Improving Measure Outcomes:
Diabetes Control

Lisa Ward, MD
Regional Medical Director

Candi Broadhead
Project Manager

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Learning Objectives

- Define the clinical background, specifications, and performance threshold definitions for the 2025 Primary Care Provider Quality Improvement Program Specifications: Comprehensive Diabetes Management - HbA1c Good Control, Retinal Eye Exam, and Blood Pressure Control for Patients with Diabetes measures.
- Apply measure specification requirements to maximize adherence and measure performance for the Comprehensive Diabetes Management – HbA1c Good Control, Retinal Eye Exams and Blood Pressure Control for Patients with Diabetes.
- Evaluate the prevalence and risk factors for diabetes mellitus and related diabetic conditions and associated health inequities prevalent in their diagnosis and treatment.
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications and technical tips to improve Diabetes Management HbA1c Good Control rates.

Overview of Clinical Guidelines for Comprehensive Diabetes Management

- HbA1c Good Control
- Retinal Eye Exam
- Controlling High Blood Pressure in Patients with Diabetes

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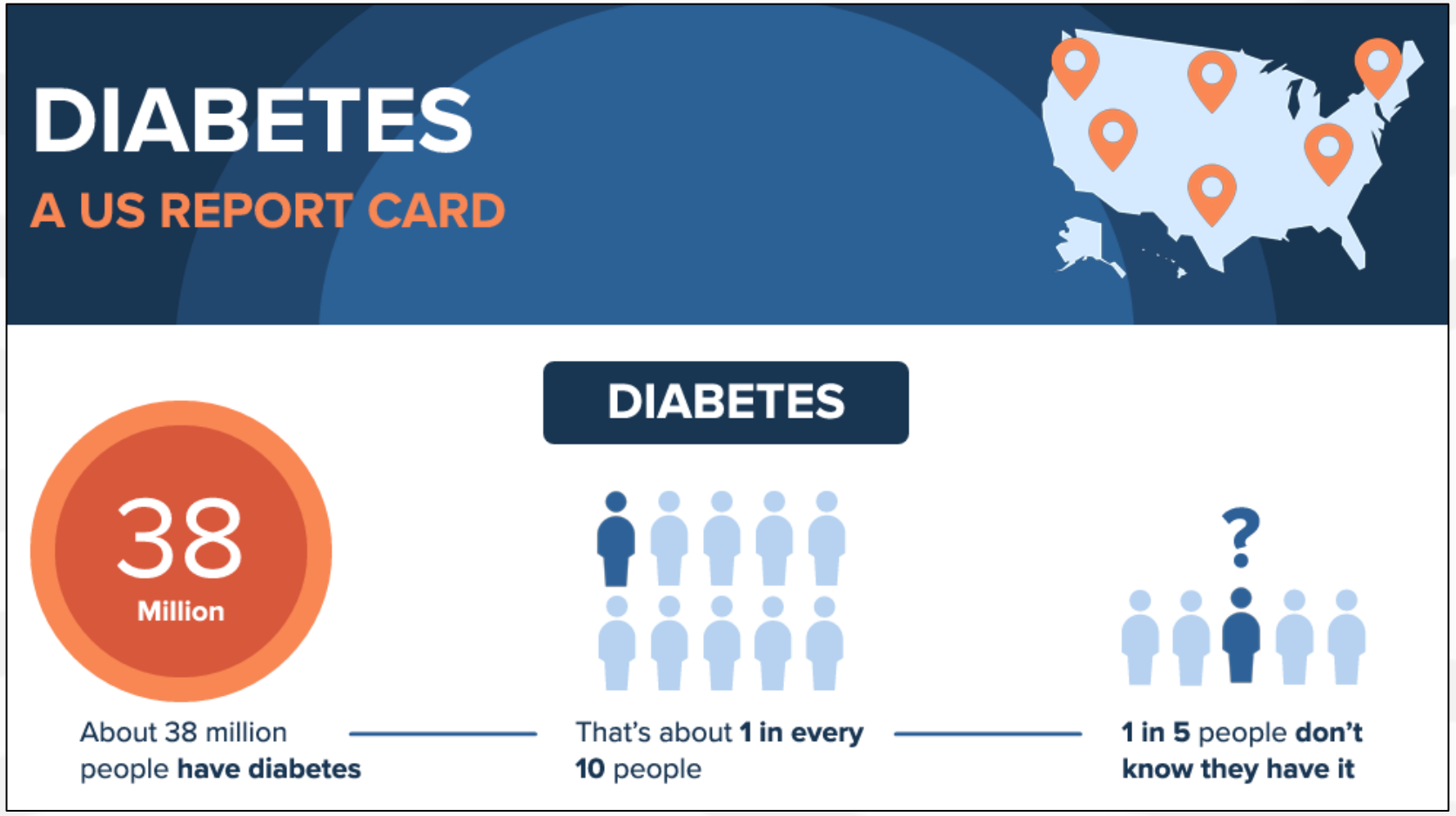
Fast Facts



https://www.cdc.gov/diabetes/about/?CDC_AAref_Val=https://www.cdc.gov/diabetes/basics/diabetes.html

Risk Factors for Diabetes

- Obesity, body fat distribution
- Western diet, sugar sweetened beverages
- History of diabetes in pregnancy, family history of diabetes
- Heart disease
- Metabolic syndrome, polycystic ovarian syndrome
- Certain medications - steroids like prednisone

Fast Facts

Diagnosis

Blood tests that show blood sugar is consistently elevated

- Blood Sugar
  - ≥ 126 mg/dL fasting
  - ≥ 200 mg/dL 2 hr OGT
- HbA1C ≥ 6.5% Measures glycosylated hemoglobin

Impacts of Poorly Controlled Diabetes

- Fatigue, low energy
- Retinopathy / blindness
- Kidney disease
- Neuropathy
- Heart disease
- Stroke and dementia
- Poor wound healing
- Infection

Components of Treatment

- Nutrition and activity changes
- Oral medications
- Injectable medications

Diabetic Retinopathy

- Screenings:
  - Type 1 diabetes – annual screenings beginning five years after diagnosis onset
  - Type 2 diabetes – annual screenings beginning immediately

- Patient education about the connection between glucose and blood pressure control is essential to decrease the risk of retinopathy or progression

- The preferred screening method is digital retinal photography

Controlling Blood Pressure in Patients with Diabetes

- Blood Pressure target is ≤130/90
- Blood Pressure goals should be individualized through a shared decision-making process to address
  - cardiovascular risks
  - potential adverse effects of medications
  - patient preferences
- Nutrition and activity interventions are first line treatments
- Medications and often multiple medications are needed to achieve goal BP measure

HbA1C Good Control

Individualizing treatment based on specific patient factors is essential.

An A1C goal for many non-pregnant adults of <7% without significant hypoglycemia is appropriate.

Higher A1C goals (such as <8%) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits.

American Diabetes Association Clinical Care Guidelines 2023

https://doi.org/10.2337/cd23-as01

Health Disparities and Inequities

- HbA1c Good Control
- Retinal Eye Exam

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Why Collect Demographics Data

Capturing demographics data like language, race, ethnicity at the organization/clinic level may assist with:

- Identifying race/ethnicity related disparities
- Enhancing availability of interpreters and translated, health-education member-facing materials
- Adaptation of existing services to better meet the cultural and health needs of members
- Improved community relations
- Improve member-clinician communication
- Improve member satisfaction

Disparities in Diabetes Rates and Complications

Diabetes Statistics by Race / Ethnicity - National	Black/African American (2021)	Native American/ Alaskan Native (2018)	Hispanic (2018)	Non-Hispanic White (2021)
DM Diagnosis (percent of adult population)	12.7	23.5	13.2	7.0
Death Rate due to DM (per 100K)	38.8	43.7	24.6	19.1
Visual Impairment	18.4	(not reported)	31.6	16
End Stage Kidney Disease (per million)	437.2	274.9	267.7	111.8

CDC 2022. National Diabetes Surveillance System and
2021. Summary Health Statistics: National Health Interview Survey
https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.html#

Health Disparities - Potential Drivers

Barriers to diabetic care include:

- Access to healthy food options impact inequities in management and control
- Limited health care access
- Poor control seen in those without a PCP visit > 1 year
- Dietary patterns by race and ethnicity
- Implicit bias, racism
- Culturally congruent care (providers reflect culture)
- Concerns with language and immigration status
- Poverty, unequal access to health care
- Lack of education
- Lack of transportation
- Difficulty to take time off work for care - financial stressors (transportation associated costs, reduction in pay)
- Competing priorities, including caring for other children, school schedules, and caregiver's own medical needs

Overview of Measures: QIP Specifications, Tools and Resources

- HbA1c Good Control
- Retinal Eye Exam

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Measure Specification-
HbA1c Good Control –Diabetes Control

Importance

Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death (National Diabetic Statistics Report, 2020).

Denominator: The number of continuously enrolled assigned members
18 - 75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1950, and December 31, 2007).

Numerator: The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1c ≤9.0% during the measurement year.

Partnership's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Measure Specification- Retinal Eye Exam

Importance

Left unmanaged, diabetes can lead to serious complications, including blindness (National Diabetic Statistics Report, 2020).

