Diabetes Care Toolkit

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Molina Healthcare
Your Extended Family.
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Introduction

This toolkit is intended to be an easy-to-follow guide that covers the Diabetes Healthcare Effectiveness Data and Information Set (HEDIS®) measures. We want to work with our providers to promote the importance of preventive health care to collaborate with your to encourage members with diabetes to lead healthier lifestyles and be more active participants in their ongoing health care.

As a National Committee for Quality Assurance (NCQA) accredited health plan, Molina Healthcare strive to meet HEDIS® requirements. HEDIS® is regarded as the industry standard for measuring and comparing health plan performance.

We understand that HEDIS® specifications can be complex, so we have designed this manual to include tips to assist your practice with increasing utilization of recommended diabetes services.

We welcome your feedback and look forward to supporting all your efforts to provide quality healthcare to our members and your patients. We would be interested in your feedback on the usefulness of this tool, along with any suggestions for improvement.

We thank you for your continued commitment to providing quality medical care to Molina Healthcare members.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
Diabetes Care Overview - General HEDIS Tips to Improve Scores

Work with Molina Healthcare.
We are your partners in care and would like to assist you in improving your HEDIS® scores.

Use HEDIS® specific billing codes when appropriate.
We have tip reference guides on what codes are needed for HEDIS®.

Use HEDIS® Needed Services lists that Molina Healthcare provides you to identify patients who have gaps in care.
If a patient calls for a sick visit, see if there are other needed services (e.g. well-care visits, preventive care services). Keep the needed services list by the receptionist’s phone so the appropriate amount of time can be scheduled for all needed services when patients call for a sick visit.

Avoid missed opportunities.
Many patients may not return to the office for preventive care, so make every visit count. Schedule follow up visits before the patients leave.

Improve office management processes and flow.

✓ Review and evaluate appointment hours, access and scheduling processes, billing and office/patient flow. We can help to streamline processes.
✓ Review the next day’s schedule at the end of each day.
✓ Identify appointments where test results, equipment, or specific employees are available for the visit to be productive.
✓ Call patients 48 hours before their appointment to remind them about their appointment and anything they will need to bring. Ask them to make a commitment that they will be there. This will reduce no-show rates.
✓ Use non-physicians for items that can be delegated. Also, have them prepare the room for items needed.
✓ Consider using an agenda setting tool to elicit patient’s key concerns by asking them to prioritize their goals and questions.
✓ Use the Prescription for Wellness document to ensure patients understand what they need to do. This improves the patient’s perception that there is good communication with their provider.

Take advantage of your Electronic Medical Record (EMR).
If you have an EMR, try to build care gap “alerts” within the system.
HEDIS® Tips
Comprehensive Diabetes Care – Medical Record Documentation

All of these exams/screenings must be completed annually.

Hemoglobin A1c Testing

• Note when HbA1c test was performed and the finding

HbA1c Control (<8.0%)

• Note the date and results of the HbA1c test
  – Ranges and thresholds do not meet the criteria for this threshold

Eye Exam (retinal or dilated)

• A note or letter prepared by a health care professional indicating the exam was completed by an optometrist or ophthalmologist, the date and the results
• A chart or photograph of retinal abnormalities indicating date performed and evidence an optometrist or ophthalmologist performed the exam
• Documentation of a negative exam in the year prior where results indicate retinopathy was not present

Medical Attention for Nephropathy

• Note the date and results of the urine test for albumin or protein
• Documentation of a visit to nephrologist
• Documentation of a renal transplant
• Documentation for medical attention of: nephropathy screening or monitoring test
• Treatment for nephropathy or ACE/ARB therapy
• Stage 4 CKD
• ESRD
• Kidney transplant
• Visit with a Nephrologist
• ACE/ARB dispensed (must include a note indicating the member received an ambulatory prescription)

Blood Pressure Control (<140/90 mm Hg)

• Most recent Blood Pressure level in chart
**HEDIS® Tips**

**Comprehensive Diabetes Care**

**MEASURE DESCRIPTION**

Adults 18-75 years of age with diabetes (type 1 and type 2) who had each of the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)*  
  * a lower rate is better
- HbA1c control <8.0%
- Eye exam (retinal or dilated) performed
- BP control (<140/90 mmHg)
- Nephropathy monitoring
  - Nephropathy screening or monitoring test
  - Treatment for nephropathy or ACE/ARB therapy
  - Stage 4 CKD
  - ESRD
  - Kidney transplant
  - Visit with a nephrologist
  - ACE/ARB dispensed

