# Positive Practice

NEWS AND EDUCATION FOR POSITIVE HEALTHCARE PROVIDERS Issue 28 Spring 2024

## In this Issue




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## What is Health Equity?

Health equity refers to the principle of ensuring that all individuals have an equal opportunity to attain their highest level of health. It involves addressing and eliminating health disparities, which are differences in health outcomes and access to healthcare that are unjust and avoidable. Health equity recognizes that factors such as social, economic, and environmental conditions can significantly impact an individual's health and seeks to create fair and just opportunities for everyone to achieve optimal health. To address the root causes of health Equity, it is crucial to understand the core definitions.

### Socio-Economically Disadvantaged

Socioeconomic disadvantage refers to a condition in which individuals or communities experience lower social and economic status compared to others in society. It is characterized by limited access to financial resources, educational opportunities, healthcare services, employment prospects, and other social determinants of health. Socio-economic disadvantage can contribute to health disparities, as individuals facing these challenges may have reduced access to quality healthcare, nutritious food, safe housing, and other resources necessary for good health. Addressing socio-economic disadvantages is crucial for promoting health equity and ensuring that everyone has an equal opportunity to live a healthy life.

### Disparity

Variations or gaps in various aspects, such as income, education, health, opportunities, or outcomes. The disparity highlights the contrast, imbalance, or disparity between different groups, individuals, or entities. It often implies an unfair or unjust distribution of resources, privileges, or opportunities. Addressing disparities involves recognizing and addressing the underlying factors that contribute to these differences, with the create a more equitable and inclusive society.

### Inequality

The state of being unequal or the existence of disparities or differences in various aspects, such as wealth, income, power, opportunities, or social status, among individuals or groups. Inequality can manifest in various forms, including economic inequality, gender inequality, racial inequality, or educational inequality. It highlights the unequal distribution of resources, privileges, or opportunities, often resulting in social or economic disadvantages for certain individuals or groups. Addressing inequality involves recognizing and challenging the structural and systemic factors that contribute to these disparities, to promote fairness, justice, and equal opportunities for all.

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### Equality

The state of being equal or having the same rights, opportunities, and treatment as others. It emphasizes the absence of discrimination or bias based on factors such as gender, race, ethnicity, religion, socioeconomic status, or sexual orientation. Equality promotes fairness, justice, and the idea that all individuals should have an equal chance to succeed and thrive. It involves providing equal access to resources, opportunities, and benefits, as well as ensuring that everyone is treated with dignity and respect. Equality is a fundamental principle of human rights and is often pursued through legal and social measures to eliminate discrimination and create a more inclusive and equitable society.

### Social Drivers of Health

Social drivers of health are nonmedical-related factors that can directly influence health outcomes in positive and negative ways. Here are some examples:

1. Income
2. Education
3. Work Life Conditions
4. Housing and Basic Amenities
5. Environment
6. Food Insecurity
7. Access to Healthcare Services

## Promote and Support your Patients in Prioritizing their Colon Cancer Screenings

PHP and PHC California are unwavering in their efforts to actively engage our members and providers in promoting the significance of preventive screenings. By December 31st of this year, PHP and PHC California will incentivize members with a gift card upon completion of a Colorectal Cancer Screening and Diabetic Retinal Eye Exam. Our steadfast commitment lies in partnering to ensure that our members have equitable access to superior healthcare and pertinent information to support their well-being. As we are halfway through the year, PHP and PHC California extend a challenge to our network providers to actively encourage members to undergo essential preventive screenings, thereby improving the quality of their care and rewarding them in the process. Health equity remains a crucial focus in these screenings, ensuring equal opportunities for all.

PHP and PHC California are offering two different ways for members to receive Colorectal Cancer Screenings; COLOGUARD & COLONOSCOPY.

- Cologuard (noninvasive, done at home, no special preparation, to be completed every 3 years, Receive a $40 Gift Card for Completion).
- Colonoscopy (Invasive screening, implemented by a GI Specialist, special preparation required, to be completed every 10 years, can receive a $100 Gift Card for Completion) Card after test completion is verified in the member's medical record.

People Living with Diabetes are at risk of diabetic retinopathy and are advised to complete a Diabetic Retinal Eye Exam.