Denominator: The number of continuously enrolled Medi-Cal members 18 - 75 years of age (DOB between January 1, 1950, and December 31, 2007) with diabetes identified as of December 31 of the measurement year.

Numerator: An eye screening for diabetic retinal disease as identified by administrative data.

Partnership's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Comprehensive Diabetes Control
PCP QIP Measure Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2024 – December 31, 2025) and who meet either of the following criteria:

- Members receiving palliative care during the measurement year.
- Members who had an encounter for palliative care any time during the measurement year.
- Members aged 66 and older by the end of the measurement period, with frailty and advanced illness.

Primary Care Provider Quality Improvement Program

PCP QUALITY IMPROVEMENT PROGRAM

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience

Contact Us

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2025 PCP QIP

Equity Adjustment - PCP QIP Payment Methodology

Webinars

PCP QIP webinars

Upcoming Webinars and Trainings

On Demand Courses

Quality Incentive Program (QIP) Tools

PCP QIP Tool Links:

- **PCP QIP Webpage** > Click the link: '*Learn More about the 2025 PCP QIP*'
- **eReports** >
  - **Diagnosis Crosswalk**
  - **Disparity Analysis Dashboard**

Coding Questions

QIP ACADEMY

Back to Basics

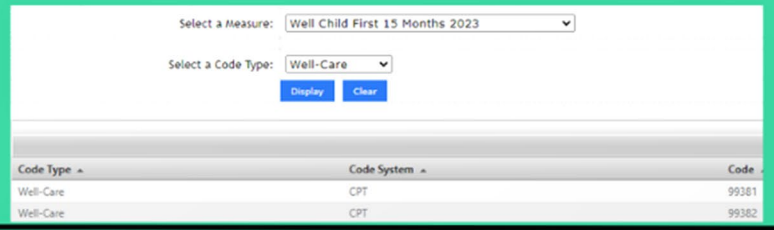
DID YOU KNOW?

About the

Diagnosis Crosswalk

Found in eReports, the **Diagnosis Crosswalk** contains billing codes required for numerator compliance for *all* QIP clinical measures.

Choose your measure of interest and all codes included in the measure logic are listed.



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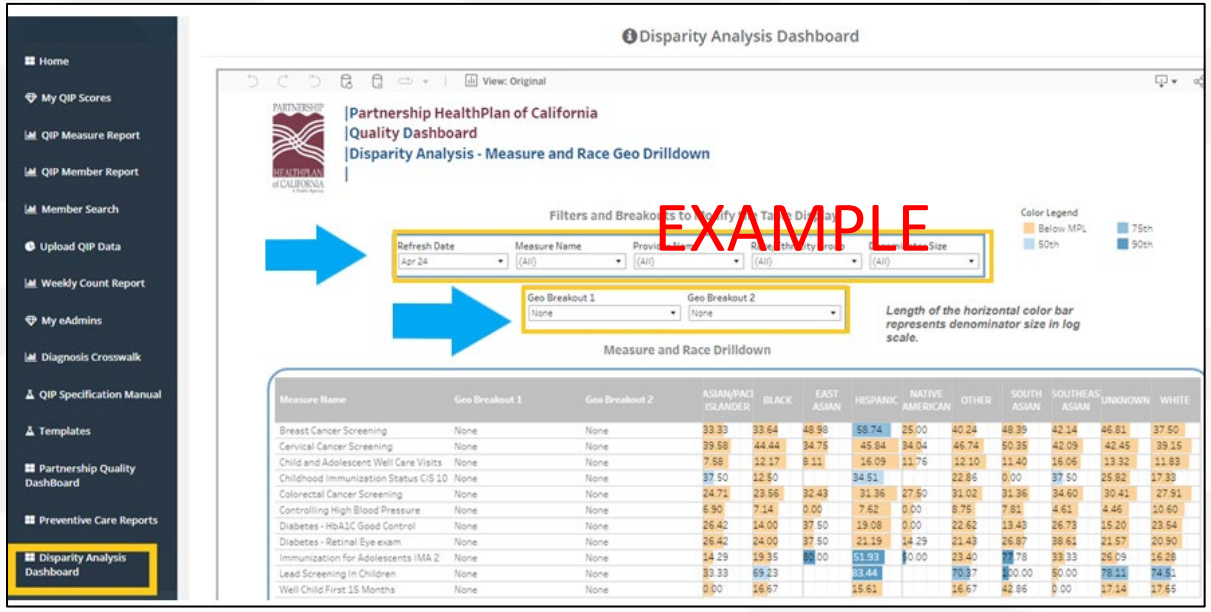
Disparity Analysis Dashboard

Purpose: To promote the ease of identification of PCP QIP measure performance across race/ethnicity groups within various levels of geographic stratification. The dashboard also offers the ability to filter by denominator size for selected geographic and race/ethnicity group stratification.



Putting Quality Into Practice

- Measure Best Practices
- Resources
- Voices from the Field

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Measure Best Practices - Diabetes Management

Outreach

- Designate a team member to contact patients due for testing (phone call, post card, letter signed by provider, text).
- Call patients within a week to reschedule missed in-house blood draws.

Patient Education

- Reinforce medication use and physical activity.
- Refer to nutrition education, in-house, or via telehealth.
- Reinforce the importance of self-testing and self-management.
- 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.

Measure Best Practices - Diabetes Management

MEASURE BEST PRACTICES

The 2025 Measure Best Practices documents are resources for the Primary Care Provider Quality Improvement Program (PCP QIP) measure set, which aligns closely with the Managed Care Accountability Set (MCAS) measures for which Partnership HealthPlan of California is held accountable by the Department of Health Care Services (DHCS). Each Measure Best Practice document includes Partnership tools and resources, guidelines to facilitate optimal member care, opportunities for patient education, outreach, and equity, data and coding resources, and helpful links to improve measure performance.

Breast Cancer Screening

Cervical Cancer Screening

Child & Adolescent Well Care

Childhood Immunizations Status

Chlamydia Screening

Colorectal Cancer Screening

Controlling Blood Pressure

Comprehensive Diabetes Care: HbA1c - Good Control ★

Comprehensive Diabetes Care: Retinal Eye Exam ★

2025 Best Practices

Comprehensive Diabetes Care

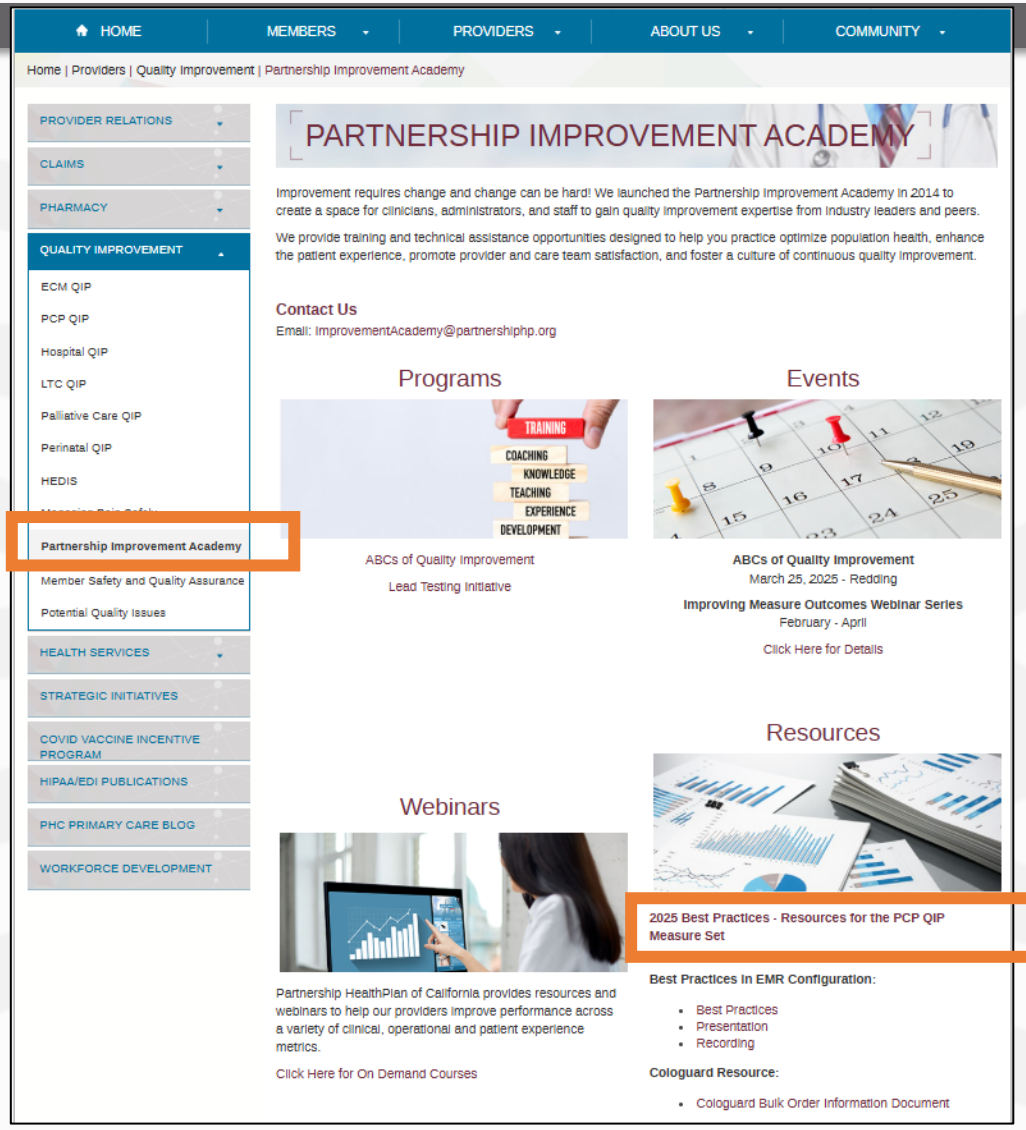
Comprehensive Diabetes Management – HbA1c - Good Control

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.