**USING CORRECT BILLING CODES**

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
</table>
| Codes to Identify Diabetes | *ICD-9: 250.00-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04  
  ICD-10: E10, E11, E13, O24 |
| Codes to Identify HbA1c Tests | CPT: 83036, 83037  
  CPT II: 3044F (if HbA1c <7%), 3045F (if HbA1c 7% - 9%), 3046F (if HbA1c >9%) |
| Codes to Identify Nephropathy Screening Test (Urine Protein Tests) | CPT: 81000-81003, 81005, 82042, 82043, 82044, 84156  
  CPT II: 3060F, 3061F, 3062F |
| Codes to Identify Eye Exam (must be performed by optometrist or ophthalmologist) | CPT: 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245  
  HCPCS: S0620, S0621, S3000 |
| Codes to Identify Diabetic Retinal Screening With Eye Care Professional billed by any provider | CPT II: 2022F, 2024F, 2026F, 3072F |

*ICD-9 codes are included for historical purposes only and can no longer be used for billing.

**HOW TO IMPROVE HEDIS® SCORES**

- Review diabetes services needed at each office visit.
- Order labs prior to patient appointments.
- Bill for point of care testing if completed in office and ensure HbA1c result and date are documented in the chart.
- Adjust therapy to improve HbA1c and BP levels; follow-up with patients to monitor changes.
- Make sure a digital eye exam, remote imaging, and fundus photography are read by an eye care professional (optometrist or ophthalmologist) so the results count. Use 3072F if member’s eye exam was negative or showed low risk for retinopathy in the prior year.
- Prescribe statin therapy to all diabetics age 40 to 75 years.
- Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
HEDIS® Tips
Statin Therapy for Patients with Diabetes

MEASURE DESCRIPTION

The percentage of patients 40 – 75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported:

1. Received Statin Therapy. Members who were dispensed at least one statin medication of any intensity during the measurement year.
2. Statin Adherence 80%. Members who remained on a statin medication of any intensity for at least 80% of the treatment period.

### High, Moderate and Low-Intensity Statin Prescriptions

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-intensity statin therapy</td>
<td>• Atorvastatin 40-80 mg,</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 80 mg</td>
</tr>
<tr>
<td>Moderate-intensity statin therapy</td>
<td>• Atorvastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Amlodipine-atorvastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-atorvastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Rosuvastatin 5-10 mg</td>
</tr>
<tr>
<td></td>
<td>• Simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-simvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 20-40 mg,</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 40-80 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 40 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin XL 80 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 40 mg bid</td>
</tr>
<tr>
<td></td>
<td>• Pitavastatin 2-4 mg</td>
</tr>
<tr>
<td>Low-intensity statin therapy</td>
<td>• Simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Ezetimibe-simvastatin 10mg</td>
</tr>
<tr>
<td></td>
<td>• Sitagliptin-simvastatin 10 mg</td>
</tr>
<tr>
<td></td>
<td>• Pravastatin 10-20 mg</td>
</tr>
<tr>
<td></td>
<td>• Lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Niacin-lovastatin 20 mg</td>
</tr>
<tr>
<td></td>
<td>• Fluvastatin 20-40 mg</td>
</tr>
<tr>
<td></td>
<td>• Pitavastatin 1 mg</td>
</tr>
</tbody>
</table>

*Please refer to the Molina Healthcare Drug Formulary at [www.molinahealthcare.com](http://www.molinahealthcare.com) for statin medications that may require prior authorization or step therapy.

