ALAMEDA Alliance FOR HEALTH

Thank you for joining us today!

This webinar is being recorded for quality assurance and training purposes.

After the conclusion of the Measure Highlight series, a condensed recording of this training and others in the series will be available on the Alameda Alliance for Health's ***Training and Technical Assistance Opportunities*** *webpage.*

Please reach out to us via email with any questions you may have at: ***DeptQITeam@alamedaalliance.org*****.**

Measure Highlight: Chronic Disease Focus

ALAMEDA Alliance FOR HEALTH

Agenda

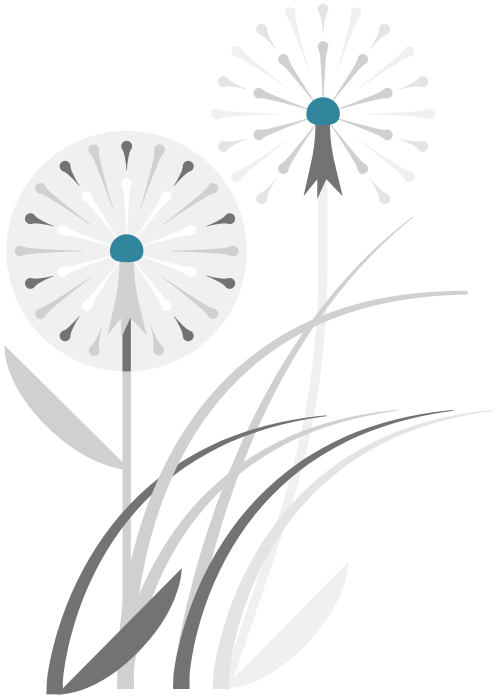
1) Background & Objectives
2) Measure Descriptions
    a) What counts for HEDIS®
3) Sharing Best Practices
4) Open Discussion

Objectives

- At the end of this webinar, you will be able to:
  - Have a better understanding of the measure expectations.
  - Identify best and promising practices that can be used in your clinics.
  - Increase understanding of the impact of implicit bias on chronic disease care

Icebreaker

Word cloud: What is something you do to support your health every day?



Why Chronic Disease Care?

Quality

- DHCS Quality Strategy Goal: Focus on and address disparities to support the treatment of hypertension, diabetes, and asthma
- Cost effectiveness, reduce disease burden
- Quality performance metrics

People

- In Alameda County:
  - Nearly 30% of adults have hypertension
  - 9.2% of adults have diabetes
  - 18.5% of adults and 6.9% of kids and teens have asthma
- Quality of life, patient-centered care, access to support structures that lead to healthier lives

Role of Implicit Bias in Chronic Disease Treatment

Implicit bias can have an impact on medical decision making, communication, adherence to medical advice and provider-patient interactions.

- Implicit biases based on race, gender, sexual orientation, weight, health insurance and other group identifications can affect how healthcare providers interact with patients in several ways:
  - the quality of the clinical interview
  - the diagnostic decision-making
  - symptom management
  - treatment recommendations
  - referrals to specialty care
  - interpersonal behaviors – trust, communication, empathy, etc.
- Practice from a stance of dignity and respect: inclusion, view people as individuals, build partnerships, focus on empathy and building trust

Measure Descriptions

Definitions, what counts for HEDIS®, and

Best & Promising Practices

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Controlling High Blood Pressure

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Controlling High Blood Pressure (CBP)

- Percentage of adults, 18-85 years of age, who had a **diagnosis of hypertension** and whose blood pressure was **adequately controlled (<140/90 mm Hg)** during the measurement year.
- Inclusion in measure:
  - Members who had **at least two (2) outpatient visits** on different dates of service with a diagnosis of hypertension on or between January 1 of the prior measurement year and June 30 of the current measurement year.

What counts for HEDIS?

