	Insulin
Humalog Mix	Insulin 70/30
Humulin 50/50	Insulin Lente Pork
Humulin 70/30	Insulin Pork Mix
Humulin L	Insulin Purified NPH Pork
Humulin N	Insulin Purified Regular Pork
Humulin R	Lispro Insulin
Humulin U	Novolin
Iletin II Lente Pork	Novolin 70/30
Iletin II NPH Pork	Novolin L
Iletin II Regular Pork	Novolin N
Iletin Insulin	Novolin R
Iletin Lente	NPH Insulin
Iletin NPH	Regular Insulin
Iletin Regular	Velosulin BR

**When was a contraindication to or intolerance of aspirin therapy noted by the provider?**

Accept:

- A statement by the provider that aspirin therapy was contraindicated
- A statement by the provider that antiplatelet therapy was contraindicated

Contraindications may include:

- Hypersensitivity or allergy to salicylates (rare)
- Clinically active hepatic disease
- Bleeding tendency
- Anticoagulant therapy
- Bleeding within past 4 weeks (including gastrointestinal bleeding, melena, epistaxis, any bleeding requiring transfusion; excluding menses and occult hemoglobin in stools)

Do NOT accept:

- ◆ Occult blood in the stool
- ◆ Bleeding related to menses

**Aspirins**

Acuprin 81	Easprin
Arthritis Foundation Aspirin	Ecotrin
Arthritis Pain	Ecotrin Low Strength Adult
ASA	Ecotrin Maximum Strength
Ascriptin Enteric	Empirin
Aspergum Cherry	Entaprin
Aspergum Original	Entercote
Aspirin	Extra Strength Bayer
Aspirin Enteric Coated	Genacote
Aspirin Litecoat	Gennin-FC
Aspirin Lo-Dose	Genprin
Aspirin Low Strength	Halfprin
Aspirin Tri-Buffered	Litecoat Aspirin
Aspirin, Extended Release	Low Dose ASA
Aspirin-Antacid	Med Aspirin
Aspir-Low	Minitabs
Aspirtab	Norwich Aspirin
Aspir-trin	Ridiprin
Bayer Aspirin	Sloprin
Bayer Low Strength	St. Joseph Aspirin
Bayer Plus	St. Joseph Aspirin Adult Chewable
Buffered Aspirin	Stanback Analgesic
Bufferin	Therapy Bayer
Bufferin Arthritis Strength	Tri-Buffered Aspirin
Bufferin Extra Strength	Uni-Buff
Buffex	Uni-Tren
Coated Aspirin	Valomag
CTD Aspirin	Zorprin

## LABORATORY TESTS

### General guidelines:

Hierarchy for determining date entry

- Date on lab report indicated when the specimen was obtained.
- Date on which results were reported as indicated on the lab report.
- Date indicated by the provider that the test was performed.
- Date ordered if result not in chart (e.g., provider order and no results noted)

### **HEMOGLOBIN A1c**

**Record the date, results and reference range for all outpatient Hemoglobin A1c (HgbA1c) tests between 5/1/1998 and 8/31/2000. If more than one test per month record only the lowest value for that month.**

Glycosylated hemoglobin is a blood chemistry test that provides an estimation of the average blood glucose level during the preceding 2-3 months. Values are reported as a percentage of the total hemoglobin within an erythrocyte. The normal range is about 4% - 7% depending on the performing laboratory.

Accept:

- Total glycosylated hemoglobin
- HgbA1, HgbA1c, HbA1c, Hemoglobin A1C, Hemoglobin A1
- GHb, Glycated hemoglobin, Glycohemoglobin
- Total fasting hemoglobin
- (Hgb)A1a, A1b, A1c
- HbA1a1, HbA1a2, HbA1b

Do **not** accept:

- ♦ Hgb or HGB (i.e., must include "A1," "A1c," etc.)

Enter the date of all outpatient tests (either ordered or performed), the results of the test and the reference range (highest and lowest values) for what is considered to be normal glycosylated hemoglobin values for the laboratory that performed the test.

- If a test was ordered or performed but the results were not noted or available, select "Results not available."
- Test indicated as "normal" (nl, w/i nl limits, etc.), but value not given: code as "Result Unavailable."
- If there is more than one outpatient test in any single month record only the date and measurement for the lowest value for that month.

