FACT SHEET

Title: DIABETES MANAGEMENT INCENTIVE

Date: April 2006

Eligible Patient Enrolment Models (PEMs):

- Family Health Networks (FHNs)
- Family Health Groups (FHGs)
- Comprehensive Care Models (CCMs)
- Group Health Centre (GHC)
- St. Joseph’s Health Centre
- Primary Care Networks (PCNs)
- Health Service Organizations (HSOs)
- Rural and Northern Physician Group Agreement (RNPGA)
- South Eastern Ontario Academic Medical Organization (SEAMO)

Appendix E, Section 3.1 of the Memorandum of Agreement (MOA) between the Ministry of Health and Long-Term Care and the Ontario Medical Association (OMA) includes provisions for a Diabetes Management Incentive effective April 1st, 2006. Information and guidelines on how to submit for the Diabetes Management Incentive are provided below.

- The Diabetes Management Incentive is a sixty dollar ($60) annual payment available to physicians in the Patient Enrolment Models (PEMs) listed above for coordinating, providing, and documenting all required elements of care for enrolled diabetic patients. This requires completion of a flow sheet to be maintained in the patient’s record and that includes the required elements of diabetes management and complication risk assessment consistent with the Canadian Diabetes Association (CDA) 2003 Clinical Practice Guidelines (Overview of CDA guidelines attached).

- Physicians may choose to use the attached Diabetes Patient Care Flow Sheet or one similar to track a patient’s diabetic care. All the required elements must be recorded. It is intended that the flow sheet be completed over the course of the year to support a planned care approach to diabetes management.

Flow Sheet Requirements:

The flow sheet must track the following:

- Lipids, cholesterol, HgbA1C, blood pressure, weight and body mass index (BMI), and medication dosage (included in K030 Diabetic Management Assessment (DMA) code)
- Discussion and offer of preventive measures including vascular protection, influenza and pneumococcal vaccination
- Documentation of health promotion counselling and patient self-management support
- ACR (albumin to creatinine ratio)
- Discussion and offer of referral for dilated eye examination
- Documentation regarding foot examination and neurologic examination as per CDA guidelines.
Physicians will be required to coordinate care and ensure that all elements are documented in the flow sheet. Other interdisciplinary providers may assist in providing some elements of care and completing and maintaining the integrity of the flow sheet.

- To claim the Diabetes Management Incentive, a physician may submit a Q040A fee code for an enrolled diabetic patient once per 365 day period. The Q040A may be submitted separately or in combination with other fee schedule codes once all elements of the flow sheet are completed.

- The Diabetes Management Incentive (Q040A) is payable for patients enrolled with the billing physician. Note: In models that have group enrolment, a physician is eligible to submit and receive payment for the Q040A for patients affiliated to him/her by virtue of the physician’s acknowledgement on the Patient Enrolment and Consent to Release Personal Health Information (E/C) form.

For more information, please contact your local Ministry office or your Ministry site team contact at 1-866-766-0266.
# DIABETES PATIENT CARE FLOW SHEET

## Patient Name: ____________________________  Diabetes Diagnosis:  □ Type I  □ Type II  Pneumococcal Vaccine: ____________________________

## Date of Birth: ____________________________  Date of Diagnosis: ________________

### Required Elements of Diabetes Care

<table>
<thead>
<tr>
<th>3 TO 6 MONTHS</th>
<th>Date:</th>
<th>Date:</th>
<th>Date:</th>
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</thead>
<tbody>
<tr>
<td><strong>Glycemic Control</strong></td>
<td></td>
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<tr>
<td>A1C target &lt; 7%</td>
<td>Indicate value</td>
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<tr>
<td>Hypoglycemic Episodes</td>
<td>Indicate yes / no</td>
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<tr>
<td>List medications / start date</td>
<td>Indicate changes</td>
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<tr>
<td>BP target ≤ 130/80 mmHg</td>
<td>Indicate value</td>
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<tr>
<td>List medications / start date</td>
<td>Indicate changes</td>
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<tr>
<td><strong>Blood Pressure Control / Vascular Protection</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Consider ASA / ACE Inhibitors for vascular protection</td>
<td>Indicate use</td>
<td>□ ASA</td>
<td>□ ASA</td>
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<tr>
<td></td>
<td></td>
<td>□ ACE Inhibitor</td>
<td>□ ACE Inhibitor</td>
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<tr>
<td><strong>BMI (Target ≤ 25 kg/m²)</strong></td>
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<tr>
<td>¹Waist-to-Hip Ratio: &lt;0.9 ♂ / &lt;0.85 ♀</td>
<td>□</td>
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<tr>
<td>¹Waist circumference: ≤ 40” (102cm) ♂ / ≤ 35” (88 cm) ♀</td>
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<tr>
<td>Indicate value</td>
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<tr>
<td><strong>Other</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Motivational Counselling</td>
<td>Indicate lifestyle / behavioural factors</td>
<td>□ Nutrition</td>
<td>□ Nutrition</td>
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<tr>
<td></td>
<td></td>
<td>□ Exercise</td>
<td>□ Exercise</td>
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<tr>
<td></td>
<td></td>
<td>□ Smoking Cessation</td>
<td>□ Smoking Cessation</td>
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<tr>
<td></td>
<td></td>
<td>□ Other</td>
<td>□ Other</td>
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<tr>
<td>Collaborative Goal Setting</td>
<td>Indicate goal</td>
<td></td>
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<tr>
<td><strong>Self Management</strong></td>
<td></td>
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<td></td>
<td>Indicate challenge</td>
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<tr>
<td><strong>Lipid Control</strong></td>
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<tr>
<td>LDL &lt; 2.5 mmol/L</td>
<td>Indicate LDL value</td>
<td>□</td>
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<tr>
<td>TC:HDL Ratio &lt; 4.0</td>
<td>Indicate ratio</td>
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<tr>
<td>List medications / start date</td>
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<td></td>
<td>Indicate changes</td>
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<tr>
<td><strong>Complication Risk Assessment</strong></td>
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<tr>
<td>Dilated Eye Exam</td>
<td>Completed yes / no</td>
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<tr>
<td>ACR Target ≤ 2 ¹ &lt; 2.8</td>
<td>Indicate value</td>
<td>□</td>
<td></td>
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<tr>
<td>¹eGFR (consider referral if eGFR &lt; 60 ml/min/1.73m² or &gt; 60 and increased ACR)</td>
<td>Indicate value</td>
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<tr>
<td>Additional Urine Testing</td>
<td>Indicate value</td>
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<tr>
<td>Foot Examination</td>
<td>Indicate normal/abnormal</td>
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<tr>
<td>Neurologic Examination</td>
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<tr>
<td>10-g Monofilament or 128-Hz tuning fork</td>
<td>Indicate normal/abnormal</td>
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<tr>
<td><strong>Self Management</strong></td>
<td></td>
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<tr>
<td>Annual Influenza Immunization</td>
<td>Indicate Date</td>
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<tr>
<td>Fasting glucose meter / lab comparison</td>
<td>Calibrated yes/ no</td>
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<tr>
<td>Education / self-management training</td>
<td>Referred yes/no</td>
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<tr>
<td><strong>Self Management</strong></td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