Link to Measure Best Practices

Quality Improvement
Partnership Improvement Academy Landing Page



[Link to Partnership Improvement Academy]

Measure Best Practices - Diabetes Management

Workflows

- On-site HbA1c testing, possibly performed while rooming patients.
- Perform/order testing regardless of the reason for the office visit.
- Leverage telehealth for diabetes medication management visits.
- Cross-departmental coordination of care.
- Ensure patients are informed of results and next step(s).
- Point incentive program to encourage self-management (gift card or other rewards).
- Refer/enroll with Chronic Case Management.
- Consider holding a diabetes management day every quarter: HbA1c checks, eye exams, foot screenings, consults (education, nutritional info).

Measure Best Practices - Diabetes Management

Diabetic Eye Exams

- If your practice offers vision services, schedule the patient's diabetic retinopathy exam visit during check-out, or as part of the rooming process.
  - Or search for VSP locations with the American Diabetes Association logo.
  - Or consider adding retinal photography to clinic services with remote reading by experts.

- Follow up on referral processes and ensure completion of visit and results received.

- EHR alert when patients are due for a comprehensive eye exam.

Measure Best Practices - Diabetes Management

Strategies with a Health Equity Focus

- The Drilldown Clinical tab in the eReports portal shows race/ethnicity information for each member 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 patient community.
- Identify possible barriers by specific communities (race, ethnicity, location by zip code, and preferred language).
- Ensure member information is consistent, welcoming, plain and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Identify and address barriers to care (transportation, language, and cultural beliefs). Partner with established community agencies such as schools, community centers, and faith-based organizations.

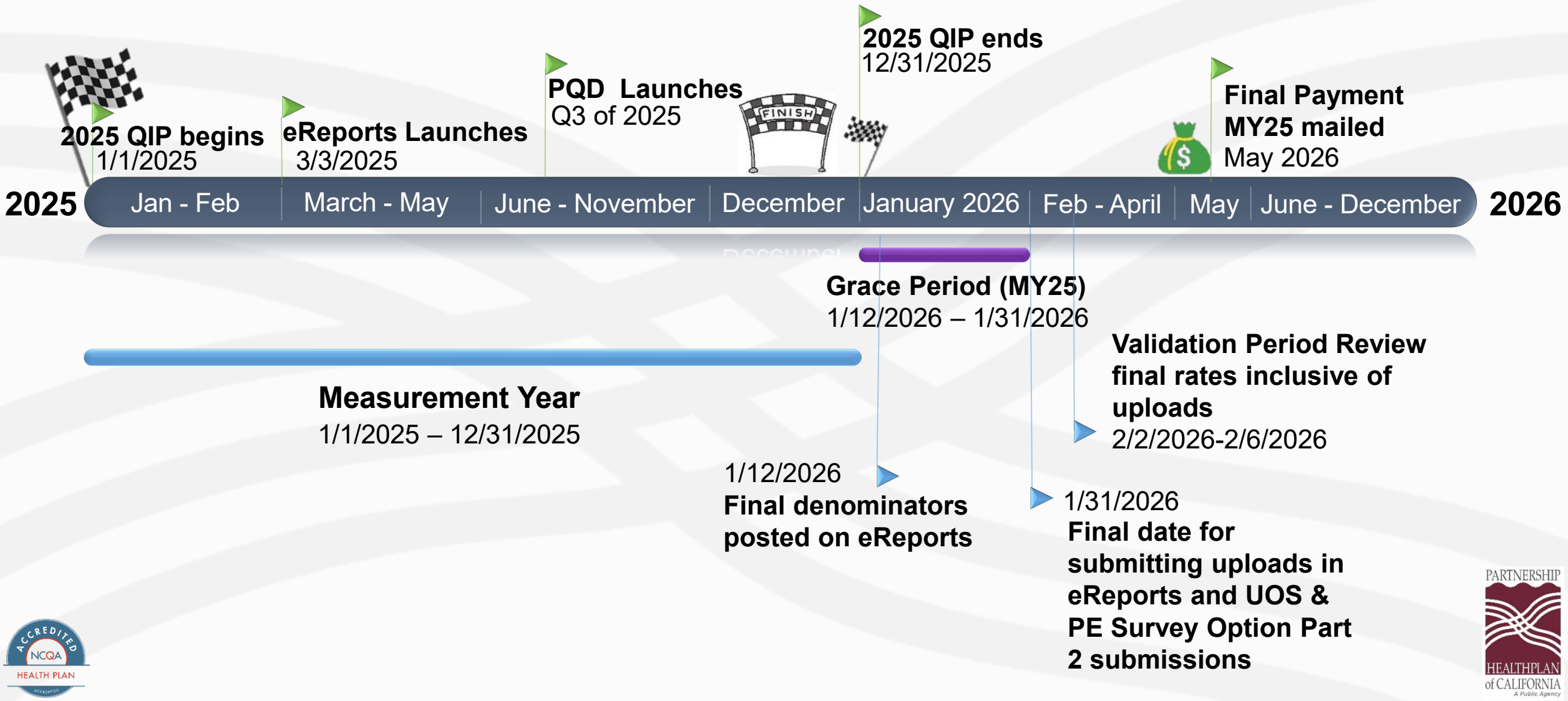
Care Gap Identification by Staff

Best practice for pre-visit and/or check-in processes is to identify needed care gaps within the PCP QIP. This can be done two ways:

- **eReports > Member Search**
  - Provide staff involved in these processes with access to eReports. They can conduct a member search and will display the care gaps from the PCP QIP.
  - Access to eReports can be given by your organization's designated eAdmin.

- **Provider Online Services > ePrompts**
  - Ensure staff involved with insurance verification knows about and utilizes ePrompts within the Provider Online Services.

PCP QIP Timeline



Resources - Partnership

- Partnership Website - Provider Diabetes Resources: https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Diabetes.aspx
- TeleMed2U – Paid by Partnership
  - Program Link
  - Link to Partnership Referral Instructions
- Medical Nutrition Therapy (MNT) - More Information
- Partnership Care Coordination Department
  - Patient call (800) 809-1350
  - Provider secure email to: CareCoordination@PartnershipHP.org
- Covered Diabetic Medications: Medi-Cal RX Contract Drug List

2025

DIABETES:

HbA1c Good Control

Retinal Eye Exam

Martha Ugbinada
Quality Manager
530.999.9030 ext. 5161
mugbinada@mountainvalleys.org

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HEALTH CENTERS

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Mountain Valleys Health Centers (MVHC) are located in the heart of beautiful, northeastern California. Our seven clinics span over a *200-mile* radius.

Big Valley, Fall River Mills, Burney, Butte Valley, Tulelake, Mount Shasta and Weed,

MVHC served over 12,000 patients in 2024.

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MVHC had 227 total Partnership Diabetics in the Denominator - of those 159 are in the Numerator for the Diabetes - HbA1C Good Control for the calendar year 2024.

70%

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50%

MVHC had 227 final Partnership Diabetics in the Denominator - of those 113 are in the Numerator for the Diabetes – Retinal Eye Exam for CY 2024.

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Major Changes of 2024

MVHC changed EMRs to OCHIN EPIC mid-April of 2024. Which changed the previous workflows steps.

Armed with OCHIN EPIC, the front office staff and clinical support staff (MAs, LVNs, RNs) continued their normal workflows and followed our internal standing orders.

This was a huge change but the team did amazing!

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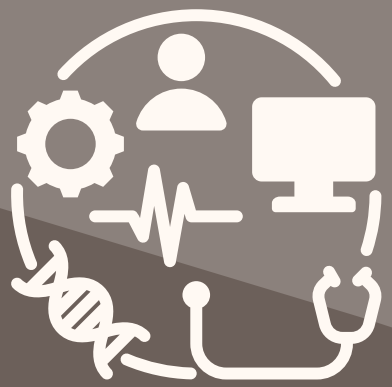
OCHIN EPIC - MVHC utilizes

- MyChart (pre-registration)
- Artera Messaging System (Appt Reminders)
- Welcome Tablet for intake (Check-In)



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- MVHC has POC HbA1c machines at all 7 sites
- 2 RetinaVue 700 Imagers shared at all sites

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- MVHC uses the Retina Eye Camera to perform in-house retinal eye screenings for diabetic patients that have not yet been seen for their annual eye exam.
- Quality focus for the 2025 CY.
- New Staff training will start in June

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The HbA1c is a standing order and the clinical support staff obtain an A1c prior to the provider entering the exam room.
OCHIN EPIC automatically pulls in the correct CPTII codes-removing the step from the previous workflow.