## LIPID TESTS

**Enter the date and results of the following outpatient lipid tests performed between 5/1/1998 and 8/31/2000, the unit of measurement and whether it was a fasting test**

**Total Cholesterol (Cholesterol),  
Triglycerides  
High Density Lipoproteins (HDL) Cholesterol  
Low Density Lipoproteins (LDL) Cholesterol**

Enter all outpatient tests (either ordered or performed).

- If more than one test was performed on a given date, re-enter the date as many times as needed.
- If a test was ordered or performed but the results were not noted or available, select "Results not available."
- Test indicated as "normal" (nl, w/i nl limits, etc.), but value not given: code as "Result Unavailable."
- For "lipid panel" assume all components were tested (cholesterol, triglycerides, HDL, LDL)
- For each test, select the units of measurement and indicate whether the test was fasting.
  - Fasting - when the patient has been fasting for at least 12 hours or noted to be fasting without indicating number of hours.
  - Post-prandial (after meal) blood glucose (PPG).
  - **Note:** If PP is the abbreviation used, be certain that it is referring to post-prandial (after meal) and NOT pre-prandial (before meal)
  - If there was no notation regarding fasting or not fasting, select "No data."

## MICROALBUMINURIA TESTS

**Enter the date and results of the following outpatient microalbuminuria tests performed between 5/1/1998 and the first positive microalbuminuria test.**

**UA (Urinalysis - Microscopic)  
Urine Dipstick  
Microalbuminuria (random urine)  
24 hour urine collection  
Time urine collection  
Urine protein/Creatinine ratio  
Albumin/Creatinine ratio  
Albumin Excretion Rate  
Spot urine  
Micral  
Other microalbuminuria test/Type unknown**

A microalbuminuria test measures the protein or albumin in a urine sample.

Do **not** accept:

- ◆ Blood tests that measure protein or albumin (e.g., serum protein, serum albumin)
- ◆ Urine tests for anything other than protein, albumin, protein/creatinine (ration) or albumin/creatinine (ratio)

Enter the date of each outpatient test (either ordered or performed), select the type of test, and indicate whether the test was positive or negative. If a type of microalbuminuria test other than those listed is indicated, or the type of microalbuminuria test is unknown (e.g., "microalbuminuria test"), select "Other type/Type unknown and indicate the results if available.

Begin with the earliest test in the study period and enter the subsequent tests chronologically. When you have entered a positive result, that entry will be the last entry for this question. So, for example, if the first test is positive, you will enter only that first test. Or if there are 2 negative tests followed by 3 positive tests, you will enter the 2 negative tests and the first positive test.

The tests do not need to be entered in chronological order into the tool. Therefore, if you find a positive microalbuminuria test, you can enter it first and then enter all microalbuminuria tests that precede the positive test. If there are no positive tests, enter all microalbuminuria tests during the study period.

If more than one test is done on a single date (e.g., microalbuminuria, creatinine and albumin/creatinine ratio), and one of the tests is positive, enter only the positive test. If the tests are all negative, enter the last test listed for that date – usually the ratio.

To determine if the result is positive (higher than normal), use the reference range for normal that is noted on the lab report. If there is no reference range, use the guidelines below.

NOTE: If you see results expressed in terms other than listed here, consult with the RAND research team to determine if test is positive.

<u>TEST</u>	<u>POSITIVE RESULT</u>
UA (Urinalysis - microscopic) *	> trace protein (i.e., any result other than negative)
Urine Dipstick	> trace protein (i.e., any result other than negative)
Microalbumin (random urine)**	> 30 mg/L or > 3 mg/dL or > 3,000 mcg/dL
24 hour urine protein collection (24 hour total protein or TP)	≥ 30 mg/24 hours
Time urine protein collection	≥ 20 mcg/min
Urine protein/Creatinine (ratio) ***	≥ 0.4 mg
Albumin/Creatinine (ratio)	≥ 30 mcg/mg or ≥ 30 mg/gm
Albumin Excretion Rate	> 15 mcg/minute
Spot urine	≥ 30 mcg/mg creatinine
Micral	≥ trace protein

\* UA (Urinalysis-microscopic):

- For a "negative urinalysis", code "UA (Urinalysis-microscopic) and "Negative"
- Refer only to the microalbuminuria results and disregard results such as bacteria, WBC, etc.