- Members can simply, call their doctor's office to request a diabetic retinal exam
- Complete the eye exam by December 31, 2024
- Have the provider's office who did the Diabetic Retinal Eye Exam sign the form,
- Can receive a $20 Gift, once signed form is received

All the completed incentive forms can be completed online or by mail and sent to P.O. Box 46160 Los Angeles, CA 90046.

# Save Lives, Take Action: Screen for Colorectal Cancer!

Here are some important facts about colon cancer from the American Cancer Society:

**1. Colon Cancer Incidence:** Colon cancer is the third most commonly diagnosed cancer in both men and women in the United States. It is estimated that in 2024, there will be around 106,590 new cases of colon cancer.

**2. Colon Cancer Mortality:** Colon cancer is the third leading cause of cancer-related deaths in both men and women in the United States. It is estimated that in 2024, approximately 53,010 deaths will occur due to colon cancer.

**3. Age and Risk:** The risk of developing colon cancer increases with age. The average age at the time of diagnosis is 68 for men and 72 for women. However, colon cancer can occur in younger individuals as well.

**4. Screening Saves Lives:** Regular screening for colon cancer can help detect the disease at an early stage when it is highly treatable. It can also help prevent colon cancer by identifying and removing precancerous polyps. Screening has been shown to reduce the risk of dying from colon cancer.

**5. Screening Guidelines:** The American Cancer Society recommends that individuals at average risk start regular colon cancer screening at the age of 45. However, for individuals with a family history of colon cancer or certain genetic conditions, screening may need to start earlier.

**6. Colonoscopy:** Colonoscopy is considered the gold standard for colon cancer screening. It involves the examination of the entire colon using a long, flexible tube with a camera. Colonoscopy not only helps detect colon cancer but also allows for the removal of precancerous polyps during the procedure.

**7. Stool-Based Tests:** Stool-based tests are non-invasive screening options for colon cancer. These tests detect blood or DNA markers in the stool, which may indicate the presence of colon cancer or precancerous polyps. Examples of stool-based tests include fecal occult blood test (FOBT) and Cologuard.

**8. Follow-Up after Positive Tests:** If a stool-based test shows positive results, further evaluation with a colonoscopy is typically recommended to confirm the presence of colon cancer or precancerous polyps.

**9. Lifestyle Factors:** Certain lifestyle factors can influence the risk of developing colon cancer. Maintaining a healthy weight, being physically active, consuming a balanced diet rich in fruits, vegetables, and whole grains, limiting red and processed meat intake, avoiding tobacco use, and moderating alcohol consumption can help reduce the risk of colon cancer.

**10. Early Detection and Survival:** The five-year relative survival rate for localized colon cancer is around 90%. This emphasizes the importance of early detection through screening, as it significantly improves the chances of successful treatment and long-term survival. Remember, these facts are based on the most recent data available from the American Cancer Society. It is important to consult with healthcare professionals and follow their recommendations regarding colon cancer screening and prevention.

# Community Health Workers (CHW)

### What Do They Do?

CHW will work on locating patients who have fallen out of routine care for various reasons.
CHW will contact patients who meet the requirements to be contacted:

- No provider appointment between 6-12 months
- Missed 2 or more appointments in 6-12 months and have no follow-up appointments scheduled
- Referred by a medical provider
- Follow-up on patients who are back in care after their 2nd completed Appointment

### How Do They Do It?

CHWs are provided with communication equipment and tools to reach out to patients via phone calls, messages, emails, postal mail, voicemails, and home visits if needed.

CHW investigates and checks patients' charts in the electronic medical record and uses SalesForce as the main portal to find targeted patients.

### Why Do They Do It?

CHWs help with re-engaging eligible patients in care. They collaborate with the clinic front desk staff and practice managers to schedule appointments for re-engaged patients and keep them in care for a year at least.

# MODEL OF CARE 2024 PROVIDER TRAINING

## What's this Model of Care (MOC) and Why Do We Have to Have One?

1. Medicare Special Needs Plans (SNPs) were created by Congress in the Medicare Modernization Act (MMA) of 2003, as a new type of Medicare managed care plan that focuses on certain vulnerable groups of Medicare beneficiaries which includes care for seniors and persons with disabilities (SPD).