CPTII Codes Previously Utilized:

- **HbA1C Codes:**
  - **3044F <7.0%**
  - **3051F =>7.0% and <9.0%**
  - **3052F >9.0%**

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MVHC provided Clinical Support Staff Standing Orders/Guidelines

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Back-Office Standing Orders/Guidelines

DIABETES	
These standing orders are protocols that authorize designated staff members to complete certain tasks without first having to obtain a provider's order.	
Diabetes Management	❖ Retinal/Eye Exam 1 time per year ❖ Foot Exam 1 time per year ❖ Urine Microalbumin 1 time per year ❖ HbA1c • Uncontrolled HbA1c >9 ○ DM Visit every 3 months ○ HbA1c every 3 months • Controlled HbA1c <9 ○ DM Visit every 6 months ○ HbA1c every 6 months

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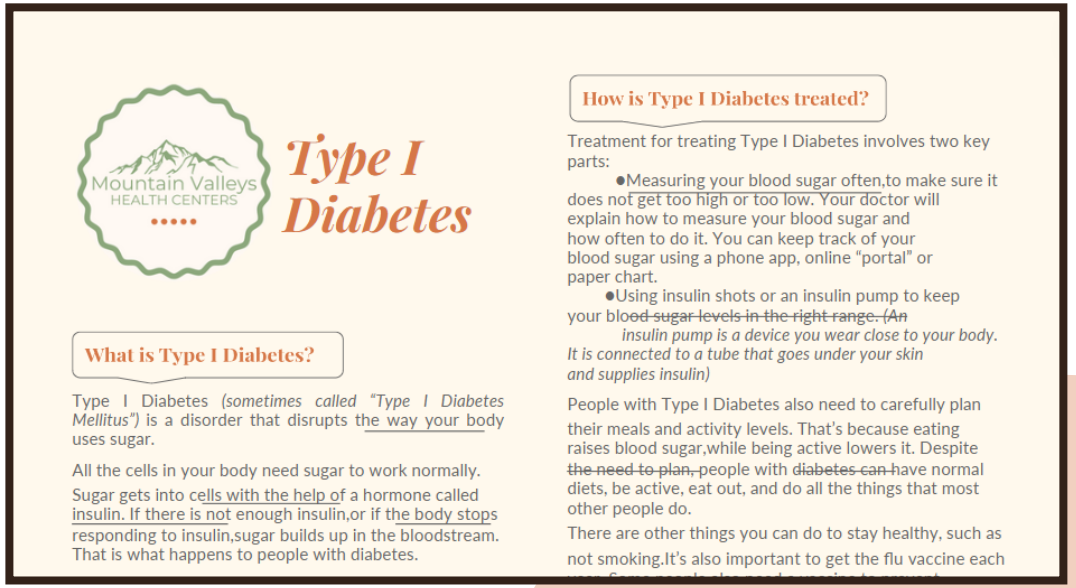
Provider/Patient Education

MVHC providers offer patient education for all diabetics.

Guidelines:
If a HbA1c is below 7, the patient should be seen every 6 months.

If the HbA1c is above that, they must be seen every 3 months and more frequent if above 9.

This varies by provider and patient adherence.



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Type I Diabetes

What is Type I Diabetes?

Type I Diabetes *(sometimes called "Type I Diabetes Mellitus")* is a disorder that disrupts the way your body uses sugar.

All the cells in your body need sugar to work normally. Sugar gets into cells with the help of a hormone called insulin. If there is not enough insulin,or if the body stops responding to insulin,sugar builds up in the bloodstream. That is what happens to people with diabetes.

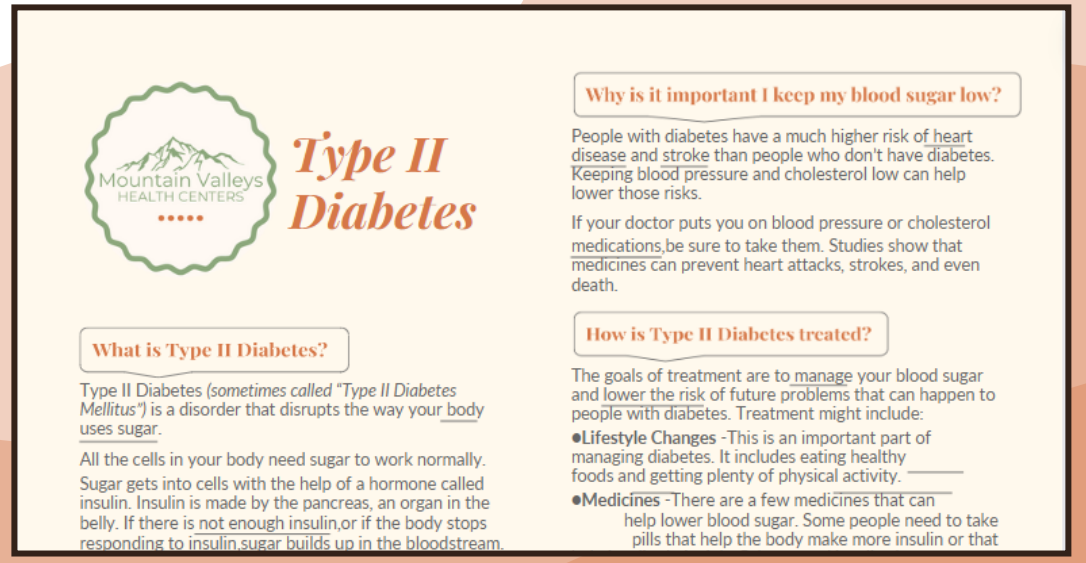
How is Type I Diabetes treated?

Treatment for treating Type I Diabetes involves two key parts:

- Measuring your blood sugar often,to make sure it does not get too high or too low. Your doctor will explain how to measure your blood sugar and how often to do it. You can keep track of your blood sugar using a phone app, online "portal" or paper chart.
- Using insulin shots or an insulin pump to keep your blood sugar levels in the right range. *(An insulin pump is a device you wear close to your body. It is connected to a tube that goes under your skin and supplies insulin)*

People with Type I Diabetes also need to carefully plan their meals and activity levels. That's because eating raises blood sugar,while being active lowers it. Despite the need to plan, people with diabetes can have normal diets, be active, eat out, and do all the things that most other people do.

There are other things you can do to stay healthy, such as not smoking.It's also important to get the flu vaccine each



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Type II Diabetes

What is Type II Diabetes?

Type II Diabetes *(sometimes called "Type II Diabetes Mellitus")* is a disorder that disrupts the way your body uses sugar.

All the cells in your body need sugar to work normally. Sugar gets into cells with the help of a hormone called insulin. Insulin is made by the pancreas, an organ in the belly. If there is not enough insulin,or if the body stops responding to insulin,sugar builds up in the bloodstream.

Why is it important I keep my blood sugar low?

People with diabetes have a much higher risk of heart disease and stroke than people who don't have diabetes. Keeping blood pressure and cholesterol low can help lower those risks.

If your doctor puts you on blood pressure or cholesterol medications,be sure to take them. Studies show that medicines can prevent heart attacks, strokes, and even death.

How is Type II Diabetes treated?

The goals of treatment are to manage your blood sugar and lower the risk of future problems that can happen to people with diabetes. Treatment might include:

- **Lifestyle Changes** -This is an important part of managing diabetes. It includes eating healthy foods and getting plenty of physical activity.
- **Medicines** -There are a few medicines that can help lower blood sugar. Some people need to take pills that help the body make more insulin or that

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MVHC has Appointment cards in all the exam rooms that providers utilize. The providers give the card to patients so they can stop at check out and schedule their follow-up appt.

Advanced Scheduling

Please contact your clinic if you are unable to keep your appointment.

Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type

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MVHC offers a yearly Wellness Labs at a flat rate in August and the voucher is good until 12/31 for those patients with private/no insurance.

Discounted Blood Draw Voucher

Voucher Expires 12/31/2024

In celebration of ***National Health Center Week***, we are offering discounted blood work.
Present this voucher to your local *Mountain Valleys Health Centers* clinic to receive your blood work.
*Vouchers will be sold August 1, 2024 – August 31, 2024

Name _____ Date _____

DOB _____ Amount Paid _____

Primary Care Provider _____

$30 Package

- Lipid Panel
- Comprehensive Metabolic Panel (CMP)
- Complete Blood Count (CBC)

$20 Each

- ☐ Hemoglobin A1c (HbA1c)
- ☐ Prostate Specific Antigen (PSA)
- ☐ Thyroid Stimulation Hormone (TSH)

$30 Each

- ☐ Vitamin D

Big Valley Health Center
(530) 999-9010

Fall River Valley Health Center
(530) 999-9020

Burney Health Center
(530) 999-9030

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www.mountainvalleys.org
www.facebook.com/MVHCenters

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MVHC staff worked QIP lists throughout the year. We had some hurdles and bumps with the new EMR.