\*\* May also be called "urine albumin."

\*\*\*To calculate the protein/creatinine ratio:

- Contact the RAND research team.

## EXAMS

### EYE EXAMS

**Enter the date of the first outpatient dilated eye exam performed between 5/1/98 and 4/30/99. If the only dilated eye exam for that time period is indicated without a date, enter it and choose "date unavailable." Select the type of provider who performed the exam.**

**Enter the date of the first outpatient dilated eye exam performed between 5/1/99 and 8/31/00. If the only dilated eye exam for that time period is indicated without a date, enter it and choose "date unavailable." Select the type of provider who performed the exam.**

#### DILATED EYE EXAM:

The "Date unavailable" selection should only be used if you are certain that the dilated eye exam took place within the specified time period and you are unable to estimate it.

Accept:

- Notation that the patient was seen by an ophthalmologist. If the exact date of the visit is unknown, use the date of the provider's note.
- Notation by an ophthalmologist that he/she saw the patient in the past and during the study period. Use the date indicated of the past visit, or calculate it.
- Documentation by the ophthalmologist regarding a patient visit
- Notation that the pupils were dilated
- Dilated ophthalmoscopy
- Notation of administration of eye drops (gtts), for example:
  - Mydracyl 1% and Neo-Synephrine 2.5% both eyes (OU)
  - M & N noted in an ophthalmology record
  - Cyclogyl (similar to Mydracil) and Mydrfrin (similar to neo-synephrine)

NOTE: The exam must clearly have been done by an ophthalmologist or optometrist OR be documented as a dilated exam.

***When was amputation or absence of the right leg or foot noted?***

***When was amputation or absence of the left leg or foot noted?***

Enter the date on which there is a notation that an amputation of the right/left leg was performed on that date or at **any time** in the past or that the patient's leg or foot was congenitally or otherwise absent. If the record notes "bilateral" amputation of the leg or foot, enter the date of the notation for both (right and left) questions.

Accept:

- AK (above the knee) amputation/amputee
- BK (below the knee) amputation/amputee
- Bilateral leg or foot amputation/amputee
- Congenital absence of the leg or foot

## FOOT/LOWER EXTREMITY EXAMS

**Enter the date and type of each outpatient foot or lower extremity exam performed between 5/1/1998 and 8/31/2000.**

Enter the date of each foot or lower extremity exam during the study period and indicate whether a visual, sensory and/or vascular exam was performed.

- If the notation simply states that the exam was normal (e.g., nl, wnl, unremarkable), enter "No/No data" for each of the components. This includes foot exams by a podiatrist (i.e., cannot assume all components were performed).
- Use provider's objective observations only.

Do **not** accept:

- ◆ The patient's subjective complaints or statements.
- ◆ A statement about the patient's care of the foot

VISUAL – look for a notation of:

- Skin condition (e.g., skin intact, scaling, skin lesions, dryness, nails, calluses, corns, ulcers, infection, gangrene, skin color changes, etc.)
- Presence/absence of erythema
- Presence/absence of swelling or edema
- Presence/absence of signs of venous stasis (e.g., discoloration of skin, varicose veins)
- "∅ C/C/C" – No clubbing, cyanosis or edema

Do **not** accept:

- ◆ Deep tendon reflexes (DTRs)

## SENSORY

A sensory exam is one in which the provider or an object touches the patient's skin in one way or another in order to determine what the patient can or cannot feel (sense). It may include use of an "instrument" such as a pin (pin prick vs. dull) or a microfilament, or holding an object.

- Sensitivity (e.g., superficial touch, sharp/dull sensation, pinprick, pressure, heat and cold, vibration, position, decreased/increased sensitivity, minor light touch elicits pain)
- Discrimination (e.g., 2-point, single point, shape and form, texture, graphesthesia)
- Statement regarding status of neurological exam (e.g., "normal neuro exam" or "normal sensory exam").
- Monofilament (also called filament): A device that uses monofilaments of varying diameter to determine the sensitivity of touch.
  - If a sensory test was performed using a monofilament, select, "Performed including monofilament."
  - If a sensory test was performed without a monofilament, by some other method, or there is no documentation regarding the use of a monofilament, select, "Performed, no monofilament/method unstated."