2. AHF PHP is a C-SNP (the "C" is for "chronic" condition) that focuses on the vulnerable group with HIV/AIDs.

3. The Social Security Act requires that every Special Needs Plan must have a Model of Care (MOC) approved by the National Committee for Quality Assurance (NCQA).

## What is the MOC?

The MOC provides the basic framework under which the SNP will meet the needs of each of its enrollees.

- The MOC is a written document.
- The MOC must ensure the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices.
- The MOC provides the foundation for promoting SNP quality, care management, and care coordination processes.

## What must be in the written MOC?

NCQA assesses MOCs from SNPS according to detailed scoring guidelines published by CMS.
The MOC requirements comprise the following standards:

- MOC 1 - Description of the SNP Population.
- MOC 2 - Care Coordination.
- MOC 3 - SNP Provider Network.
- MOC 4 - Quality Measurement & Performance Improvement.

AHF PHP received a score of 97.5%% on its written SNP Model of Care Program from NCQA/CMS for 2024.
Every member in our Plans has at least one chronic condition HIV/AIDS.
Staffing of the Plan and the Provider Network is based on the model of health service delivery described in the model of care.
The model of health service delivery is a hybrid one that combines Chronic Care Disease Management and Population Health.
QI produces an annual MOC Dashboard to measure our success with implementing the MOC for every member.

**The MOC training is also assigned to be completed by all network providers in AHF University (HealthStream). An electronic copy and a hard copy are available.**

## MOC 1 - Description of the SNP Population

- Every member of the PHP Plan has at least one chronic condition: HIV/AIDS
- Other population descriptors can be seen in table below (2022 data)

| PLAN PHC-CA 2022 | GENERAL HEALTH STATUS FAIR OR POOR | MENTAL HEALTH STATUS FAIR OR POOR | HOSPITALIZATIONS SPENT A NIGHT IN THE HOSPITAL | HYPERTENSION | DIABETES |
|---|---|---|---|---|---|
| | 33.3% | 24.3% | 86.1% | 62.5% | 33.2% |
| AGE | <65 YR | 65 YR – 74 YR | 75 YR OR OLDER | | |
| | 42.9% | 54.2% | 10.9% | | |
| GENDER | MALE | FEMALE | | — | |
| | 82.2% | 17.8% | | | — |

Additional defining characteristics of this population include:

- 45.9% of the enrollees have 4 or more comorbidities
- 31.3% have 14-30 Physically Unhealthy Days
- 25.8% have 14-30 Mentally Unhealthy Days
- 29.2% have 14-30 Days with Activity Limitations

Cultural, linguistic, and special needs sensitivity training is conducted annually. AHF publishes a monthly newsletter called CHORD which addresses these issues in addition to newsletter articles.

## MOC 2 - Care Coordination Overview

- Starts with identifying chronic disease status by using the Health Risk Assessment (HRA) by the RN Care Team Manager (RNCTM)
- Severity Level (SL) is calculated from HRA results (SL 1, 2, or 3 or Low, Medium, High)
  - o Members assigned SL 3 (High) are placed under Complex Care Management
  - o Members assigned SL 2 (Medium) are placed under Chronic Disease Management
  - o Members assigned SL1 (Low) are placed in Population Health Management
- A Care Plan, which includes member goals, is established and shared
- Interdisciplinary Care Team Meetings are held to coordinate care & discuss the best options for care and its delivery
- Ongoing support – working on the care plan – teaching self-management to member
- Annual re-evaluation of member