### HOW TO IMPROVE HEDIS® SCORES

- Educate patients on the following:
  - People with diabetes are 2 to 4 times more likely to develop heart disease or stroke.
  - Statins can help reduce the chance of developing heart disease and strokes.
  - Continue educating patients about the importance of adhering to their medication therapy and follow-up visits with their provider(s).
  - Strategies for remembering to take your medication.
- Schedule appropriate follow-up with patients to assess if medication is taken as prescribed.
- Do not rely on the patient to follow through with scheduling subsequent appointments. Routinely arrange the next appointment when the patient is in the office. If the patient misses a scheduled appointment, office staff should contact the patient to assess why appointment was missed.
- Contact Health Care Services at your affiliated Molina Healthcare State plan for additional information about Medication Therapy Management criteria and to request a referral for patients with at least six (6) chronic medications and at least three (3) qualifying diagnoses. They may be eligible for MTM sessions.
**HEDIS® Tips**

**Diabetes Screenings for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**

**MEASURE DESCRIPTION**

Adults 18-64 years of age with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test (glucose test or HbA1c test) during the measurement year.

**USE CORRECT BILLING CODES**

<table>
<thead>
<tr>
<th>Codes to Identify Diabetes Screening</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes to Identify Glucose Tests</td>
<td>CPT: 80047, 80048, 80050, 80053, 80069, 82947, 82950, 82951</td>
</tr>
<tr>
<td>Codes to Identify HbA1c Tests</td>
<td>CPT: 83036, 83037, CPT II: 3044F (if HbA1c&lt;7%), 3045F (if HbA1c 7%-9%), 3046F (if HbA1c&gt;9%)</td>
</tr>
</tbody>
</table>

**Antipsychotic Medications**

<table>
<thead>
<tr>
<th>Description</th>
<th>Generic Name</th>
<th>Brand Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Miscellaneous antipsychotic agents</td>
<td>Aripiprazole, Asenapine, Brexpiprazole, Cariprazine, Clozapine, Haloperidol, Iloperidone, Loxapine, Lurisadone, Molindone, Olanzapine, Paliperidone, Pimozide, Quetiapine, Quetiapine fumarate, Risperidone, Ziprasidone</td>
<td>Abilify, Saphris, Rexulti, Vraylar, Clozaril, Haldol, Fanapt, Loxipac/Loxitane, Latuda, Moban, Zyprexa, Invega, Orap, Seroquel, Seroquel XR, Risperdal, Geodon</td>
</tr>
<tr>
<td>Phenothiazine antipsychotics</td>
<td>Chlorpromazine, Fluphenazine, Perphenazine, Perphenazine-amitriptyline, Prochlorperazine, Thioridazine, Trifluperazine</td>
<td>Thorazine, Prolinx, Trilafon, Etrafon, Compazine, Mellaril, Stelazine</td>
</tr>
<tr>
<td>Psychotherapeutic combinations</td>
<td>Fluoxetine-olanzapine</td>
<td>Symbyax</td>
</tr>
<tr>
<td>Thioxanthenes</td>
<td>Thiothixene</td>
<td>Navane</td>
</tr>
<tr>
<td>Long-acting injections</td>
<td>Aripiprazole, Fluphenazine decanoate, Haloperidol decanoate, Olanzapine, Paliperidone palmitate, Risperidone</td>
<td>Abilify Maintena, Prolinx, Haldol Decanoate INJ, Zyprexa Relprew, Invega Sustenna, Risperdal Consta</td>
</tr>
</tbody>
</table>

**HOW TO IMPROVE HEDIS® SCORES**

- Help patients with scheduling a follow-up appointment in 1-3 months with their PCP to screen for diabetes. If the patient is not ready to schedule appointment, make note or flag chart to contact the patient with a reminder to schedule an appointment.
- Ensure patient (and/or caregiver) is aware of the risk of diabetes and have awareness of the symptoms of new onset of diabetes while taking antipsychotic medication.
- Schedule lab screening tests through PCP prior to next appointment.
- The BH provider can order diabetic lab tests for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- Patients can be referred for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
HEDIS® Tips
Diabetes Monitoring for People with Diabetes and Schizophrenia

MEASURE DESCRIPTION
Adults 18-64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year.