Do **not** accept:

- ◆ "Numbness" or other sensations documented as a symptom or patient complaint in the history
- ◆ Tenderness
- ◆ No c/o pain or presence/absence of pain on movement.
- ◆ Deep tendon reflexes (DTRs)

## VASCULAR

- Pulses: (e.g., acceptable or normal (nl) pulses; distal pulses+, specific pulses (LE): dorsalis pedis (DP), pedal, posterior/anterior tibial (PT/AT), popliteal, femoral
- Peripheral pulses - presence or absence
- Skin temperature (e.g., warm to touch)
- Capillary (cap) refill time
- Notation regarding "vascular status"

Do **not** accept:

- ◆ Presence or absence of symptoms of venous stasis.
- ◆ Deep tendon reflexes (DTRs)

## REFERRALS

**Enter each date on which there was a visit or a referral to any of the following providers and indicate the specialty of the provider.**

**Ophthalmologist**

**Podiatrist (DPM)**

**Other MD\*/NP/PA/DO**

**Dietitian (RD)/Nutritionist**

**Diabetic Educator (CDE)**

Enter the date of:

- Provider's notation that the patient is being referred to one of the listed providers
- A note by one of the listed providers that the patient is being seen on referral.
- Note that states the patient needs a to be seen by (e.g., follow-up) the specialist provider.
- Letter to patient instructing or reminding patient to see the specialist provider.
- A notation that the patient will be seeing, is scheduled for, reminded of a visit to a provider
- Referral to pain clinic – select "Other MD/NP/PA/DO"
- Visit to "eye doctor" or Eye Clinic - select ophthalmologist
- Visit to Diabetes Skills or Education clinic – select Diabetic Educator
- Refusal to see a Diabetic Educator, go to a diabetic education clinic, class or group

Do **not** accept:

- ◆ Referral to a lab for a specific test only (e.g., nerve conduction, EMG, colonoscopy)
- ◆ A notation by a provider (e.g., podiatrist) stating when the patient is to be seen again by that provider

If the diabetic educator is also an NP or PA, enter "Diabetic Educator"

\*Other MD includes specialists such as cardiologist, endocrinologist, internal medicine, surgeon, gastroenterologist, psychiatrist, allergist, etc.

## COUNSELING

**Enter each date between 5/1/1998 and 8/31/00 on which there is evidence of diabetic, hypertension risk or cholesterol lowering diet counseling. Indicate the type of counseling, the type of provider, and whether it was group counseling or individual counseling.**

Enter all dates on which any provider provides counseling, advice, education, teaching or instructions to the patient about diabetes and/or diet. Include dates on which the counseling was provided to the patient's caretaker.

- Indicate the type of counseling, the type of provider and whether the patient received counseling in a group setting (e.g., diabetic support group) or as an individual.
- If counseling was done for more than one category (e.g., diet and weight) on a single date, enter the date for each type (e.g., once for diet and once for weight) and complete the required information.

Do **not** enter:

- ◆ Counseling that took place prior to the initial diagnosis of diabetes

### Counseling:

#### GENERAL GUIDELINES:

Counseling consists of an encounter in which counseling, education, advice, teaching or instruction is received by the patient from the provider in the form of a discussion and/or written material. The notation often refers to a discussion, review of information, or encouragement with regard to the patient's management of the condition.

In order to qualify as counseling, the notation must include **at least one** of the following 4 characteristics:

1. Involvement of the patient in the management of the disease (i.e., something that the patient will do or was advised to do, not something the provider will do).  
*Note: If the statement implies that the activity is a goal **set by the patient** (e.g., patient has a goal to lose 5 pounds by the next visit), this should be entered in the following question as goal setting instead of counseling.*

Accept:

- We talked about the importance of appropriate foods and diet.

Do **not** accept:

- ◆ Will adjust patient insulin dosage to slowly lower blood sugar. (This is a provider action.)

2. A statement by the provider about what the patient will or should do in the future in the management of the disease. This does **not** include what the patient has been doing up until the time of the notation.