- Members are compliant if their **most recent** BP reading is **less than 140/90.**
- The BP reading must occur on or after the date of a **second** outpatient or telehealth visit with a diagnosis of hypertension in the measurement year.
  - Acceptable readings can also be taken from subsequent visits where HTN is not specifically addressed.
- If there are multiple BP measurements on the **same date of service**, the **lowest systolic and lowest diastolic values are used**.
  - Ex: 1st reading is 142/**85**, 2nd reading is **138**/87

    →Reported value would be **138/85**

BP Reading Specifications

Accepted

- Readings taken by the member using a digital device and documented in the record.
  - Include the date the reading was taken.
- Readings reported as an "average BP" with a distinct numeric result for both the systolic and diastolic BP.
  - Reading 1: 142/87
  - Reading 2: 138/83
  - Average BP: 140/85
- CPT Category II informational codes

Not Accepted

- Readings taken during an acute inpatient setting or an emergency department (ED).
- Readings taken on the same day as a test or procedure that requires a change in diet or medication on or one day before.
  - Exception: fasting blood tests.
- Readings reported as a range or threshold.
  - "Patient BP was elevated (AHA 120-129/<80)"
  - "Patient states BP is usually between 130-135/80-85"

Average BP – Additional note

Medical record documentation

- If a patient has two BP readings during a visit, it's best to document both readings and not just document the average.
  - The average is acceptable, however there may be circumstances where the lowest systolic and lowest diastolic values are compliant, but the average of the two readings is not, resulting in a noncompliant BP rate.
  - If using CPT II codes, the recommendation is the same. Send the CPT II code for the lowest systolic and lowest diastolic readings rather than the average.

Key Best Practices

- Ensure patients have access to validated electronic devices to take their blood pressure at home. Members with a missing or incomplete reading are considered noncompliant.
- Train and re-train all staff in proper blood pressure measurement technique:
  - Proper patient positioning and cuff placement.
  - Allow the patient to rest before taking the reading.
  - Take a second reading after 5 minutes or at the end of the appointment if blood pressure is elevated.
- Utilize CPT II reporting codes if electronic readings cannot be stored and reported into AAH system

Glycemic Status Assessment for Patients with Diabetes

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Glycemic Status Assessment for Patients with Diabetes (GSD)

- The percentage of members 18–75 years of age with diabetes (types 1 and 2) **whose most recent HbA1c or GMI** during the measurement year is **less than 8% or greater than 9%**
- Inclusion in the measure: One of two methods
  - Members who had **at least two (2) outpatient visits** on different dates of service during the measurement year or the year prior.
  - Members who were **dispensed insulin or hypo/antihyperglycemics and have at least one diagnosis of diabetes** during the measurement year or the year prior.

Rate calculations

- Two rates are reported for this measure:
  below 8% (control) or greater than 9% (poor control)
  - The poor control rate (>9%) is a **reverse** measure: **a lower rate is better**
    - →This rate is on the DHCS MCAS
  - **The most recently reported HbA1c or GMI determines which rate the member falls into**

Measure Sort	Measure Description	EP	Num	Rate
GSD1	Glycemic Status <8.0%	3,902	779	19.96%
GSD2	Glycemic Status >9.0%	3,902	2,926	74.99%

Lab Value Specifications

Accepted

- Lab reports with a distinct numeric result.
- Member-collected samples that are sent to a lab for processing.
- Member-reported results of a previous lab test documented in a progress note.
  - "Patient reports A1c level was 6.3 on 5/28/2024."

Not Accepted

- Self-reported home tests.
- Lab values reported as a range or threshold.
  - "A1c in normal range (<5.7%)
  - "A1c above 14%"

Key Best Practices

- Ensure all members with a diabetes diagnosis have a current year HbA1c or GMI recorded. Members with a missing value are considered noncompliant.
- POC A1c tests should be coded as labs: CPT 83036 or 83037 and should include CPT II codes to report the value
- Workflows: Stratify diabetic population based on HbA1c value or medication changes

Asthma Medication Ratio

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Asthma Medication Ratio (AMR)

- The percentage of members 5–64 years of age with **persistent** asthma and had a **ratio of controller medications to total asthma medications of 0.50 or greater** during the measurement year
  - **I.e., members should fill <u>controller</u> medications at a higher rate than <u>reliever</u> medications**

$$\frac{\text{Units of Controller Medications}}{\text{Units of Total Asthma Medications}} = \text{Asthma Medication Ratio}$$

Inclusion in the Measure

- Members are included in the measure if they meet at least one of the following criteria in the **current and previous** measurement years
  - At least **one ED** visit with a principal diagnosis of asthma.
  - At least **one acute inpatient** discharge with a principal diagnosis of asthma.
  - At least **four outpatient visits** with any diagnosis of asthma and at least **two asthma medication dispensing** events.
  - At least **four asthma medication dispensing** events for any controller or reliever medication.
- Members are excluded from the measure if they had no asthma medications dispensed during the measurement year.