### Severity Level Definitions

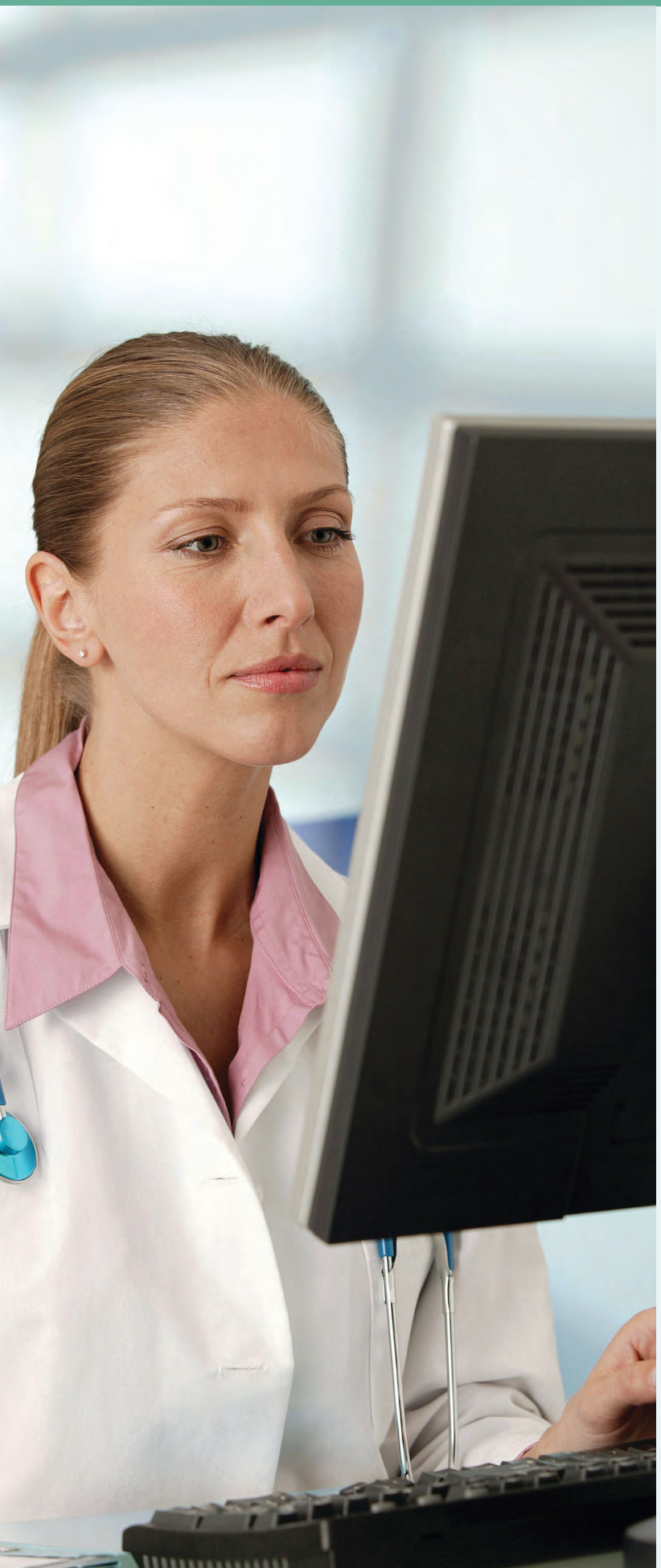
Persons with an acuity level of High, on a scale of 1 to 3, 3 being the highest acuity/vulnerability, are identified as complex care management which includes closer scrutiny and focused care management. Pertinent factors are late presenters to care, high viral and low CD4 counts, adherence to antiretroviral medication, co-morbid conditions, dual diagnosis, etc. Elements of the identification process include:

- The care management software assigns an acuity scale determination based on the HRA interview data collected. The final acuity level is determined by the RNCTM based on the health risk assessment results, and other factors such as HIV Viral load and CD 4 count; medication adherence; hospitalizations and ER use; care level/ adherence, presence of uncontrolled co-morbid conditions, member level of comprehension of self-care management and social determinants of health.
- Level 3/High acuity enrollees are considered most vulnerable and assigned to complex care management where they receive direct management by the RN Care Team Manager. The RNCTM then guides the entire care team for follow-up on care plan interventions.
- Each enrollee has access to the PHP Care Team. An RNTCM assesses the results of the HRA and assembles the ICT and ICP that will meet the specific needs of the enrollee, e.g., if the enrollee has behavioral health issues, the Behavioral Health Professional (BHP) will be a member of the ICT as well as the HIV PCP and other support staff.