*Note: If the statement implies that the activity is a goal **set by the patient** (e.g., patient has a goal to lose 5 pounds by the next visit), this should be entered in the following question as goal setting instead of counseling.*

Accept:

- Advised to check blood sugar when she feels unwell
- Encouraged to walk 5-6 days/week
- Will exercise more
- Patient is reluctant to or is resistant to doing recommended risk management (e.g., resistant to beginning an exercise program).

Do **not** accept:

- ◆ She is on a low salt diet
- ◆ Has started walking

3. Written material about the disease, medication, risk factors, complications, etc. is given to or discussed with the patient.
4. A checklist completed by provider or patient that indicates what type of counseling or advice was given to the patient or addressed at the visit (i.e., implies a discussion took place).

Do **not** accept for counseling:

- ◆ Notations regarding return appointments, RTC, etc.
  - ◆ Instructions to call or see provider or if a certain symptom or event occurs (e.g., "If swelling gets worse she is to call the clinic").
  - ◆ Descriptions of activities that have occurred entirely in the past.
  - ◆ The provider's plan (i.e., what the provider will do) such as; "will double her dose in 2 weeks if she doesn't respond."
  - ◆ Checklist completed by provider or patient that indicates what the patient had been doing prior to that visit (e.g., "adhering to diet").
- Diabetic medication
    - The note must imply or state that a medication that appears in the diabetes medication list was discussed or reviewed.
    - Counseling may be regarding side effects, compliance, when and how to take/administer the medication, how to adjust insulin dose based on blood sugars, how medication affects blood sugar, etc.

Do **not** accept for medication counseling:

- ◆ A medication order or plan.
  - ◆ List of current medication.
  - ◆ Statements that the patient was told simply what drug to take; or to continue taking the same drugs - what dose; what frequency (e.g., "advised to increase diuretic to 10mg"). There must be information other than or in addition to what the prescription is (such as a side effects, importance of taking regularly, etc.).
  - ◆ Statements that the provider is simply making adjustments in the prescribed dose (may or may not be communicating this to patient).
  - ◆ Counseling regarding medication that is not on the diabetes medication list.
- Blood sugar:
    - How and/or when to monitor home blood sugars
    - Discussion regarding target blood sugars, how to maintain desired levels, what to do if they exceed a certain level or are too low.
    - Examples: "Reviewed importance of monitoring blood sugars."
  - Weight:
    - Counseling, discussion or review regarding weight, importance of weight control
    - Advised to lose/gain weight
    - Order, referral, recommendation to enter weight control program
    - Examples: "discussed calorie intake versus calorie utilization," "encouraged to load plate less full at dinnertime," "encouraged to have 3 small meals daily"
  - Exercise:
    - Counseling, discussion or review regarding exercise, activity levels, importance of exercise
    - Advice on specific level or type of exercise
    - Order, referral, recommendation to enter exercise program
    - Examples: "talked about how much to walk/day," "encouraged to walk 5-6 days/week," "advised to increase exercise"

- Diabetic Diet:
  - Counseling, discussion, review regarding diabetic diet
  - Meal planning or food preparation methods
  - Food management, carbohydrate counting
  - Visit with dietitian/nutritionist is considered to be diet counseling
  - Examples: "reviewed importance of reducing caloric intake"

Do NOT accept for diabetic diet counseling:

- ◆ Dietary therapy for a condition other than a diabetic diet.
- ◆ An order or just a description of the diet
- ◆ Referral to dietitian or order to schedule appointment with dietitian.
- ◆ Statements that do not specifically indicate that diet was discussed such as, "pt follows no specific diabetic diet," "ability to reduce caloric intake is critical to pt's success,"

DIABETIC DIET:

- American Diabetes Association (ADA) diet
- Diabetic diet

- Other diabetes counseling:

- Counseling, discussion or review of foot care
- Recognizing, handling hypoglycemia
- Counseling regarding erectile dysfunction due to diabetes
- Notation of "diabetic counseling"
- Discussion/review of risk factors/diabetes management

Do **not** accept:

- ◆ Counseling that is not related to the management of diabetes
- ◆ FOBT instructions

- Other hypertension risk counseling:

Accept the following whether or not the patient has hypertension:

- Low-salt diet (Low Na, NAS, 2 Gm Na)
- Reduction of alcohol intake
- Home monitoring of blood pressure
- Smoking cessation, referral to smoking clinic
- Discussion/review of risk factors for hypertension