USE CORRECT BILLING CODES

<table>
<thead>
<tr>
<th>Description</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes to Identify HbA1c Tests</td>
<td>CPT: 83036, 83037</td>
</tr>
<tr>
<td></td>
<td>CPT II: 3044F (if HbA1c&lt;7%), 3045F (if HbA1c 7%-9%), 3046F (if HbA1c&gt;9%)</td>
</tr>
<tr>
<td>Codes to Identify LDL-C Tests</td>
<td>CPT: 80061, 83700, 83701, 83704, 83721</td>
</tr>
<tr>
<td></td>
<td>CPT II: 3048F, 3049F, 3050F</td>
</tr>
<tr>
<td>Codes to Identify Diabetes</td>
<td>*ICD-9 CM: 250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, 250.50-250.53, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04</td>
</tr>
<tr>
<td>*ICD-9 codes are included for historical purposes only and can no longer be used for billing.</td>
<td></td>
</tr>
</tbody>
</table>

HOW TO IMPROVE HEDIS® SCORES

- Review diabetes services needed at each office visit.
- Order labs prior to patient appointments.
- Bill for point of care HbA1c tests if completed in office. Ensure HbA1c result and date are documented in the chart.
- Order a direct LDL if patient is not fasting to avoid a missed opportunity. Some lab order forms have conditional orders – if fasting, LDL-C; if not fasting, direct LDL.
- Order diabetic lab tests through BH provider for patients who do not have regular contact with their PCP but who regularly see the BH provider. The BH provider can then coordinate medical management with the PCP.
- Adjust therapy to improve HbA1c, LDL, and BP levels; follow-up with patients to monitor changes.
- Give any patient caregiver instructions on the course of treatment, labs or future appointment dates.
- Monitor body mass index, plasma glucose level, lipid profiles and signs of prolactin elevation at each appointment.
- Educate patients about appropriate health screenings with some medication therapies.
- Refer patients for Health Management interventions and coaching by contacting Health Care Services at your affiliated Molina Healthcare State plan.
- Remember, Care Coordination with the patient’s behavioral health provider is a key component in the development of a comprehensive treatment plan.
**HEDIS® Tips**

**Medication Adherence for Diabetes Medications**

### MEASURE DESCRIPTION

The percentage of members who filled at least two prescriptions for the specified diabetes medication(s) on two unique dates of service and met the PDC (Proportion of Days Covered) threshold of 80% during the measurement period. The first fill of medication should occur at least 91 days before the end of the enrollment period.

**Note:** Plan members with one or more fills of insulin or have End Stage Renal Disease (ESRD) are not included.

### DIABETES MEDICATIONS

<table>
<thead>
<tr>
<th>Description</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Biguanides</td>
</tr>
<tr>
<td></td>
<td>Sulfonylureas</td>
</tr>
<tr>
<td></td>
<td>Thiazolidinediones</td>
</tr>
<tr>
<td></td>
<td>DiPeptidyl Peptidase (DPP)-IV Inhibitors</td>
</tr>
<tr>
<td></td>
<td>Incrétin mimetics</td>
</tr>
<tr>
<td></td>
<td>Meglitinides</td>
</tr>
<tr>
<td></td>
<td>Sodium glucose cotransporter 2 (SGLT) inhibitors</td>
</tr>
</tbody>
</table>

### HOW TO IMPROVE HEDIS® SCORES

- Help patients maintain a medication list to increase medication adherence.
- If the medication causes side effects, educate the patient on how they might be able to improve symptoms.
- Provide short and clear instructions for all prescriptions. Consider providing prescription instructions in both English and Spanish for Spanish-speaking members.
- Encourage the patient to take medications at the same time of day. Encourage the use of a pillbox or a calendar to help patients to take them each day.
- Schedule a follow-up visit when prescribing a new medication to your patient within 30 days to assess how the medication is working. Schedule this visit while your patient is still in the office.
- Adjust the timing, frequency, amount and dosage when possible to simplify the regimen and consider offering a 90 day supply.
- Inform member that mail-order prescription delivery is available if transportation is a barrier.
- Inform the patient of the benefits of taking the medication as directed and the importance of continued use. Make sure they understand the consequences of not taking the medication.
- Molina Healthcare’s Medication Therapy Management (MTM) Department provides clinical pharmacists that can review your Medicare and MMP member’s medications and identify barriers to adherence.
- Molina Healthcare’s MTM Department can help improve adherence by providing pillboxes, sending text message reminders, medication synchronization, mail order prescriptions, local pharmacy delivery and transportation.
- Refer Medicare and MMP patients to Molina’s MTM Department by phone: (855) 658-0918 or email mtm.pharmacy@molinahealthcare.com
Provider Tools
Comprehensive Diabetes Care – A Deeper Dive

Molina Healthcare recommends the following tips for improvement in HEDIS® rates

Office Staff:
- Train office staff to prep patient charts prior to visit to identify overdue tests/exams.
- Implement prompts for screenings due at point of care. Consider utilizing diabetes flow sheets.
- To assist with patient access, pilot a lab day on a weekend targeting non-compliant patients.
- Implement standing orders for all patients with diabetes (if allowed in your state).
- Design an aggressive outreach program for no-shows.
- Maintain regular follow-up and outreach to patients every 1-3 months.
- Form a partnership with health plan Care Managers and communicate regularly.