What counts for HEDIS?
Units of Medication

- One medication unit is equal to:
  - One inhaler
  - One injection
  - One 30-day supply of oral medication
    - → For prescriptions longer than 30 days, divide the total by 30
    - → A 90-day supply would be counted as 3 units (90/30=3)
- Multiple prescriptions for different medications dispensed on the same day count as separate dispensing events
- SMART therapy medications (Dulera, Symbicort, Breyna) count as controllers

AMR best practices

- Conduct academic detailing to understand prescribing patterns; educate providers on prescribing best practices.
- Educate patients on the difference between a reliever and a controller medication; ensure patients fill and use controllers.

Sharing Best Practices

Presenter

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Survey for Feedback

We would appreciate your feedback on today's webinar:

https://www.surveymonkey.com/r/ABCsOfQI2

Discussion & Questions

- What are the biggest barriers to capturing blood pressure readings in the chart?
- If you're not already using A1c POC testing, what challenges do you face in implementation?
- What are some of the main drivers for your patients not filling asthma controller medications?
- What additional resources do you need to help your patients with managing their health?

Survey QR

Quality Improvement Measure Highlight Webinars

Cancer Prevention
Date: Wednesday, May 7, 2025
12:00pm-1:00pm
Registration: Sign-Up Now!

Women's Reproductive Health
Date: Wednesday, May 21, 2025
12:00pm-1:00pm
Registration: Sign-Up Now!

Survey QR

Thanks!

You can contact us at:

DeptQITeam@alamedaalliance.org

Survey QR

Resources

Resources from the Alliance

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HTN CPT Category II Reporting

CPT Cat II Code Description	Numerator Compliance	CPT Cat II Code
Systolic Less Than 130	Systolic compliant	3074F
Systolic Between 130-139	Systolic compliant	3075F
Systolic Greater Than or Equal to 140	Systolic not compliant	3077F
Diastolic Less Than 80	Diastolic compliant	3078F
Diastolic Between 80-89	Diastolic compliant	3079F
Diastolic Greater Than or Equal to 90	Diastolic not compliant	3080F

Note: CPT Cat II codes are not reimbursable. They are informational only.

HTN Best Practices

- Ensure patients have access to validated electronic devices to take their blood pressure at home. Provide a log or facilitate remote monitoring to track daily rates.
- Educate patients on the correct way to take their own blood pressure, including waiting after consuming caffeine or being physically active.
- Train all staff in proper blood pressure measurement technique:
  - Proper patient positioning and cuff placement.
  - Allow the patient to rest before taking the reading.
  - Take a second reading after 5 minutes or at the end of the appointment if blood pressure is elevated.
- Act rapidly to start or intensify treatment with medication.
- Provide education and resources for lifestyle management: exercise, diet, medications, etc.

Diabetes CPT Category II Reporting

CPT Cat II Code Description	CPT Cat II Code
Most recent hemoglobin A1c (HbA1c) level less than 7.0%	3044F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%	3051F
Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%	3052F
Most recent hemoglobin A1c (HbA1c) level greater than 9.0%	3046F

Note: CPT Cat II codes are not reimbursable. They are informational only.

GSD Additional Details: What counts for HEDIS?

- Documentation in the medical record must indicate the date the test was performed and the result.
  - Lab test descriptions or names must clearly indicate what the test is for: A1c, GHBA1c, Glycated A1c or Glycated Hemoglobin, POC A1c, POL A1c, etc.
    - → A1c results with a procedure code alone are not acceptable. There must be an A1c test descriptor: ex. 83036 Glycated hemoglobin test.
- POC A1c tests should be coded as labs: CPT 83036 or 83037 and should include CPT II codes to report the value
- For GMI values, document the date range used to derive the value. The last date in the range is used as the assessment date.