- Cholesterol lowering diet:

- Counseling, discussion, review regarding cholesterol lowering diet
- Meal planning or food preparation methods for a cholesterol lowering diet
- Food management for a cholesterol lowering diet
- Examples: "reviewed importance of reducing fat content"

Do NOT accept for diet counseling:

- ◆ Dietary therapy for a condition other than a cholesterol lowering diet.
- ◆ An order or just a description of the diet
- ◆ Referral to dietitian or order to schedule appointment with dietitian.
- ◆ Statements that do not specifically indicate that diet was discussed such as, "pt follows no specific diet"

CHOLESTEROL LOWERING DIET

- Lipid lowering diet
- American Heart Association (AHA) diet
- Low saturated fat, low cholesterol diet (Step II Diet)
- Limiting total daily fat intake to no more than 30% of total calories
- Any mention of counseling to lower fat in diet

### Type of provider:

Enter the type of provider that provided the diabetes counseling. If the patient saw more than one type of provider on that date, enter the date twice in order to code both providers.

Diabetes Educator, RN – A registered nurse (RN) who is **also** considered to be a Diabetic Counselor. The CDE credentials are not necessary.

Diabetes Educator - not an RN– The patient saw a “Diabetes Educator (CDE).” The educator was not identified as a registered nurse (RN). The CDE credentials are not necessary.

Diabetes Educator and Dietitian (RD)/Nutritionist – The patient saw a Diabetes Educator who was **also** a dietitian (RD) or a nutritionist. The CDE credentials are not necessary.

Dietitian (RD)/Nutritionist – The patient saw a dietitian (RD)/nutritionist who was not a Diabetes Educator.

MD – A medical doctor – any specialty

Other NP/RN/PA/DO – other nurse practitioner (NP), registered nurse (RN), physician’s assistant, doctor of osteopathy (D).

### **Enter each date on which goal setting or an action plan for diabetes was noted.**

Goal setting or action plans must have at least one of the following 2 characteristics:

**1. Specific** goals that patient or provider that will take place in the future to manage the disease. The goal is specific if it has one of the following:

- A **numerical** component
- Indicates the **method** to be used in achieving the goal
- Is a specific one-time event

Accept:

Quantified numerically:

- Will reduce weight by 1 pound every 2 weeks
- Will increase exercise to 3x per week.
- Will cut cigarette smoking down to \_ pack per day.
- Will call in 1 week with record of sugars

Method specified:

- Will decrease blood sugar by cutting down on size of food portions.
- Will try to lose weight by eating dessert only once per week.

Specific one-time event

- Patient will join Weight Watcher’s program
- Patient will join American Diabetic Association (ADA)

Do **not** accept:

- ◆ Will try to lose weight (not specific in number of pounds or in method)
- ◆ Has started walking
- ◆ Goal is to stop smoking
- ◆ Has been exercising 3x/week

**2. Specific** plans or actions the patient will take if certain symptoms or a specific situation occurs or recurs.

Accept:

- If his blood sugar is above 200, he will take 3 units of insulin.”
- Insulin sliding scale
- Instructions on what actions to take (e.g., medication dosage) if the patient’s home-monitored blood sugar results exceed a certain level (e.g., insulin sliding scale, instructions to modify insulin dose according to specific blood sugar levels).

- If patient experiences symptoms of hypoglycemia, she will drink a glass of orange juice or eat a small candy bar.
- If his weight goes up by 3 pounds in a day, he will increase his dose of medication.

Do **not** accept for goal-setting or action plan:

- ◆ Notation such as, "patient to call or return to clinic in..."
- ◆ Instructions to call or see provider or if a certain symptom or event occurs (e.g., "If swelling gets worse she is to call the clinic" or "Patient to call clinic if blood sugar exceeds 175.
- ◆ Will try to keep his blood sugar under 200 (a provider goal, not the patient's).
- ◆ Statements that are counseling rather than a plan of action such as:
  - Has been advised to check blood sugar anytime she feels unwell.
  - Urged to consider insulin
  - Reviewed importance of taking blood sugars twice daily
  - Discussed preventative measures as a potentially unstable diabetic need to be taken in future.
- ◆ Statements such as: "Pt to be given note to be off work until..."