Screening Recommendations:
- Provide a handout with lab results and medication teachings at each visit.
- Provide a finger-stick HbA1c on every diabetic patient.
- Track results received for labs ordered.
- Consider more aggressive follow up standards for high risk patients.
- Adopt a policy of screening all patients with diabetes for depression.
- Standardize documentation of glycemic targets for all patients.
- Consider health literacy screening or depression screening.

Medication Adherence:
- Keep medication regimens simple minimize the number of doses per day.
- Tailor the care plan to the patient’s situation and lifestyle.
- Indicate purpose of each medication.
- Make a clear schedule for taking medications and stress the importance of following the schedule.
- Remind members to bring medications to each visit.

Patient Self-Management:
- Use motivational interviewing techniques and show patients their data (e.g. meet patients where they are).
- Assist with appropriate self-management goal setting and develop strategies to overcome barriers.
- Actively support ongoing self-management issues.
- Routinely give patients an updated care plan.
- Customize recommendations and counseling for each patient.
- Reassess patient self confidence in managing diabetes.
Agenda Setting Form

This document can be distributed to patients when they check in for their appointment. They can fill it out while they wait for the appointment. This is a useful tool so the patient does not forget to communicate anything to their medical team during their visit.

Dear Patient,

In order to address your health care concerns today, please complete the questions below:

What is the one main concern you would like your provider to focus on today?
________________________________________________________
________________________________________________________

What other concerns do you have today?
________________________________________________________
________________________________________________________
________________________________________________________

Do you need any prescriptions refilled today?
☐ Yes (please list): __________________________
☐ No

Please list any specialists you have seen and tests you have had outside of our provider group since your last visit.
________________________________________________________
________________________________________________________
________________________________________________________

Thank you!
Dilated Retinal Eye Exam

Keeping patients up to date with their annual dilated retinal eye exam. Detect diabetic retinopathy early and prevent major vision loss.

Determine if your patient is up to date on their dilated retinal eye exam

Negative results. For patients identified as having no evidence of retinopathy in the prior calendar year use CPT II code: 3072F. Patient is up to date with their dilated retinal eye exam.

Positive results. Patients positive for retinopathy need to be referred to an eye care specialist annually. An optometrist or ophthalmologist is the appropriate provider to complete this exam.

No current screening. Refer the patient to an eye care specialist. An optometrist or ophthalmologist is the appropriate provider to complete this exam.

Document annual dilated retinal eye exam in medical record

- Date exam completed
- Results of exam
  - Positive
  - Negative
  - Unknown
- Provider who completed exam
  - Optometrist
  - Ophthalmologist
  - Unknown

Refer patients for an annual dilated retinal eye exam

- Educate patient on importance of exam.
- Let them know it is not an exam for new glasses or contacts.
- Assist the patient with making the appointment.
- Referral clearly states ‘dilated retinal’ eye exam.
Cultural Competency
Connecting with your Patients
Cultural skills will help bridge health gaps.

Aging Population - Health disparities are part of America’s health care system. Unfortunately disparities do not fade with age, which is why cultural competencies will be key in preparing for an older population more diverse than ever. Older minorities tend to be in poorer health than the general population, have more functional impairments, more limited educations and lower incomes. It is important when working across diverse populations to understand the values and histories of a culture, as many older minorities have experienced social injustice, many forms of discrimination and adversity.

Food Habit Awareness – Health care professionals must possess specific knowledge about food habits, preferences, and practices (e.g. holidays, celebrations, and fasting practices) for the ethnic and racial groups they see in their practice. Patients feel as if they have been understood and their beliefs, behaviors, and values have been respected.