Supplemental Data for POC A1c Tests

- The Alliance will accept supplemental data for point of care A1c test results
- The Alliance will provide an Excel template for data submission. Required fields include:
  - Member First Name
  - Member Last Name
  - Member DOB
  - POC A1c Test Date
  - Test Result Date
  - A1c Value
- Data must be electronically extracted from EMR system. Data manually input into the spreadsheet will not be accepted.
- Data will need to pass multiple rounds of Primary Source Verification (PSV)
- Deadline to submit data for Measurement Year 2025 is 1/15/2026.
- Questions: contact DeptQITeam@alamedaalliance.org

Diabetes Best Practices

- Ensure all members with a diabetes diagnosis have a current year HbA1c or GMI recorded.
- Schedule diabetes-only visits.
- Refer to support groups to manage lifestyle changes (see resources section).
- Review practice-wide medication prescribing patterns to assess for therapeutic inertia (see citations slide).
- Workflows: Stratify diabetic population based on HbA1c value or medication changes

AMR Rate Calculation

- This is the formula used to determine a member's medication ratio and the overall compliance rate.

Step 1 For each member, count the units of asthma controller medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 2 For each member, count the units of asthma reliever medications dispensed during the measurement year. Refer to the definition of *Units of medications*.

Step 3 For each member, sum the units calculated in step 1 and step 2 to determine units of total asthma medications.

Step 4 For each member, calculate the ratio of controller medications to total asthma medications using the following formula. Round (using the 0.5 rule) to the nearest whole number.

$$\frac{\text{Units of Controller Medications (step 1)}}{\text{Units of Total Asthma Medications (step 3)}}$$

Step 5 Sum the total number of members who have a ratio of ≥0.50 in step 4.

Medication Ratio Examples

$$\frac{\text{Units of Controller Medications}}{\text{Units of Total Asthma Medications}} = \text{Asthma Medication Ratio}$$

Goal = 0.50 or greater

Patient 1	Patient 2
Qvar inhaler (controller) Filled on 1/8, 3/12, and 5/24 : **3 units**	Singulair (controller) Filled on 2/17, 4/12, 5/20, 7/22, 8/24, 9/24, 10/25, 11/26, and 12/27 : **9 units**
Albuterol inhaler (reliever) Filled on 1/8, 2/7, 3/12, 5/24, and 6/23 : **5 units**	Albuterol inhaler (reliever) Filled on 2/17, 5/20, 9/24, and 11/26 : **4 units**
3 controller + **5** reliever = **8** total **Ratio: 3/8 = 0.38**	**9** controller + **4** reliever = **13** total **Ratio: 9/13 = 0.69**

Health Education

- **Patient Health & Wellness Education**:
  - Live Healthy Library; Wellness Program & Materials Request Form
- Diabetes prevention programs
  - Yumlish: Provider or clinic referral only
- Alliance disease management programs:
  - Living Your Best Life: Adult members with asthma, diabetes, and high blood pressure
  - Happy Lungs: Pediatric members with asthma
- Tobacco cessation
  - Members: Quit Smoking – Alameda Alliance for Health
  - Providers: Tobacco Provider Guide – Alameda Alliance for Health

For questions, contact: Monique Rubalcava mrubalcava@alamedaalliance.org
Gil Duran gduran@alamedaaliance.org

Transportation Benefit


Alameda Alliance for Health
Medi-Cal Transportation Benefit

Get transportation t

At Alameda Alliance for Health
Alliance Medi-Cal members car
The Alliance covers two (2) type
1. Non-medical transportati
2. Non-emergency medical

Non-Medical Transporta
Alliance members who have M
• Pick up prescriptions and
• Travel to and from a medi
The Alliance NMT benefit cove
a medical appointment.
To schedule an NMT service, p