PHP demonstrates through the Model of Care that at the core of the Interdisciplinary Care Team (ICT) is always the enrollee and the enrollee caregiver (when requested by the enrollee), the HIV Primary Care Physician (PCP) and the Registered Nurse Care Manager (RNCTM). Upon enrollment into PHP, the enrollee is assigned to a PCP and an RNCTM to conduct the initial HRAT thus establishing the ICT from the first day of active enrollment. The diagram below depicts the structure and other team members involved in the ICT as informed by the Health Risk Assessment Tool (HRAT).

**ACUITY DETERMINATION GUIDELINES DEFINITIONS**

| Criteria | Low – Population Health Management | Moderate –Disease Management | High/Complex– Care Management |
|---|---|---|---|
| HIV Viral Load | Undetectable Viral Load | Detectable Viral Load | Increased Viral Load |
| CD4 count | CD4 Count >500 | CD4 Count <200–499 | CD4 Count <200 |
| Medication Adherence | ARV Adherence 95% or greater | ARV Adherence 85% or greater | ARV Adherence less than 85% |
| Hospitalization Acute Utilization | No hospitalization within last 6 months | >1 hospitalization within last 6 months | >2 hospitalization within last 6 months |
| Emergency Department Utilization | No Emergency Department visits in the past 6 months | >1 Emergency Department visits in the past 6 months | >3 Emergency Department visits in the past 6 months |
| Substance Abuse or Use/Addiction Disorder | No current abuse or active use/addiction disorder | Active abuse or active use/addiction disorder, not in remission or relapse in last 3 months | Active substance use/ addiction disorder |
| Depression Screening PHQ9 Score | 0–4 | 5–15 | 16 or greater |
| Mental Health Conditions (other) | May have diagnosis but no active complaints or concerns | Active diagnosis with questions or concerns | Active diagnosis with chief complaints |
| Uncontrolled Co-morbidities | 3 or less | 4 to 6 | 6 or more |
| Food Insecurity | Able to access or and obtain steady food supply without assistance | Needs occasional assistance to obtain steady food supply | Needs ongoing assistance in obtaining steady food supply |
| Interpersonal Security | Feels safe with support system | Has concerns regarding safety and limited support system | Does not feel safe and/ or is in need of support system |
| Housing | Stable Housing | Unstable or transitional Housing | Transitional housing or homeless |
| Transportation | Access to reliable transportation | Needs occasional assistance in accessing transportation | Unable to gain access to transportation – needs ongoing assistance |
| Contact Frequency | Quarterly outreach Annual Reassessment | Bi-Monthly (Q8 weeks) telephonic outreach Annual Reassessment | Monthly telephonic outreach Annual Reassessment |



## MOC 3 - Provider Network Adequate + Specialized

1. • AHF Primary Care Physicians
   - Network Primary Care Physicians
   - Specialists
2. • Provider Contracts • Vision
   - Skilled Nursing Homes • Home Health
   - DME • Dental • Hospitals • Lab
   - Radiology • PT, OT & ST • Hospice

**PROVIDER NETWORK MOC TRAINING**

Code of Federal Regulations (42CFR §422.101(f)(2)(ii)) require SNPs to conduct MOC training for their network of providers.

- Training is provided initially and on an annual basis.
- Attendance at training must be documented.
- PHP uses a multidisciplinary team to implement the comprehensive training program.

## MOC 4 - Quality Measurement & Performance Improvement Overview

Code of Federal Regulations (42 CFR §422.152(g)) require that all SNPs conduct a Quality Improvement Program (QIP) that measures the effectiveness of its MOC.

- The QI Plan outlines a coordinated and integrated system for organization-wide assessment and improvement. This is accomplished by:
  - o Using comparative data to focus on areas of greatest opportunity for improvement.
  - o Working collaboratively to develop or enhance mechanisms for patient safety oversight.
  - o Working collaboratively to enhance the adverse events and peer review processes.
  - o Dissemination of results across the organization.

