

# Diabetes Criteria Changes

## *Patient care groups*

There are now 3 patient care groups for the diabetes enhanced service these are displayed on the SV Tool as follows:

- Diabetics not on insulin
- Insulin dependant diabetics on practice programme
- Insulin dependant diabetics on shared care programme

Payment criteria are split into 2 sections: screening and outcomes, these are the same for all 3 patient care groups.

Screening consists of all the previous screening criteria, with height and weight no longer a requirement, and all of the previous management criteria other than the 3 value audits for blood pressure, HbA1c and total cholesterol.

The 3 value audits are now covered under outcomes, the outcome audit applies to the total population of the care group and the percentage passed for that group determines the payment for the practice.

## *Screening Audit Criteria*

The SV tool now always checks diabetes using the financial year end (based on the date the SV Tool was run up to), this means that no six monthly criteria can pass until August.

Previously the overall pass rate for screening and the non-value based management criteria could become lower as the year progressed due to results going out of date if no new results were recorded. With the new model the overall pass rate for screening will only ever increase as more results are recorded.

- To achieve the full screening payment a patient must meet 15 or 16 screening criteria.
- To achieve the reduced screening payment a patient must meet 11 to 14 screening criteria.
- If a patient meets 10 or fewer screening criteria they will fail to generate a claim.

## **Once ever**

Ethnicity remains the same as before, at least one result recorded on any date.

## **Six Monthly**

- BMI
- Blood pressure
- HbA1c
- Current treatment

These remain the same as before, a result recorded on any date within 8 months of the audit date (31<sup>st</sup> March) and an additional result recorded between 4 and 8 months prior to that result, all results recorded within 8 months of the audit date are tested until the criteria is passed or all results within the 8 months are exhausted which will result in a fail.

On the SV tool any 6 monthly criteria item with multiple results recorded can be expanded to list all results, this will also indicate the 4-8 month window in which a result was required for the oldest result within 8 months of the audit date.

If the patient received their first ever diabetes diagnosis during the financial year being audited or there was only one result recorded ever for that item then they will only require a single result within 8 months of the audit date.

When the SV Tool is run up to any date between April 1<sup>st</sup> and July 31<sup>st</sup> any six monthly criteria that has had a result recorded since December in the previous year will be marked with a warning triangle which indicates that although a result was recorded another will be required before the financial year end.

## **Annual**

- Locus of care
- Smoking Status
- Smoking cessation advice\*
- eGFR
- Total Cholesterol
- Microalbumin result
- Foot screening
  - Foot pulses
  - Foot sensation
  - Foot risk status
- Management plan
- Alcohol consumption
- Albumin excretion stage
- ACE / Angiotensin II use\*\*

- \* *Smoking cessation advice is not required if the last recorded smoking status is never smoked or ex-smoker.*
- \*\* *ACE/Angiotensin II use is not required if the patients albumin excretion stage is recorded as urine protein normal.*

All annual criteria are now only required once in the 15 months prior to the audit date, that means for financial year 09/10 one entry will be required between the 1<sup>st</sup> of January 2009 and the 31<sup>st</sup> March 2010.

This will mean that not all annual criteria which patients were passing on using the old SV Tool will be passing under the new rules unless they had a result recorded since the 1<sup>st</sup> of January 2009.

## **Outcomes**

The 3 outcome criteria are:

- Blood pressure of 140/80 or less
- Total cholesterol of 5 mmol/l or less
- HbA1c of 7.5% or less

The most recent result within 15 months of the audit date that has a valid value will be used for the outcome audit.

The percentage of the total possible outcomes for each of the 3 care groups is used to determine overall payment for the practice.

For practices with a small number of insulin dependant diabetics a confidence interval correction may be applied to the percentage of outcomes achieved, this correction is to allow compensation for statistical variation that may occur as a result of a small sample size. This correction value is calculated based on the total number of insulin dependant diabetics then applied individually to each of the 2 insulin dependant care groups to give an increase in the percentage used to determine the payment level.