- Standing Orders
- POC
- Advanced Scheduling Cards
- Provider/Patient Education
- Constant Vigilance of QIP numbers

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Sustained Success

- **Stable & Sustainable Process:** Since 2019, our success built on the foundation of the ADVANCE project with PHC
- **Standing Orders:** Ensuring consistent, evidence-based care for diabetes management
- **Ongoing Staff Training:** Regular education and reinforcement of best practices for all clinical team members
- **Comprehensive Patient Education:** Empowering patients with the knowledge and resources needed for self-management

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Sustained Success Continued…

- **Continuous Improvement:** Each year, we refine and enhance our process based on data and feedback
- **Partnership Trainings:** The skills and knowledge gained through PHC training have been instrumental in maintaining high-quality diabetes care management

Conclusion: Our success in achieving HbA1c good control/Retinal Eye Exams is the result of strong foundational processes, continuous learning, and commitment to patient-centered care.

Mountain Valleys HEALTH CENTERS

Thank you, Partnership, for Your Continued Support!

Martha Ugbinada
Quality Manager
530.999.9030 ext. 5161
mugbinada@mountainvalleys.org

Shasta Community Health Center
a californiahealth+ center

Shasta Community Health Center's Diabetes Program

Rae Sanchez, Director of Quality Improvement
530.246.5832
rae-sanchez@shastahealth.org

Overview:

Mission:

To provide high-quality health care to our community with compassion and understanding.

Vision:

Removing barriers to healthcare and promoting wellness for our entire community.

Values:

Compassion: Caring with kindness.
Adaptability: Finding new ways to meet patients' needs.
Respect: Welcoming all with dignity.
Education: Creating a learning environment.
Service: Dedicated to whole-person care with honesty and integrity.

- Established in 1988 as an FQHC.
- 8 Locations: Redding, Anderson, and Shasta Lake City
- In 2024, served 36,400 patients with over 159,559 clinical encounters
- Services include:
  - Primary care
  - Pediatrics
  - Dental
  - Vision
  - Behavioral Health
  - Urgent care
  - HIV care
  - Street Medicine
- Team: approximately 500 staff and 100 healthcare providers.

Shasta Community Health Center
a californiahealth+ center

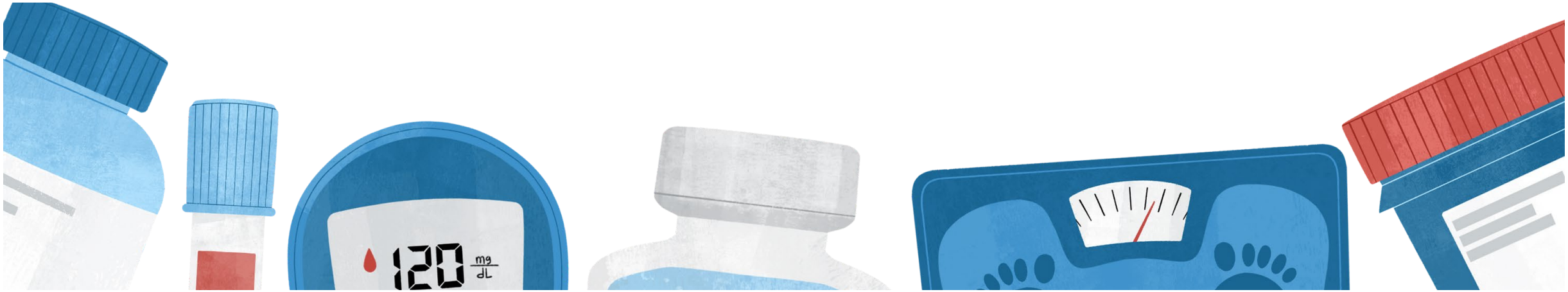
By The Numbers

Shasta Community Health Center
a californiahealth+ center

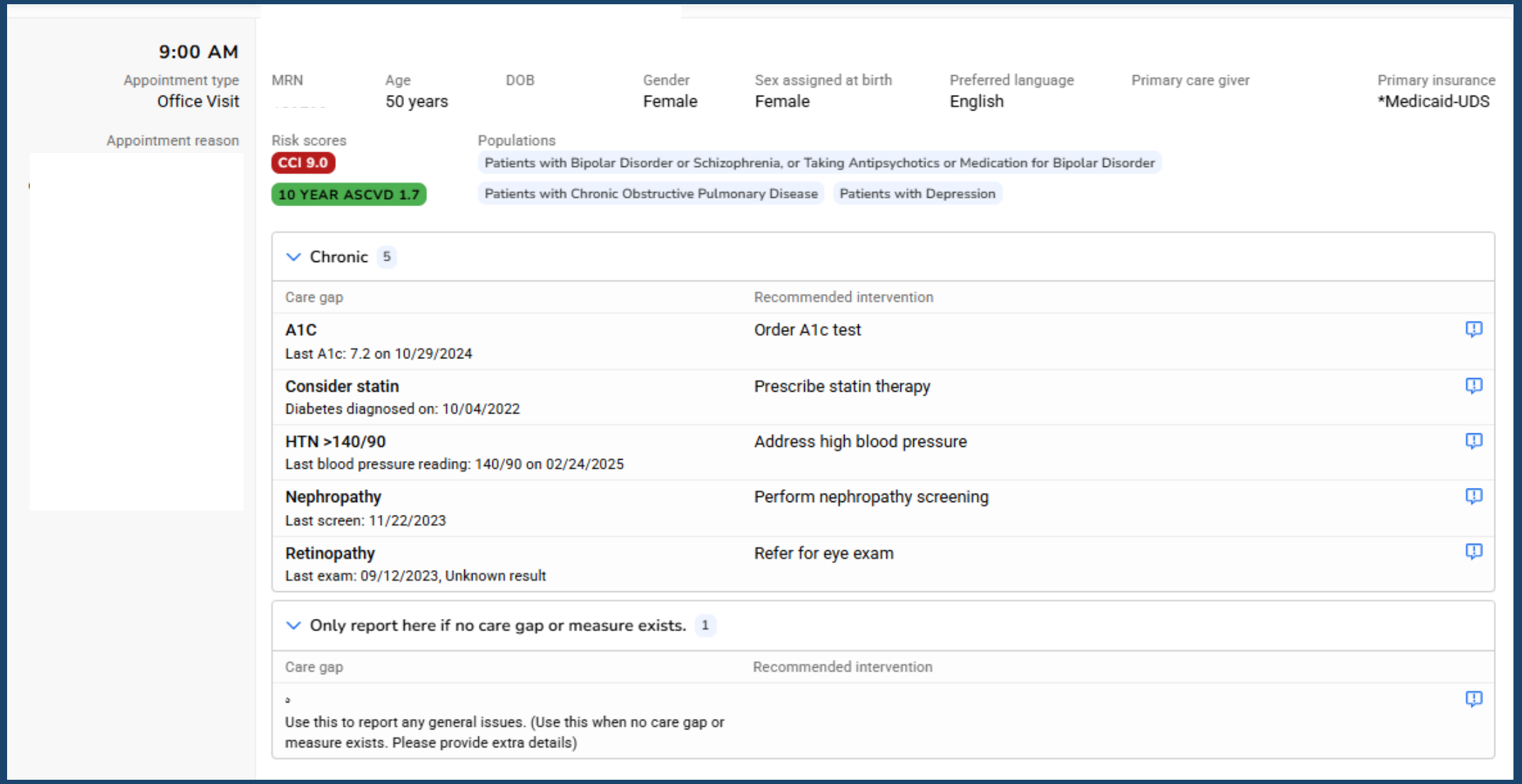
In 2024, SCHC had 1142 patients in their denominator for the QIP Program.