**Data Used to Evaluate if MOC Goals Met**

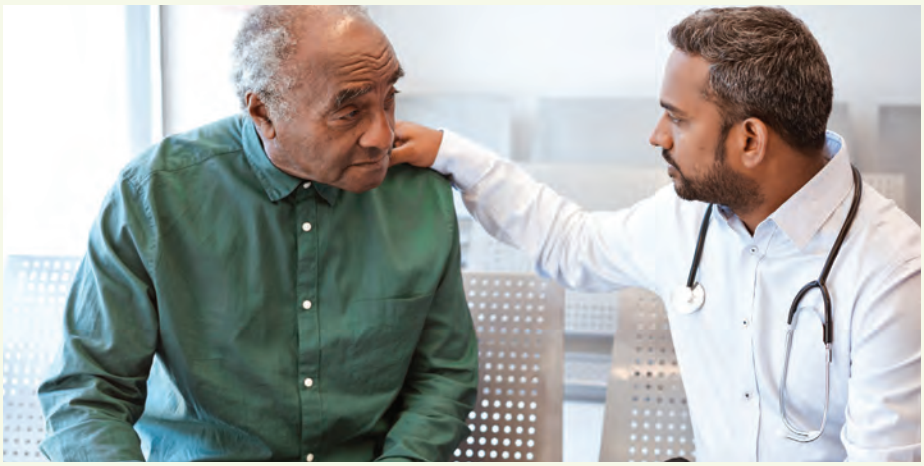
PHP participates in both CMS required activities and internally developed activities that monitor quality of care and service. These measures are regularly reported out at least annually to the QMC, EOC, the Provider Meetings, ICT Meetings, and All Staff Meetings. The following outline summarizes the key components:

- Healthcare Effectiveness Data and Information Set (HEDIS)
- Health Outcome Survey (HOS)
- Consumer Assessment of Healthcare Providers & Systems (CAHPS) Survey
- Quality Improvement Project (QIP)
- Performance Improvement Project (PIP)
- Chronic Care Improvement Project (CCIP)
- Collection and reporting of Part C Reporting Elements (HPMS)
- Collection and Reporting of Part D Medication Therapy Management Data
- Grievance Aggregation and Category Stratification
- Initial Assessment and Reassessment Timeliness
- Star Ratings
- Internal Initiatives and Key Indicators

# 2024 PHP Model of Care (MOC) Dashboard Measures

| SCREENING | NAME OF SCREENING | BENCHMARK | TIMEFRAME |
|---|---|---|---|
| **Appropriate Use of Services for Chronic Conditions** | | | |
| % members with Viral Load Suppression | The percent of members with a viral load suppression < 200 mg. | 88% | Annual |
| % members with at least 3 visits per year | The percent of members with at least 3 provider visits, 90 days apart or more, annually. | 90% | Annual |
| CDC- Retinal Eye Exam | Screening or monitoring for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: • A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year. • A negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. | 60% | Annual |
| CDC – HbA1c Blood Sugar Controlled | The percentage of diabetic enrollees 18–75 (denominator) whose most recent HbA1c level is less than 9%, or who were tested during the measurement year (numerator). | 70% | Annual |
| **Improving Coordination of Care** | | | |
| Functional Status Assessment | Percentage of enrollees with at least one functional status assessment during the measurement year, as documented through either administrative data or medical record review. | 85% | Annual |
| Medication Review | Percentage of enrollees with a review of all medications, including prescription medications, OTC medications and herbal or supplemental therapies. | 85% | Annual |
| Pain Screening | Percentage of enrollees with at least one pain assessment during the measurement year, as documented through either administrative data or medical record review. | 85% | Annual |
| **Improving Access to Care:** | | | |
| % members satisfied with access to routine care | Percentage of members who respond positively to the CAHPS question: "In the last 12 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" | 80% | Annual |
| % members satisfied with access to urgent care | Percentage of members who respond positively to the CAHPS question: "In the last 12 months, when you needed care right away, how often did you get care as soon as you needed?" | 75% | Annual |
| **Improving Affordability** | | | |
| % members saying "No" to delay/not filled RX because could not afford it | Percentage of members who responded "No" to the CAHPS question: "In the last 6 months, did you delay or not fill a prescription because you felt you could not afford it?" | 85% | Annual |
| **Improving Delivery of Service** | | | |
| % members said provider had medical records/information during appointment | Percentage of members who respond positively to the CAHPS question: "In the last 6 months, when you visited your personal doctor for a scheduled appointment, how often did they have your medical records or other information about your care?" | 80% | Annual |
| % members said received help to manage care from different providers and services | Percentage of members who respond positively to the CAHPS question: "In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services?" | 80% | Annual |
| **Enhanced Care Transition** | | | |
| Advance Care Planning | Percentage of enrollees with evidence of advance care planning as documented through either administrative data or medical record review. | 50% | Annual |
| Medication Reconciliation Post-Discharge (MRP) | The percentage of discharges from January 1– December 1 of the measurement year for members 18 years of age and older for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days). | 50% | Annual |
| **Preventative Health** | | | |
| Colorectal Cancer Screening (COL) | The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. | 68% | Annual |
| Controlling High Blood Pressure (CBP) | The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: • members 18–59 years of age whose BP was <140/90 mm Hg. | 70% | Annual |
| Breast Cancer Screening | The percentage of female members 50 – 75 years of age who received a mammogram during the measurement year. | 60% | Annual |
| % members reporting flu vaccine received | The percentage of Medicare members 65 years of age and older who received a flu vaccination between July 1 of the measurement year and the date when the Medicare CAHPS survey was completed. | 80% | Annual |
| **Compliance with Model of Care Requirements** | | | |
| % members with timely Health Risk Assessment (HRA) | Percentage of members who received an initial or annual health risk assessment during the year based on the members due date. | 100% | Annual |
| % members with Interdisciplinary Care Plan (ICP) | Percentage of members who has an interdisciplinary care plan during the year based on the members enrollment due | 100% | Annual |
| % members with Interdisciplinary Care Team (ICT) | Percentage of members who has an interdisciplinary care team meeting during the year based on the members due date. | 100% | Annual |