Cultural Knowledge - To acquire cultural knowledge, health care professionals may investigate the literature and ask themselves the following questions:
1. What is the prevalence of diabetes among various ethnic and racial cultural groups?
2. To what extent does the biomedical model for the causation of diabetes agree with the client’s cultural perspective? What other culturally based theories affect or conflict with the biomedical model?
3. What is the client's perspective about who is responsible for his or her diabetes management?
4. How does the client perceive a visit with the health care professional to receive diabetes care and education?
5. How do food habits and preferences affect the client's ability and willingness to manage his or her diabetes?

Cultural Skill – To acquire cultural skills, health care professional may ask their patients the following questions:
1. What languages do you speak?
2. Do you prefer an interpreter?
3. What kinds of foods do you like to consume when you feel well and when you are not feeling well?
4. What, if any, foods do you avoid when you are ill?
5. Do you avoid any foods for cultural or religious reasons?
6. What do you think are the causes of your diabetes?
7. How do you think we should manage and treat your diabetes?
Connecting with your patients.

Language & Culture – A critical need is language. Finding a bilingual staff will be key. Learning how to communicate with diverse populations could help curb diseases such as diabetes, which affects about one in three elderly Hispanics.

Helplines – Translation lines established to aid communication between medical professionals and their patients.

Generic Medications – Prescribing a lower cost generic medication instead of a brand-name helps ensure a patient can sustain a regimen.

Community-Based Organizations – The key to getting the message out about health promotion is going where the audience goes. Partnering with community-based organizations can help get the word out. A main venue for reaching elderly blacks with prevention is through churches. Working with pastors is instrumental.

Literacy – Even though your patient may speak English you never know about their education level. Be sensitive and find a balance to addressing your audience.

Cultural Ideas – Be sensitive to cultural ideas about illness and healing. Self-care can be based on belief systems that are more than just European medicines. A provider has to listen carefully to what the elder is saying with regards to the meaning of symptoms, ideas for healing and ideas for intervention.

Elders - Elders are the main stakeholders of influence for accepting the health system in American Indian/Alaskan Native communities. Earning trust among the elder generation could mean gaining trust among the entire community. Being able to reach this population with prevention message, especially around diabetes, which is epidemic in some Indian communities, could bridge access gaps.

For more information specific to the diabetic population, please visit the National Institute of Diabetes and Digestive and Kidney Diseases.
Clear Communication Tools

To practice culturally sensitive health care, use the following guidelines around the mnemonics LEARN, ETHNIC and RESPECT.

The L.E.A.R.N. Model of Cross Cultural Communication

A communication framework called the LEARN model can be used to help health care providers overcome communication and cultural barriers to successful patient education. There are 5 steps to the model from Berlin EA. & Fowkes WC. (1983).

- **Listen** with sympathy and understanding to the patient’s perception of the problem.
- **Explain** and share your perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities between these two perspectives.
- **Recommend** a treatment plan.
- **Negotiate** a mutually agreed-on treatment plan.


The E.T.H.N.I.C. Model of Cross Cultural Communication

The goal of ETHNIC is to help a provider learn about the patient’s health beliefs and practices, be open and respectful, and incorporate the patient’s beliefs into the care plan as much as possible.

- **Explanation**
  - How do you explain your illness?
  - Have you heard or seen any information about your illness?

- **Treatment**
  - What treatments have you tried for your illness?
  - Is there anything that you do or do not eat or drink to stay healthy?

- **Healers**
  - Who else has helped you with your illness?
  - Have you gotten advice from alternative or folk medicine for your illness?

- **Negotiate**
  - What can I do to help you the most?
  - What do you feel are the best options for you?

- **Intervention**
  - Based on the options that you have suggested, let’s agree on a few.