Denominator breakdown by site:

- Main 754
- Shasta Lake 131
- Anderson Medical 193
- Enterprise Medical 64



Empowering the Care Team-Huddles and Previsit Planning



9:00 AM

Appointment type: Office Visit

Appointment reason

MRN	Age	DOB	Gender	Sex assigned at birth	Preferred language	Primary care giver	Primary insurance
[redacted]	50 years		Female	Female	English		*Medicaid-UDS

Risk scores

CCI 9.0

10 YEAR ASCVD 1.7

Populations

Patients with Bipolar Disorder or Schizophrenia, or Taking Antipsychotics or Medication for Bipolar Disorder

Patients with Chronic Obstructive Pulmonary Disease

Patients with Depression

Chronic 5

Care gap	Recommended intervention
A1C Last A1c: 7.2 on 10/29/2024	Order A1c test
Consider statin Diabetes diagnosed on: 10/04/2022	Prescribe statin therapy
HTN >140/90 Last blood pressure reading: 140/90 on 02/24/2025	Address high blood pressure
Nephropathy Last screen: 11/22/2023	Perform nephropathy screening
Retinopathy Last exam: 09/12/2023, Unknown result	Refer for eye exam

Only report here if no care gap or measure exists. 1

Care gap	Recommended intervention
Use this to report any general issues. (Use this when no care gap or measure exists. Please provide extra details)	

Empowering the Care Team-Standing Orders

Nursing/MA:

Test	Criteria	Interval	Order/Collect/Perform
Adult Standing Orders			
HbA1C	Diagnosis of diabetes	Every 6 months if last A1c <7%, Every 3 months if last A1c >7%, (or per clinician preference)	Order Collect Perform
Urine Micro Albumin Creatinine Ratio	Diagnosis hypertension, diabetes, or on persistent medications (ACE, ARB, Diuretic)	Annually	Order Collect
Diabetic Retinal Eye Screening (In house camera)	Adults between the ages of 18-75 with a diagnosis of diabetes	Onset of diabetes and annually thereafter	Order Perform

Patient Navigator:

2. AIC Labs

A. A1c Ordering Criteria (October-December)

A1c can be ordered for a patient living with diabetes by a Patient Navigator or QI Team member during October-December of the measurement period in the following scenarios.

i. Diabetic patients with no A1C recorded in the measurement period (current calendar year).
OR
ii. Patients with a last A1c of 9 or 10 (greater than 3 months ago)
AND
whose assigned PCP does not have appointment availability for the rest of the measurement period
AND
No pending A1c labs are in the system.
AND
No pending Diabetic appointment.
iii. The following scenarios are *excluded* from this measure: Diagnosis of gestational diabetes or steroid-induced diabetes.
iv. Follow the process below before ordering an A1c:
   a. Check for pending A1C orders – call patient to remind them to complete any pending labs **(Do not order additional A1c)**
   b. Check scanned labs to see if the patient has had the test done elsewhere. If you find an A1C here, follow the lab manual entry

B. A1c Ordering Criteria (Diabetes Group Visit participants)

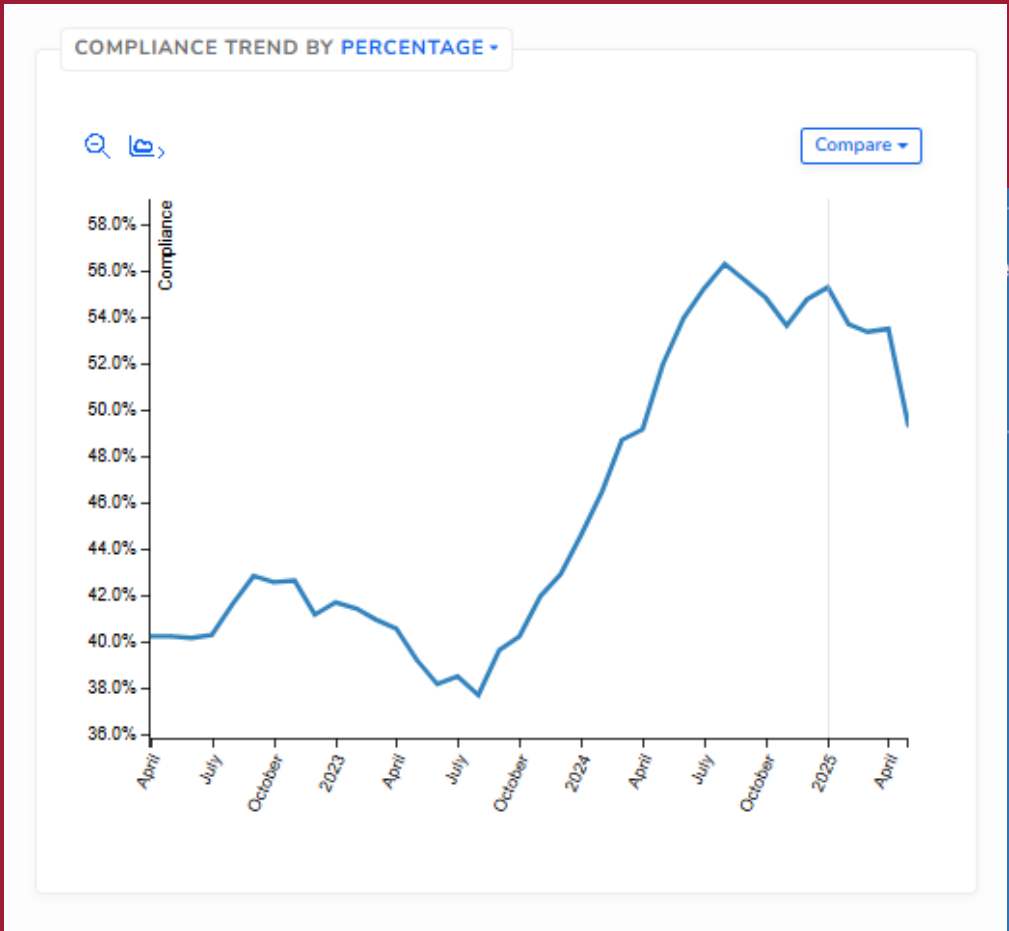
A1c can be ordered for a patient living with diabetes who is participating in the monthly Diabetes Group Visit program by a Patient Navigator or QI team member in the following scenarios:

i. Diabetic patients with no A1C recorded in the measurement period (current calendar year).
OR
ii. Patients with a last A1c (greater than 3 months ago)
AND
No pending A1c labs are in the system.
iii. The following scenarios are *excluded* from this measure:
Diagnosis of gestational diabetes or steroid-induced diabetes.
iv. Follow the process below before ordering an A1c:
   a. Check for pending A1C orders – call patient to remind them to complete any pending labs **(Do not order additional A1c)**
   b. Check scanned labs to see if the patient has had the test done elsewhere. If you find an A1C here, follow the lab manual entry process to enter it into thechart. **(Do not order additional A1c)**

Meeting Patients Where They Are-Point of Care Testing

All Primary Care sites have:

- HbA1c machines
- RetinaVue Imagers



ordering a DEE in-house test.

Date: 8/1/2023

Performance Remeasurement (n/d* and %):

- Family Practice: 54.6% (365/669)
- Anderson Medical: 48.6% (235/484)

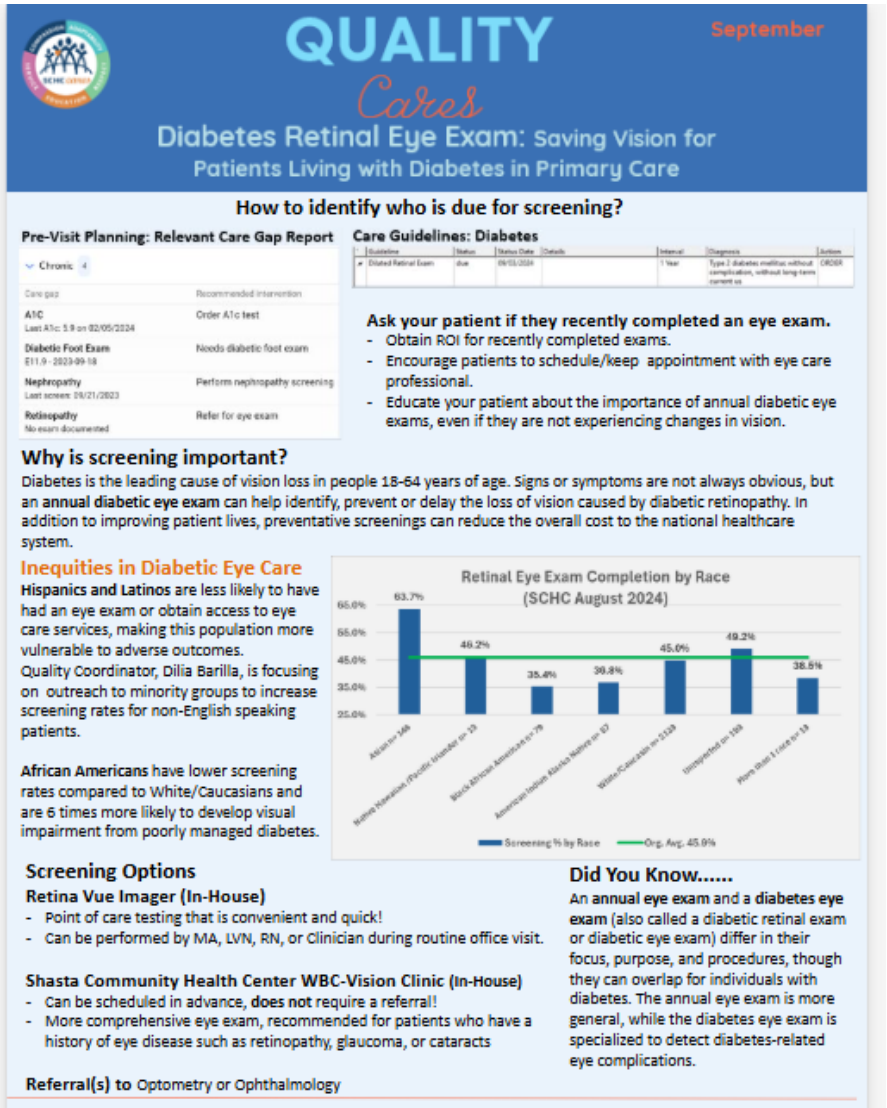
The Diabetic Eye Exam PDSA project aimed to improve compliance with the diabetic eye exam clinical quality measure across our organization by identifying and adopting best practices from the Fellowship department's successful initiative. Over a three-month period, we focused on purchasing new RetinaVue Scanners, identifying clinical champions, developing SOPs, conducting staff training, and addressing barriers such as staff hesitancy and IT connectivity issues.