# 2024 HEDIS MEASURE UPDATES



## Colorectal Cancer Screening (COL)

**2024 HEDIS Measure Updates**

Just a few reminders for Quality Measure changes: Colorectal Cancer Screening (COL)

**Description**

The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

***Note the age change that began in 2023*

| | |
|---|---|
| **Ages** | 46–75 years as of December 31 of the measurement year. Report two age stratifications and a total rate:<br>46–49 years.<br>50–75 years.<br>Total.<br>The total is the sum of the age stratifications. |
| **Required exclusions** | **Exclude members who meet any of the following criteria:**<br>• Members who had colorectal cancer (Colorectal Cancer Value Set) or a total colectomy (Total Colectomy Value Set; History of Total Colectomy Value Set) any time during the member's history through December 31 of the measurement year.<br>• Members in hospice or using hospice services anytime during the measurement year. Refer to General Guideline 15: Members in Hospice.<br>• Members who died any time during the measurement year. Refer to General Guideline 16: Deceased Members.<br>• Members receiving palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set; ICD-10-CM code Z51.5) any time during the measurement year. |
| **Numerator** | **One or more screenings for colorectal cancer. Any of the following meet criteria:**<br>• Fecal occult blood test (FOBT Lab Test Value Set; FOBT Test Result or Finding Value Set) during the measurement year. For administrative data, assume the required number of samples were returned, regardless of FOBT type.<br>• Flexible sigmoidoscopy (Flexible Sigmoidoscopy Value Set; History of Flexible Sigmoidoscopy Value Set) during the measurement year or the 4 years prior to the measurement year.<br>• Colonoscopy (Colonoscopy Value Set; History of Colonoscopy Value Set) during the measurement year or the 9 years prior to the measurement year.<br>• CT colonography (CT Colonography Value Set) during the measurement year or the 4 years prior to the measurement year.<br>• Stool DNA (sDNA) with FIT test (sDNA FIT Lab Test Value Set; sDNA FIT Test Result or Finding Value Set) during the measurement year or the 2 years prior to the measurement year. |

## Diabetes Care is comprised of multiple measures:

**1. Hemoglobin A1c Control (must have at least one HgA1c annually)**

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose hemoglobin A1c (HbA1c) was at the following levels during the measurement year:

- HbA1c Control (<8.0%).
- HbA1c Poor Control (>9.0%).

**2. Blood Pressure Control**

The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.

**3. Eye Exam for Patients with Diabetes**

The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.
Must be completed annually

**4. Kidney Health Evaluation (KED)**

The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin creatinine ratio (uACR), during the measurement year.