Non-Emergency Medical Transportation
Non-emergency medical transportation (NEMT) is fo
appointment (medical, dental, mental health, or sub
NMT level of service.
NEMT uses the following levels of service:
• Air transport • Litter/gurney van
• Ambulance • Wheelchair van
The doctor must complete and submit the Physician C
NEMT request. After the form is sent to the Alliance
the number below. The PCS Form can be foun

Scheduling
Please schedule the ride request
appointments, please call a

If you are…	
An Alliance member	
An Alliance **provider** calling on behalf of an Alliance member	Toll-Free: **1.866.529.2128**
An Alliance provider who needs to report real-time concerns	Toll-Free Escalation Line: **1.866.779.0569**

To schedule a ride, Alliance members can also download and use the **Modivcare App** from Google Play® or the Apple App Store® on a smartphone or tablet.

Questions?
Please call the Alliance Member Services Department
Monday – Friday, 8 am – 5 pm
Phone Number: **1.510.747.4567** • Toll-Free: **1.877.932.2738**
People with hearing and speaking impairments (CRS/TTY): **711/1.800.735.2929**
www.alamedaalliance.org

ALAMEDA Alliance FOR HEALTH

CMDM_TRANSPO BENEFIT 04/2024

2/2

Scheduling

Please schedule the ride request at least three (3) business days before the appointment. For urgent appointments, please call as soon as possible. Please have the Alliance member ID card ready when you call.

If you are…	Phone Number
An Alliance member	Toll-Free: **1.866.791.4158**
An Alliance **provider** calling on behalf of an Alliance member	Toll-Free: **1.866.529.2128**
An Alliance provider who needs to report real-time concerns	Toll-Free Escalation Line: **1.866.779.0569**

To schedule a ride, Alliance members can also download and use the **Modivcare App** from Google Play® or the Apple App Store® on a smartphone or tablet.

Reference Link: https://alamedaalliance.org/members/medi-cal/benefits-and-covered-services/

Interpreter Services

Telephonic

- Available **24/7**
- To access, call **1.510.809.3986**
  - Refer to the **Alliance Interpreter Services Guide** for your Pin Number.
- For deaf, hard of hearing or speech impaired, call the California Relay Service (CRS) at **711.**

Prescheduled Telephonic and Video

- Available for hard-to-reach languages
- Interpreter Service Request Form is required (**5 business days** prior to an appointment)

In-person

- Available when the following situations are present:
  - American Sign Language (ASL) for the deaf or hard of hearing
  - Complex procedures or courses of therapy
  - Abuse or sexual assault issues
- End-of-life issues
- Interpreter Service Request Form is required (**5 business days** prior to an appointment)
- Request form may be submitted by:
  - Alliance **Provider Portal**
  - **Fax** at 1.855.891.9167

For more information on **how to submit a request** and **interpreter services**, visit the Alliance website at: **www.alamedaalliance.org/language-access**.

Reports

Gap in Care Lists

- HEDIS Measures
- Initial Health Appointment (IHA)
- Emergency Department Utilization

Project Support

Quality Improvement Team

- Project Management
  - Contact: DeptQITeam@alamedaalliance.org

Citations

- American Lung Association: https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/treatment/medication
- American Lung Association: https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/managing-asthma/create-an-asthma-action-plan
- Health and Human Services National Institutes of Health: https://www.nhlbi.nih.gov/files/docs/guidelines/asthma_qrg.pdf
- American Diabetes Association: 2023 Standards of Care in Diabetes: https://professional.diabetes.org/standards-of-care/practice-guidelines-resources
- American Diabetes Association: Therapeutic Inertia Practice Improvement Resources: https://therapeuticinertia.diabetes.org/practice-improvement-resources
- Improving Asthma Care and the Asthma Medication Ratio https://www.partnershiphp.org/Providers/Quality/Documents/Performance%20Improvement%202023/AMR%20Academic%20Detailing%20Deck_3-16-23_COMMS_FINAL_032223_web.pdf
- Asthma Resources https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Asthma.aspx
- BP Average Calculator https://www.ama-assn.org/node/27271
- The Role of Implicit Bias and Culture in Managing or Navigating Healthcare https://www.hss.edu/conditions_role-implicit-bias-culture-managing-navigating-healthcare.asp#affect-healthcare