1 Not included in 2003 CDA Guidelines

* Required for Diabetes Management Incentive

N.B. One-time re-vaccination recommended for individuals aged >65 years if original vaccine was administered when they were <65 years and >5 years earlier.
**Prevention and Management of Diabetes**

**Overview of Canadian Diabetes Association Clinical Practice Guidelines (2003)**

Refer to Guidelines for detailed information

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**Every 3 years in individuals 40 years of age or over with no other risk factors. Earlier and/or more frequently in individuals < 40 years of age with risk factors.**

**As clinically indicated in individuals 40 years of age and over with additional risk factors.**

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**Screening and Prevention**

- **< 5.7 mmol/L**
- **5.7-6.9 mmol/L + risk factors**
- **6.1-6.9 mmol/L no risk factors**
- **7.0 mmol/L or greater on 2 separate days**

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**Classify patient as**

- **Normal**
- **Isolated IFG**
- **Isolated IGT**
- **IFG and IGT**
- **Diabetes**

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**Health Promotion / Self Management**

- Weight management (BMI <25 kg/m²)
- Nutrition - to optimize glycemic control
- Smoking cessation - to optimize vascular protection
- Increased physical activity - to increase HDL-C
- Education
- Collaborative goal setting
- Influenza (Annually) / Pneumococcal vaccination
- Consider ASA and ACE inhibitors for vascular protection

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**Glycemic Control**

- **A1C < 7%**
- Glycemic control assessed every 3-6 months or as clinically indicated
- Consider using medical directives to maximize RN/RD scope of practice

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**Blood Pressure Control**

- **< 130/80 mmHg (threshold recommended to initiate treatment)**
- Blood pressure assessed every 3-6 months or as clinically indicated

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**Lipid Control**

- For patients at high risk of a vascular event:
  - **TC: HDL-C < 4.0mmol/L**
  - **LDL-C < 2.5mmol/L**
- Lipid profile assessed every 1-3 years or as clinically indicated

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**Nephropathy**

- Annual screening for microalbuminuria (Albumin to Creatinine Ratio (ACR))
  - **Men < 2.0mmol/mmol**
  - **Women < 2.8mmol/mmol** (Repeat if targets exceeded)
- Consider ACE inhibitor / ARB / Calcium Channel Blocker
- Creatinine clearance testing annually or every 6 months if ACR elevated
- Referral to renal specialist if creatinine clearance <60 ml/minute

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**Neuropathy**

- Neurologic Examination: 10g monofilament or 128-Hz tuning fork
  - Annually at time of diagnosis of Type 2 and after 5 years with Type 1
  - Tighter glycemic control if testing abnormal
- Consider tricyclic antidepressants / anticonvulsants for pain management

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**Retinopathy**

- Eye Examination:
  - 5 years after diagnosis of Type 1 in all individuals 15 years and over
  - All individuals at diagnosis of Type 2 diabetes
- Intensify glycemic, blood pressure, and lipid control if abnormal

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**Foot Care**

- Foot Examination:
  - Performed annually or more often if clinically indicated
  - All patients should be instructed on proper foot care

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ACE = Angiotensin converting enzyme  
ARB = Angiotensin II receptor antagonist  
FPG (or FBG) = fasting plasma (blood) glucose  
mmol/L = millimoles per Litre  
PG = plasma glucose  
2hPG = 2-hour plasma glucose  
OGTT = oral glucose tolerance  
PG = plasma glucose  
TC HDL = Total cholesterol to high density lipoprotein ratio  
LDL = low density lipoprotein  
CVD = cardiovascular disease  
IGT = impaired glucose tolerance  
IFG = impaired fasting glucose  
ACR = Albumin to Creatinine Ratio