Outcomes and Results:

- **Best Practices Identified and Adopted:** We successfully identified and documented key best practices, which were implemented across participating departments.
- **Performance Improvements:**
  - **Anderson Medical:** Achieved a 5.5% improvement in diabetic eye exam compliance.
  - **Family Practice:** Saw a 3.2% improvement, screening 74 patients within the three-month timeframe. Although they did not fully meet the 5% improvement goal, their progress is notable.

Moving forward, we will continue to track these improvements to ensure sustainability. Given the positive outcomes of this project, we recommend expanding these strategies to other primary care departments to further enhance our organizational performance in diabetic eye exams. The project has been deemed a success, with valuable lessons learned for continued improvement.

Educating Our Team



QUALITY Cares

September

Diabetes Retinal Eye Exam: Saving Vision for Patients Living with Diabetes in Primary Care

How to identify who is due for screening?

Pre-Visit Planning: Relevant Care Gap Report

Chronic 4

Care gap	Recommended intervention
A1C Last A1c: 5.9 on 02/05/2024	Order A1c test
Diabetic Foot Exam E11.9 - 2023-09-18	Needs diabetic foot exam
Nephropathy Last screen: 09/21/2023	Perform nephropathy screening
Retinopathy No exam documented	Refer for eye exam

Care Guidelines: Diabetes

Guideline	Status	Status Date	Details	Interval	Diagnosis	Action
Dilated Retinal Exam	due	09/01/2024		1 Year	Type 2 diabetes mellitus without complication, without long-term current us	ORDER

Ask your patient if they recently completed an eye exam.
- Obtain ROI for recently completed exams.
- Encourage patients to schedule/keep appointment with eye care professional.
- Educate your patient about the importance of annual diabetic eye exams, even if they are not experiencing changes in vision.

Why is screening important?

Diabetes is the leading cause of vision loss in people 18-64 years of age. Signs or symptoms are not always obvious, but an **annual diabetic eye exam** can help identify, prevent or delay the loss of vision caused by diabetic retinopathy. In addition to improving patient lives, preventative screenings can reduce the overall cost to the national healthcare system.

Inequities in Diabetic Eye Care

Hispanics and Latinos are less likely to have had an eye exam or obtain access to eye care services, making this population more vulnerable to adverse outcomes.
Quality Coordinator, Dilia Barilla, is focusing on outreach to minority groups to increase screening rates for non-English speaking patients.

African Americans have lower screening rates compared to White/Caucasians and are 6 times more likely to develop visual impairment from poorly managed diabetes.

Retinal Eye Exam Completion by Race (SCHC August 2024)

Screening Options

Retina Vue Imager (In-House)
- Point of care testing that is convenient and quick!
- Can be performed by MA, LVN, RN, or Clinician during routine office visit.

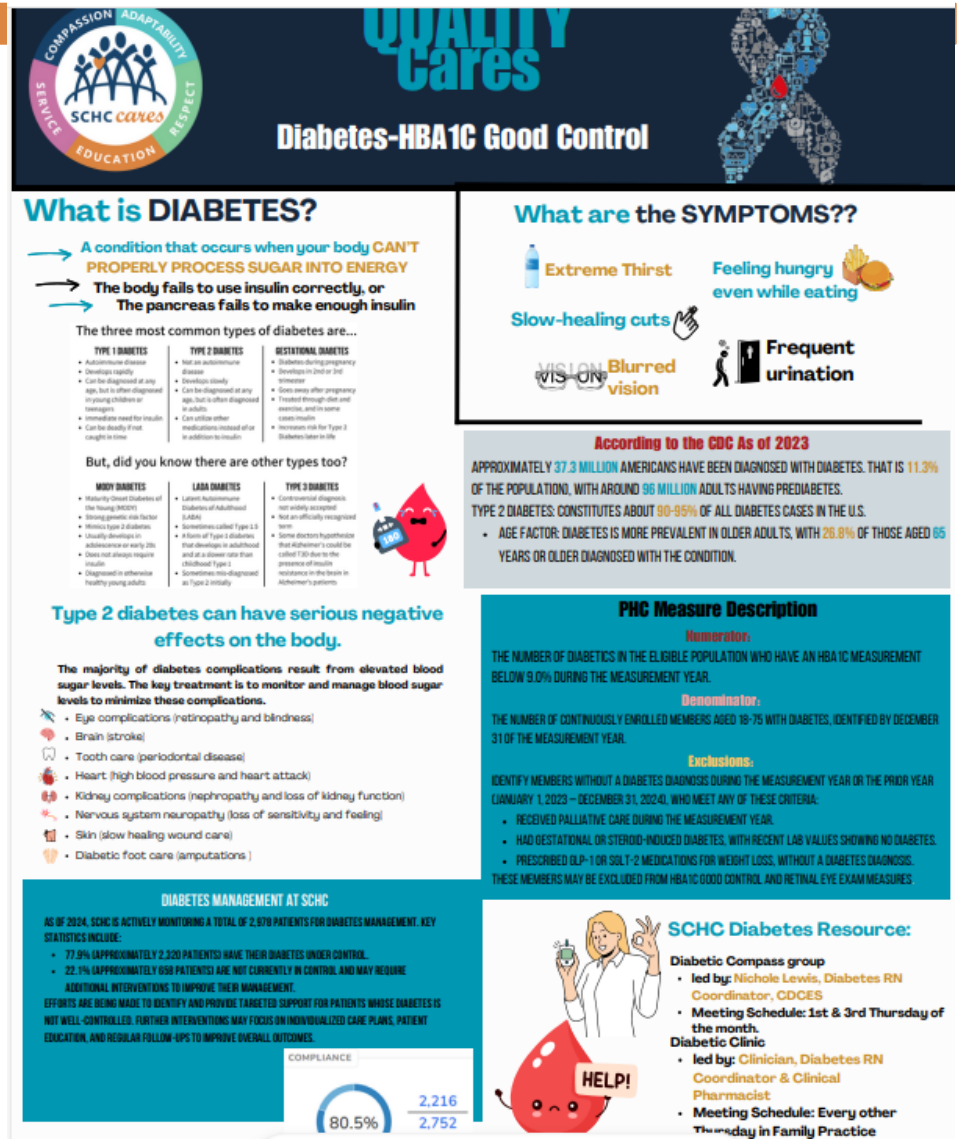
Shasta Community Health Center WBC-Vision Clinic (In-House)
- Can be scheduled in advance, **does not** require a referral!
- More comprehensive eye exam, recommended for patients who have a history of eye disease such as retinopathy, glaucoma, or cataracts

Referral(s) to Optometry or Ophthalmology

Did You Know.....

An **annual eye exam** and a **diabetes eye exam** (also called a diabetic retinal exam or diabetic eye exam) differ in their focus, purpose, and procedures, though they can overlap for individuals with diabetes. The annual eye exam is more general, while the diabetes eye exam is specialized to detect diabetes-related eye complications.

- Quality Cares Newsletter
- Interactive Department Meetings
- Monthly QIP Performance Updates



QUALITY Cares

Diabetes-HBA1C Good Control

What is DIABETES?

A condition that occurs when your body CAN'T PROPERLY PROCESS SUGAR INTO ENERGY
The body fails to use insulin correctly, or
The pancreas fails to make enough insulin

The three most common types of diabetes are...

TYPE 1 DIABETES	TYPE 2 DIABETES	GESTATIONAL DIABETES
• Autoimmune disease • Develops rapidly • Can be diagnosed at any age, but is often diagnosed in young children or teenagers • Immediate need for insulin • Can be deadly if not caught in time	• Not an autoimmune disease • Develops slowly • Can be diagnosed at any age, but is often diagnosed in adults • Can utilize other medications instead of or in addition to insulin	• Diabetes during pregnancy • Develops in 2nd or 3rd trimester • Goes away after pregnancy • Treated through diet and exercise, and in some cases insulin • Increases risk for Type 2 Diabetes later in life

But, did you know there are other types too?

MODY DIABETES	LADA DIABETES	TYPE 3 DIABETES
• Maturity Onset Diabetes of the Young (MODY) • Strong genetic risk factor • Mimics type 2 diabetes • Usually develops in adolescence or early 20s • Does not always require insulin • Diagnosed in otherwise healthy young adults	• Latent Autoimmune Diabetes of Adulthood (LADA) • Sometimes called Type 1.5 • A form of Type 1 diabetes that develops in adulthood and at a slower rate than childhood Type 1 • Sometimes mis-diagnosed as Type 2 initially	• Controversial diagnosis not widely accepted • Not an officially recognized term • Some doctors hypothesize that Alzheimer's could be called T3D due to the presence of insulin resistance in the brain in Alzheimer's patients

Type 2 diabetes can have serious negative effects on the body.