- **Collaborate**
  - How can we work together on this?
  - Who else needs to be included on our treatment plan?
The R.E.S.P.E.C.T. Model of Cross Cultural Communication

**Rapport**
- Connect on a social level
- Seek the patient's point of view
- Consciously attempt to suspend judgment
- Recognize and avoid making assumptions

**Empathy**
- Remember that the patient has come to you for help
- Seek out and understand the patient's rationale for his or her behaviors or illness
- Verbally acknowledge and legitimize the patient's feelings

**Support**
- Ask about and try to understand barriers to care and compliance
- Help the patient overcome barriers
- Involve family members if appropriate
- Reassure the patient you are and will be available to help

**Partnership**
- Be flexible with regard to issues of control
- Negotiate roles when necessary
- Stress that you will be working together to address medical problems

**Explanations**
- Check often for understanding
- Use verbal clarification techniques

**Cultural Competence**
- Respect the patient and his or her culture and beliefs
- Understand that the patient's view of you may be identified by ethnic or cultural stereotypes
- Be aware of your own biases and preconceptions
- Know your limitations in addressing medical issues across cultures
- Understand your personal style and recognize when it may not be working with a given patient

**Trust**
- Self-disclosure may be an issue for some patients who are not accustomed to Western medical approaches
- Take the necessary time and consciously work to establish trust

Continuing Medical Education Course

Molina Healthcare’s goal is to deliver excellent service to all we serve—including providers. In order to reach this goal, Molina Healthcare has referenced the Physicians Practical Guide E-Learning Program. Up to 9 CMEs can be earned for completing this course.

“Informative, relevant, and engaging... A marvelous e-learning program that will improve the quality of care provided to all patients... This is likely to be the ‘gold standard’ in cultural competency training for many years to come!”

Robert C. Like, MD, MS
Director, Center for Healthy Families and Cultural Diversity
Department of Family Medicine

The Office of Minority Health – Up to 9 CME credits
A Physician's Practical Guide to Culturally Competent Care is a free online CME program from the Office of Minority Health. This innovative training is a case-study based curriculum with video vignettes and interactive exercises. Learn how to work with patients from diverse backgrounds and develop cultural competency training for staff. Earn up to 9 free CME credits (Physicians and Physician Assistants), 9 contact hours (Nurse Practitioners), or 9 contact hours (0.9 CEUs) (Pharmacists).

A Physician’s Practical Guide to Culturally Competent Care
Patient Handouts
Caring for My Diabetes with the Help of My Provider

When I visit my pharmacist, I will...

- Make a list of my medicines:
  - My prescribed medicines
  - My over-the-counter medicines
  - My herbal, vitamin, or dietary supplements
- Share the list with my pharmacist.

When I visit my primary care provider (PCP), I will...

- Ask if I need to schedule a urine test for nephropathy screening.
- Ask if I need to schedule HbA1c testing.
- Ask if my HbA1c is under control (less than 8%). If not under control, I will ask for tips to improve.
- Ask about types of exercises that are safe for me.

When I visit my eye care provider, I will...

- Ask for a full eye exam each year that includes a retinal or dilated eye exam.
- Ask how to prevent diabetic eye disease.
- Let my provider know if I have any vision changes.
To control my diabetes each day, I will...

- Exercise each day. I can go for a walk with a friend or try low-impact exercises.
- Make healthy diet choices. I can plan my meals ahead of time. I can include more lean meats and vegetables.
- Quit using tobacco products because they can make my diabetes worse.
- Ask all my providers to share my exam results with my other health care providers, including my PCP.

Tests and screenings I may need:

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HbA1c Test:</strong></td>
<td>A blood test that shows the average blood glucose control for the past 2-3 months.</td>
</tr>
<tr>
<td><strong>Kidney Screening:</strong></td>
<td>A yearly urine test to make sure your kidneys are in good health.</td>
</tr>
<tr>
<td><strong>Retinal Eye Exam:</strong></td>
<td>A yearly exam that can help detect diabetic retinopathy early and prevent major vision loss.</td>
</tr>
</tbody>
</table>
Diabetes Fact Sheet

What is diabetes?
Diabetes is caused when blood glucose (blood sugar) levels are too high. Diabetes does not go away, but it can be controlled. If not controlled, high blood glucose can cause serious health problems.

How can you control diabetes?
- Lose weight.
- Be physically active.
- Eat healthy meals.
- Control your blood pressure and cholesterol.
- Monitor blood glucose levels.
- Take medicines as directed by your provider.
- Visit your provider regularly.

How can you lose weight?
The best way to lose weight is to eat healthy meals and be physically active. Eating the right foods, at the right time, in the right amounts can help you lose weight safely. Talk with your provider before you change your diet. The wrong diet can be dangerous.

What exercise is good for you?
The type and amount of exercise you should do will depend on you. Talk with your provider before starting any exercise. Examples of exercise include walking, strengthening muscles and stretching.