LifeLong Medical Care
Health Services For All Ages
a california health center

ALAMEDA ALLIANCE FOR HEALTH WEBINAR
CHRONIC CARE MEASURES: DIABETES & HYPERTENSION

April 17th, 2025

QUALITY IMPROVEMENT: WORKFLOWS

Patient Outreach

- Targeted outreach campaigns
- Various modes of outreach

Remote Patient Monitoring Programs

- * BPAH – HTN
- ** RPM (GOJJI) – HTN and DM

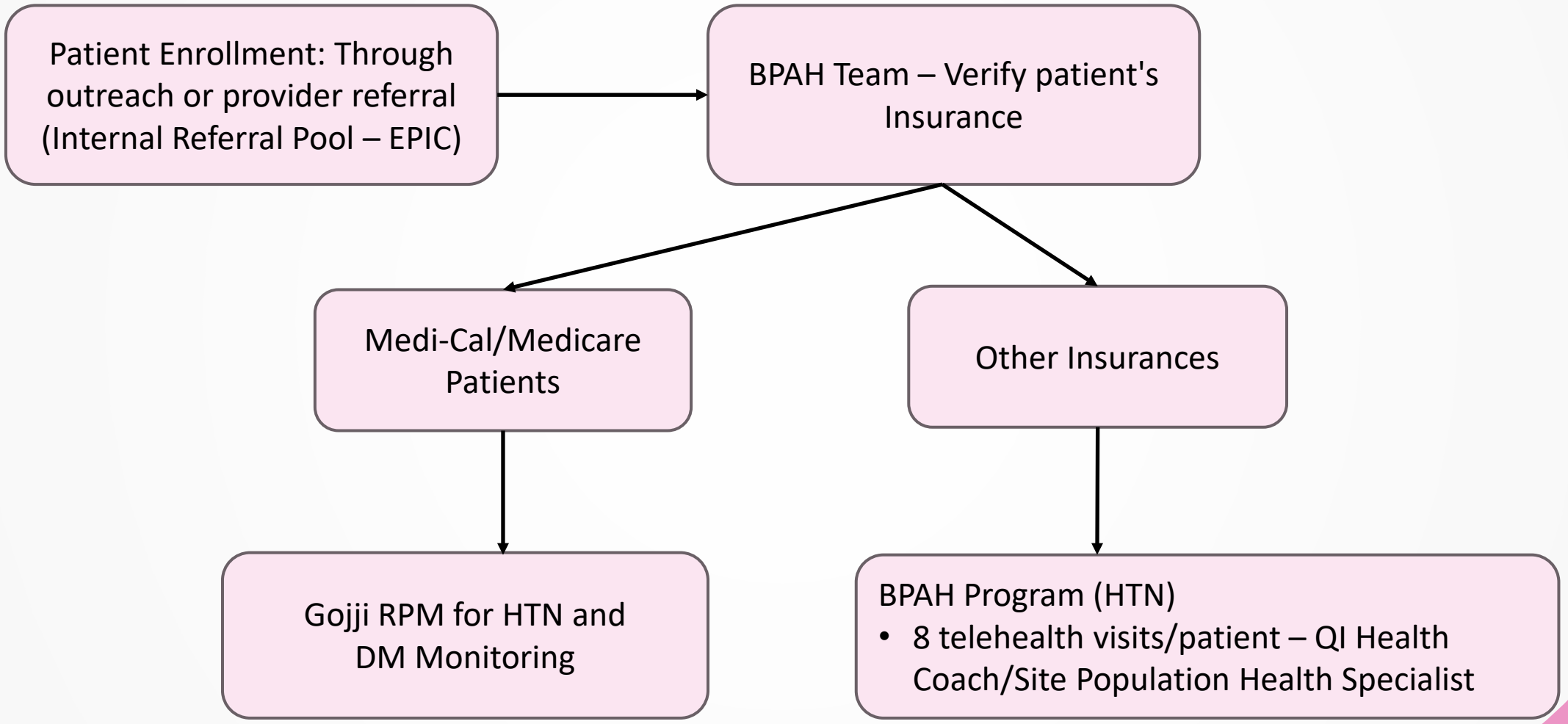
Patient Education

- Educational materials/flyers
- Events to increase awareness