The majority of diabetes complications result from elevated blood sugar levels. The key treatment is to monitor and manage blood sugar levels to minimize these complications.
- Eye complications (retinopathy and blindness)
- Brain (stroke)
- Tooth care (periodontal disease)
- Heart (high blood pressure and heart attack)
- Kidney complications (nephropathy and loss of kidney function)
- Nervous system neuropathy (loss of sensitivity and feeling)
- Skin (slow healing wound care)
- Diabetic foot care (amputations)

What are the SYMPTOMS??

Extreme Thirst
Feeling hungry even while eating
Slow-healing cuts
Blurred vision
Frequent urination

According to the CDC As of 2023

APPROXIMATELY 37.3 MILLION AMERICANS HAVE BEEN DIAGNOSED WITH DIABETES. THAT IS 11.3% OF THE POPULATION, WITH AROUND 96 MILLION ADULTS HAVING PREDIABETES.
TYPE 2 DIABETES: CONSTITUTES ABOUT 90-95% OF ALL DIABETES CASES IN THE U.S.
- AGE FACTOR: DIABETES IS MORE PREVALENT IN OLDER ADULTS, WITH 26.8% OF THOSE AGED 65 YEARS OR OLDER DIAGNOSED WITH THE CONDITION.

PHC Measure Description

Numerator:
THE NUMBER OF DIABETICS IN THE ELIGIBLE POPULATION WHO HAVE AN HBA1C MEASUREMENT BELOW 9.0% DURING THE MEASUREMENT YEAR.

Denominator:
THE NUMBER OF CONTINUOUSLY ENROLLED MEMBERS AGED 18-75 WITH DIABETES, IDENTIFIED BY DECEMBER 31 OF THE MEASUREMENT YEAR.

Exclusions:
IDENTIFY MEMBERS WITHOUT A DIABETES DIAGNOSIS DURING THE MEASUREMENT YEAR OR THE PRIOR YEAR (JANUARY 1, 2023 – DECEMBER 31, 2024), WHO MEET ANY OF THESE CRITERIA:
- RECEIVED PALLIATIVE CARE DURING THE MEASUREMENT YEAR.
- HAD GESTATIONAL OR STEROID-INDUCED DIABETES, WITH RECENT LAB VALUES SHOWING NO DIABETES.
- PRESCRIBED GLP-1 OR SGLT-2 MEDICATIONS FOR WEIGHT LOSS, WITHOUT A DIABETES DIAGNOSIS.

THESE MEMBERS MAY BE EXCLUDED FROM HBA1C GOOD CONTROL AND RETINAL EYE EXAM MEASURES.

DIABETES MANAGEMENT AT SCHC

AS OF 2024, SCHC IS ACTIVELY MONITORING A TOTAL OF 2,978 PATIENTS FOR DIABETES MANAGEMENT. KEY STATISTICS INCLUDE:
- 77.9% (APPROXIMATELY 2,320 PATIENTS) HAVE THEIR DIABETES UNDER CONTROL.
- 22.1% (APPROXIMATELY 658 PATIENTS) ARE NOT CURRENTLY IN CONTROL AND MAY REQUIRE ADDITIONAL INTERVENTIONS TO IMPROVE THEIR MANAGEMENT.

EFFORTS ARE BEING MADE TO IDENTIFY AND PROVIDE TARGETED SUPPORT FOR PATIENTS WHOSE DIABETES IS NOT WELL-CONTROLLED. FURTHER INTERVENTIONS MAY FOCUS ON INDIVIDUALIZED CARE PLANS, PATIENT EDUCATION, AND REGULAR FOLLOW-UPS TO IMPROVE OVERALL OUTCOMES.

COMPLIANCE
80.5%
2,216
2,752

SCHC Diabetes Resource:

Diabetic Compass group
- led by: Nichole Lewis, Diabetes RN Coordinator, CDCES
- Meeting Schedule: 1st & 3rd Thursday of the month.

Diabetic Clinic
- led by: Clinician, Diabetes RN Coordinator & Clinical Pharmacist
- Meeting Schedule: Every other Thursday in Family Practice

Supporting Our Patients

- Group Support: Diabetic Compass Group
  - Open to public (all welcome)
- Internal support/referrals:
  - Diabetes Nurse, Certified Diabetes Care and Education Specialist (CDCES) certification
  - Clinical Pharmacist
  - Registered Dietician
- Diabetes Clinic

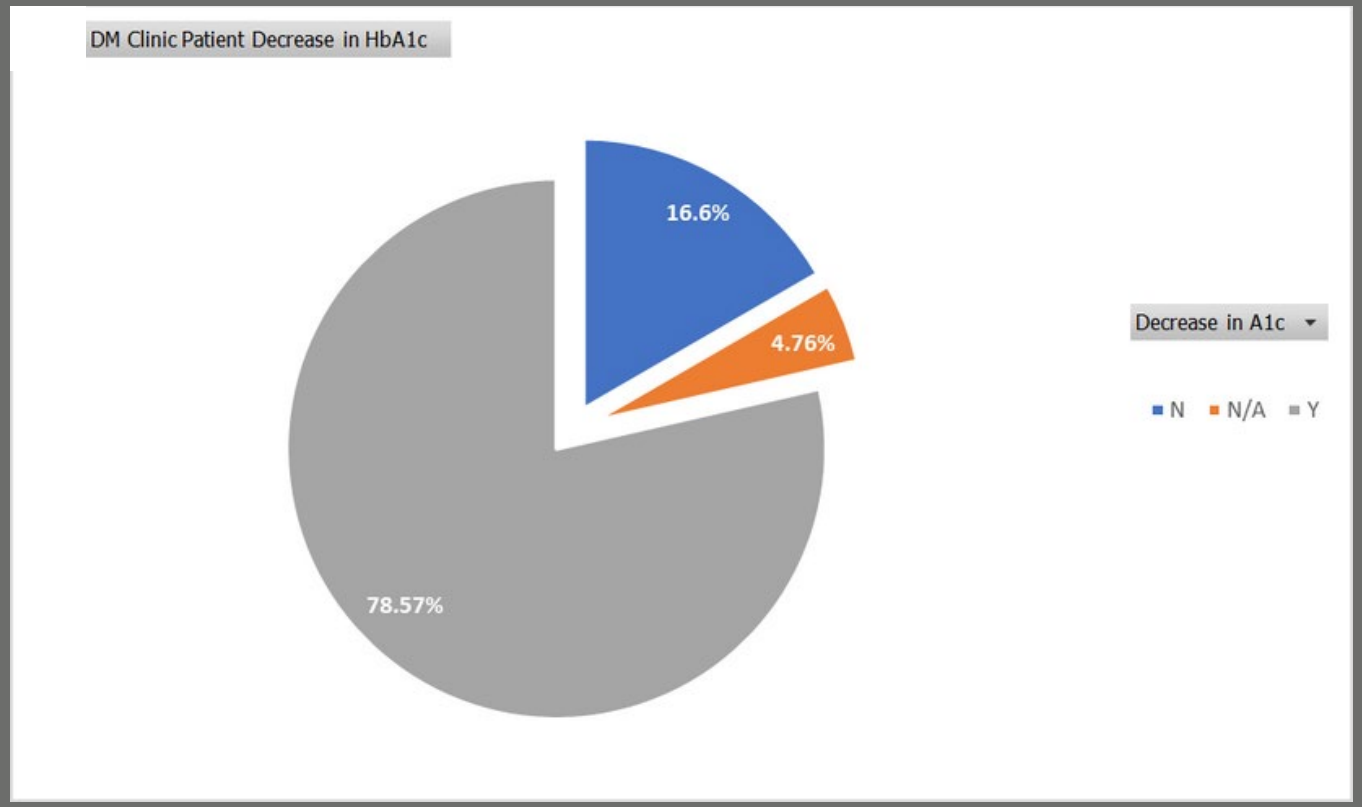
Focused, Coordinated Care: Diabetes Clinic

Family Practice and Fellowship has a monthly diabetes clinic.

½ day clinic for patients with type II diabetes that are uncontrolled (HBA1C >9%)

Clinic consists of :

- Clinician
- Diabetes Nurse, Certification Board for Diabetes Care and Education (CBDCE)
- Clinical Pharmacist



79% of patients that engaged in the Diabetes Clinic have seen a decrease in their HBA1C

Shasta Community Health Center
a californiahealth+ center

THANK YOU!

Additional Resources

Need to reach the PCP QIP Team? QIP@partnershiphp.org

- eReports access
- Measure specification questions

Interested in coaching resources for improving measure performance? Reach out to the Performance Improvement Team: pit@partnershiphp.org

- Coaching, measure best practices, sounding board, project planning guidance, facilitation

Partnership Quality Dashboard (PQD) User Guide

Link to PCP QIP Webinars Page: 2025 Kick-Off Webinar recordings are now available for PCP QIP and eReports

Contact Us

Lisa Ward MD, Regional Medical Director
lward@partnershiphp.org

Performance Improvement Team
pit@partnershiphp.org

Evaluation

Please complete your evaluation. Your feedback is important to us!