# 2026 Best Practices
# Comprehensive Diabetes Care
## Kidney Health Evaluation

**Partnership Tools, Programs, and Promising Practices:**

- The **DrillDown Clinical tab** in the eReports portal shows race / ethnicity information for each patient included in the measure. Export this dashboard to look at compliance rates for *Controlling Blood Pressure* by race and ethnicity to learn more about inequities within your patient community.
- Watch Partnership's **Improving Measure Outcomes training** on *Chronic Disease Management.*
- Refer Partnership members with uncontrolled hypertension to the **Partnership Care Coordination Department**. Care Coordination can assist members 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. To refer a Partnership member to Care Coordination, call or have the member call **(800) 809-1350**, or send a secure email to CareCoordination@partnershiphp.org.
- Provider health education materials are available on **Partnership's website** or by emailing CLHE@partnershiphp.org. Providers can access flyers and member materials in multiple languages for distribution.
- 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 Transportation Services** at **(866) 828-2303**, Monday – Friday, 7 a.m. – 7 p.m.
- Partnership covers **Medical Nutrition Therapy (MNT)** for both diabetes and prediabetes. Primary care providers (PCPs) can refer Partnership members to a contracted registered dietician or certified diabetes educator within 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**.
- **TeleMed2U** connects Partnership members with diabetes to a Diabetes Care Program. This telehealth program provides personalized and evidence-based care tailored to each member'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 the Diabetes Care program through TeleMed2U, follow these referral instructions.

**Patient Care:**

- Use pre-visit planning and daily MA-provider huddles to complete chart prep and proactively add needed preventive services, such as KED, as add-on tasks for any visit.

- Reassess patients every three months, or sooner based on A1c levels, risk factors, and co-morbidities, to support blood sugar control, detect kidney damage early, and improve outcomes through timely KED testing.
- Offer telehealth visits for diabetes management and kidney health evaluation as appropriate.
- Care teams or front office staff should promptly follow up and reschedule no-show appointments to maintain continuity of care.
- Implement cross departmental coordination of care.
- Incorporate care team members using standing orders for nursing, pharmacists, registered dieticians, and behavioral health.
- Create patient and/or staff incentive programs that offer rewards or recognition to increase preventive care completion, support self-management, and motivate staff to conduct consistent outreach.
- To meet the KED measure, a patient must receive at least one eGFR and one uACR test during the measurement year. For the uACR component, ensure you either complete a quantitative urine albumin test and a urine creatinine test within four days of each other, or use a single uACR test.

**Patient Education:**

- Assess and address the patient's knowledge, gaps, and barriers related to diabetes self-management (i.e., cultural, financial, literacy / health literacy, social support, health beliefs).
- Provide and encourage the use of virtual tools to support self-management such as computer / phone apps and programs for healthy eating, physical activity, and medication management.
- Consistently reinforce the importance of blood sugar testing and self-management at each visit.

**Outreach:**

- Designate a staff team member to contact patients due for HbA1c testing and KED scheduling (i.e., phone call, postcard, letter signed by provider, text).
- Call patients within a week to reschedule if a lab completion or provider appointment is missed.

**Equity Approaches:**

- Consider using an equity approach to increase screening rates for targeted communities. By looking at the Comprehensive Diabetes Care measure compliance rates with 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.
- Ensure patient information is consistent, welcoming, plain, person-centered, and language appropriate, as well as distributed in print and digital applications, per patient's preference.

- Each visit should include a conversation with the patient to confirm that health information, medication management, and next steps covered in the visit are mutually understood; the 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 (i.e., local schools or faith-based organizations) that align with your practice's demographics.
- Identify and address barriers to care (i.e., transportation, hours of operation, and access to pharmacy services).

**Data and Coding:**

- Submit claims and encounter data within 90 days of service.
- Exclude members as appropriate and use coding to document reason for exclusion. Use CPT-II coding to document:
  - **Blood Test:** An estimated glomerular filtration rate (eGFR) to check kidney function.
  - **Urine Test:** A urine albumin-creatinine ratio to detect early signs of kidney damage.
- Review lab requisition forms and visit superbills (EMR/EHR or paper) to ensure codes align with HEDIS technical specifications.

**Helpful Links:**

**2026 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