How can you eat a healthy diet?
- Eat whole grain breads and cereals.
- Eat fruits and vegetables.
- Eat lean meats, fish and beans.
- Eat low or non-fat dairy products.
- Space your meals evenly throughout the day.
- DO NOT SKIP MEALS.
Managing Diabetes

See your provider regularly to manage your diabetes. The chart below will help you keep track of these medical visits.

<table>
<thead>
<tr>
<th>EVERY OFFICE VISIT</th>
<th>Results</th>
<th>Date</th>
<th>EVERY 3-6 MONTHS</th>
<th>Results</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure</td>
<td></td>
<td></td>
<td>Blood test to measure blood sugar control (A1c)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A brief foot exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight check</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EVERY 6 MONTHS</th>
<th>Results</th>
<th>Date</th>
<th>ONCE A YEAR</th>
<th>Results</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental visit to check teeth and gums</td>
<td></td>
<td></td>
<td>Blood test to measure cholesterol levels</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Retinal eye exam with dilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Complete foot exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urine test to measure kidney function</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Flu shot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It is important to feel comfortable asking your provider questions and talking about your concerns. Ask your provider about:

- How to monitor your blood glucose at home
- What the side effects are of the medicines you take
- Creating a diabetes action plan
- Exercise, eating healthy and staying at a healthy weight
- How to lose weight (if you are overweight)
- How to join a smoking cessation program
- How to lower your blood pressure and cholesterol levels

Develop a good trusting relationship with your provider. If you want a new provider, call Member Services. The number is on the back of your Member ID card
Diabetic Retinopathy

What is retinopathy?
Retinopathy is damage to the part of your eye called the retina. The retina is a thin layer of tissue that is sensitive to light. You need a healthy retina to see clearly.

What is diabetic retinopathy?
Diabetic retinopathy is damage to the retina from diabetes. When you have diabetes, your body does not use or store sugar in your blood correctly. Too much sugar in the blood can cause damage to the tiny blood vessels that keep the retina healthy.

What are the symptoms?
The early stages of diabetic retinopathy may not cause symptoms to appear. Symptoms appear after there is damage to the retina. A retinal eye exam can help detect diabetic retinopathy early and prevent major vision loss.

- Visual symptoms can include:
- Blurred vision
- Floaters, flashes or spots in your vision
- Trouble seeing well at night
- A dark spot in the center of your vision
- Total loss of vision

Can you cure diabetic retinopathy?
No. Vision loss cannot be regained. Surgery, laser treatments or medicine can slow down vision loss. You may need ongoing care to prevent total loss of vision.

What can you do to protect your eyes?
- Take your diabetes medicine.
- Eat healthy foods.
- Exercise often.
- Control your high blood pressure and blood sugar levels.
- Avoid alcohol and smoking.

Visit your provider for a retinal eye exam at least once a year. This exam will check for early signs of retinopathy. Getting treatment right away can reduce the risk of total vision loss.
Prescription for Wellness

Patient Name: ___________________________ DOB: ___________________________

Diagnosis: ___________________________ Date of Service: ___________________________

Primary Care Provider (PCP) Name: ___________________________
Phone: ___________________________

Healthcare Provider Name: ___________________________
Phone: ___________________________

Congrats on deciding to improve your health. Here is the plan we talked about to start you on your way.

<table>
<thead>
<tr>
<th>Types of Screening</th>
<th>HbA1c</th>
<th>Nephropathy</th>
<th>Retinal Eye Exam</th>
<th>Foot Exam</th>
<th>Blood Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Result</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

1. Prescription Info & Instructions:

2. Diet Info & Instructions:

3. Things to stop or avoid: ______________________________________________________________________________________

4. Exercise plan: ______________________________________________________________________________________
   Start with: ___________________ for _______ minutes ____ days per week
   Slowly increase to: _______ minutes _______ days per week

5. Other:

   ______________________________________________________________________________________

Physician Signature: ___________________________ Date: ___________________________

Follow Up Appointment: ______________________________________________________________________________________

Thank you for coming to see me today. I appreciate you choosing ____________________ for your medical care. If you have any questions about your visit today or if your symptoms worsen, please call our office. My staff will forward your message to me. I will get back to you as soon as possible.