2025 Best Practices
Comprehensive Diabetes Care
Comprehensive Diabetes Management – HbA1c - Good Control

Partnership Tools, Programs, and Promising Practices:

- Partnership's Pharmacy Department offers **Academic Detailing** analysis of Diabetes A1c Rate measure performance and opportunities for improvement based on prescribing and pharmacy fill data. Please contact the Pharmacy Department at RxConsult@partnershiphp.org if you would like to request Academic Detailing for your practice.
- Attend or view Partnership's **Improving Measure Outcomes training** on *Diabetes Management.*
- Provider health education materials are accessible on **Partnership's website** or by contacting CLHE@partnershiphp.org. Providers can access flyers and member/patient materials for distribution in multiple languages.
- Partnership members can access transportation for non-emergency medical services for assistance in traveling to and from appointments. Members can access services by calling **Partnership's Transportation Services** at (866) 828-2303, Monday – Friday, 7 a.m. – 7 p.m.
- **TeleMed2U** is a diabetes care program that is available for Partnership members with diabetes. This telehealth program provides personalized and evidence-based care tailored to each members/patient's specific needs that include treatment options, medication regimes, and lifestyle modifications that are essential for effective diabetes management. To refer a Partnership member to TeleMed2U, **follow the instructions for referring on the Partnership portal.**
- Partnership covers **Medical Nutrition Therapy (MNT)** for both diabetes and prediabetes. PCP providers can refer Partnership members to a contracted Registered Dietician or Certified Diabetes Educator in the network or with Partnership-contracted providers for in-person or telehealth visits. Information on these services is available in the **Partnership Online Services Portal**.
- Refer/enroll members/patients with uncontrolled diabetes to Partnership's Care Coordination Department. The Care Coordination Department can assist patients needing additional assistance navigating the health care system to ensure they are accessing prescribed medications and follow up on referrals to nutrition therapy and other specialty care. You can refer a Partnership member to Care Coordination by calling or having them call (800) 809-1350 or by sending a secure email to CareCoordination@PartnershipHP.org.
- For members/patients whose foot care needs cannot be managed in the primary care office, a referral to Partnership's network of contracted podiatrists may be found in the **Partnership Provider Directory**.

Patient Care:

- Use **Medi-Cal Rx's Contract Drug List** for a list of covered diabetic medications.

- Utilize “flag” alerts in the EMR/EHR system that each care team/staff can use to identify and communicate to patients who are due for their screening services, including annual eye exam, at every member/patient encounter.
- Perform testing as part of the rooming process for members/patients with diabetes **regardless of the reason for the visit.**
- Offer on-site HbA1c testing or phlebotomy.
- Chart prep and huddles to add HbA1c as an add-on service for any visit.
- Create standing orders for HbA1C that can be completed by non-provider staff.
- Streamline or automate pathways to HbA1c testing; a lab order should not require a PCP visit.
- Leverage telehealth for diabetes medication management visits.
- Cross departmental coordination of care:
    - Incorporate care team members using standing orders for nursing, pharmacists, and registered dieticians.
    - Diabetic panel manager coordinates care for members/patients with uncontrolled diabetes, including HbA1c testing.
- Ensure members/patients are informed of HbA1c results and next step(s).
- Refer/enroll members/patients with uncontrolled diabetes with Partnership’s Chronic Case Management. Optimize pathways for referrals to case management, health education, and clinical pharmacy teams.
- Point incentive program to encourage self-management (gift card or other rewards).

Patient Education:

- Assess and address the member’s/patient’s knowledge, gaps, and barriers related to diabetes self-management (e.g., cultural, financial, literacy/health literacy, social support, health beliefs).
- Provide/encourage the use of virtual tools to support self-management (computer/phone apps and programs for healthy eating, physical activity, and medication management).
- Refer for medical nutrition therapy, in-house or via telehealth.
- Inform member/patient that all services included in comprehensive diabetic care, including vision, diabetic footwear, medical nutrition therapy and approved monitoring devices including continuous glucose monitors and insulin pumps, are covered benefits under Medi-Cal.
- Reinforce the importance of testing and self-management.

Outreach:

- Designate a care team/staff to contact members/patients due for HbA1c testing and scheduling (e.g., phone call, post card, letter signed by provider, text).
- Call members/patients within a week to reschedule if a lab or provider appointment is missed.

Equity Approaches:

- Consider using an equity approach to increase screening rates for targeted communities. By looking at Comprehensive Diabetes Care measure compliance rates by factors such as race,

ethnicity, gender, location (i.e., zip code), and preferred language; it is possible to identify barriers that affect specific communities and plan interventions to address these barriers.

- Additionally, the **DrillDown Clinical tab** in the eReports portal shows race/ethnicity information for each member/patient included in the measure. Export this dashboard to look at Comprehensive Diabetes Care compliance rates by race and ethnicity to learn more about inequities within your member/patient community.
- Ensure member/patient information is consistent, welcoming, plain, and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Each visit should include a conversation with the member/patient to confirm that health information, medication management, and the next steps covered in the visit are mutually understood; member/patient agrees with any plans made; and they have the opportunity to ask questions.
- Consider literacy and health literacy barriers, and alternative ways of providing diabetes management and medication management instructions.
- Use approaches and partnerships that align with your practice's demographics (partner with local schools, faith-based organizations).
- Identify and address barriers to care (transportation, hours of operation, and access to pharmacy services).

Data and Coding:

- Submit claims and encounter data within 90 days of service.
- Exclude members/patients as appropriate and use coding to document reason for exclusion.
- Use CPT-II coding to document HbA1c test results.
- Review lab requisition forms and visit superbills (EMR/EHR or paper) to ensure codes align with HEDIS technical specifications.

Helpful Links:

2025 PCP QIP Technical Specifications:

- Measure Description
- Exclusions
- PCP QIP Full Points, Partial Points, Relative Improvement Definitions
- Notes for eReports and PQD

QIP eReports Portal:

- Measure Reports
- Diagnosis Code Crosswalk Report
- QIP Member Report

Medi-Cal Rx's Contract Drug List:

- List of Covered Diabetes Medications and Medical Supplies
- List of Covered Blood Pressure Medications and Medical Supplies