- Major Barriers: Accessibility and lack of awareness

**Blood Pressure at Home Program*
***Remote Patient Monitoring*

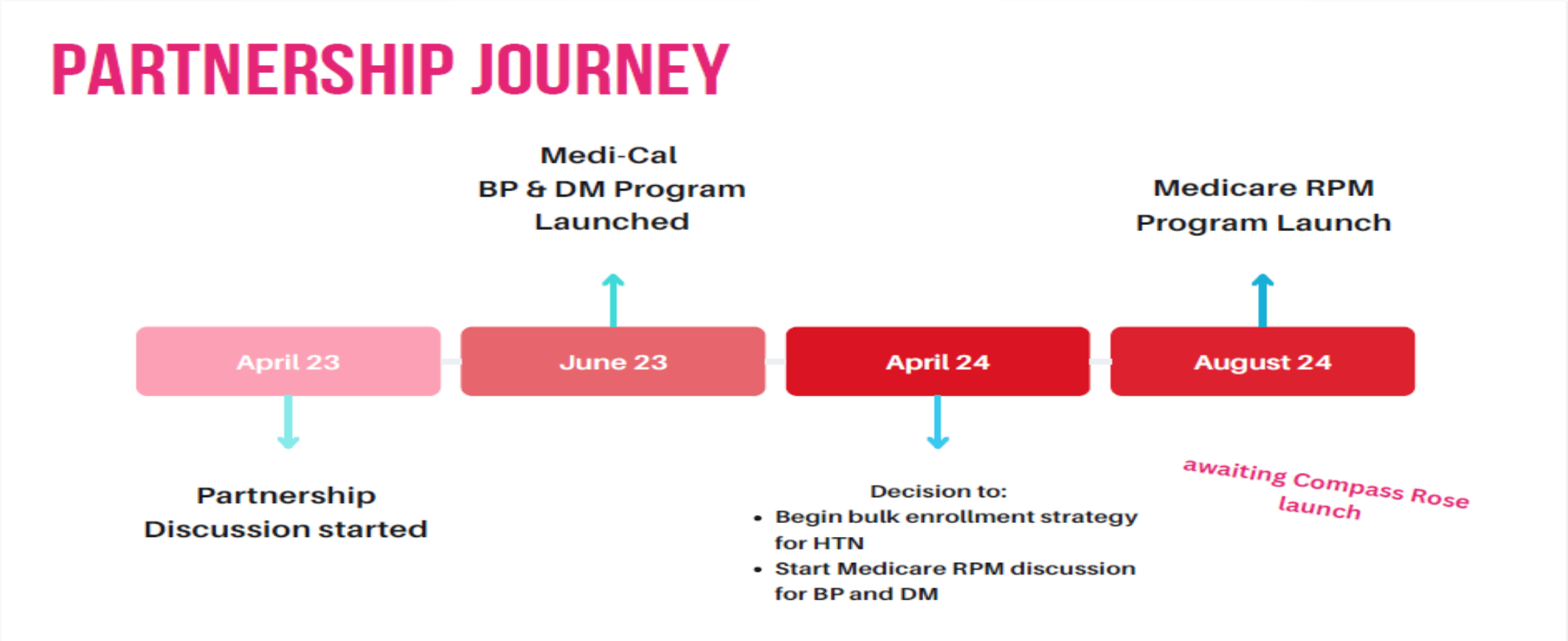
RPM WORKFLOW



BLOOD PRESSURE AT HOME PROGRAM

BPAH Enrollments (Since November 2020 – March 2025	1390
BPAH Outreach Data	Total Outreached: 4794 48% Connected with Post Outreach 22.4% Declined 66% Enrollment Post-Connection
BPAH – Completed 4 Visits	68%
BP Control by 4th Visit	59%
BPAH – Completed 8 Visits	36%
BP Control by 8th Visit	61%

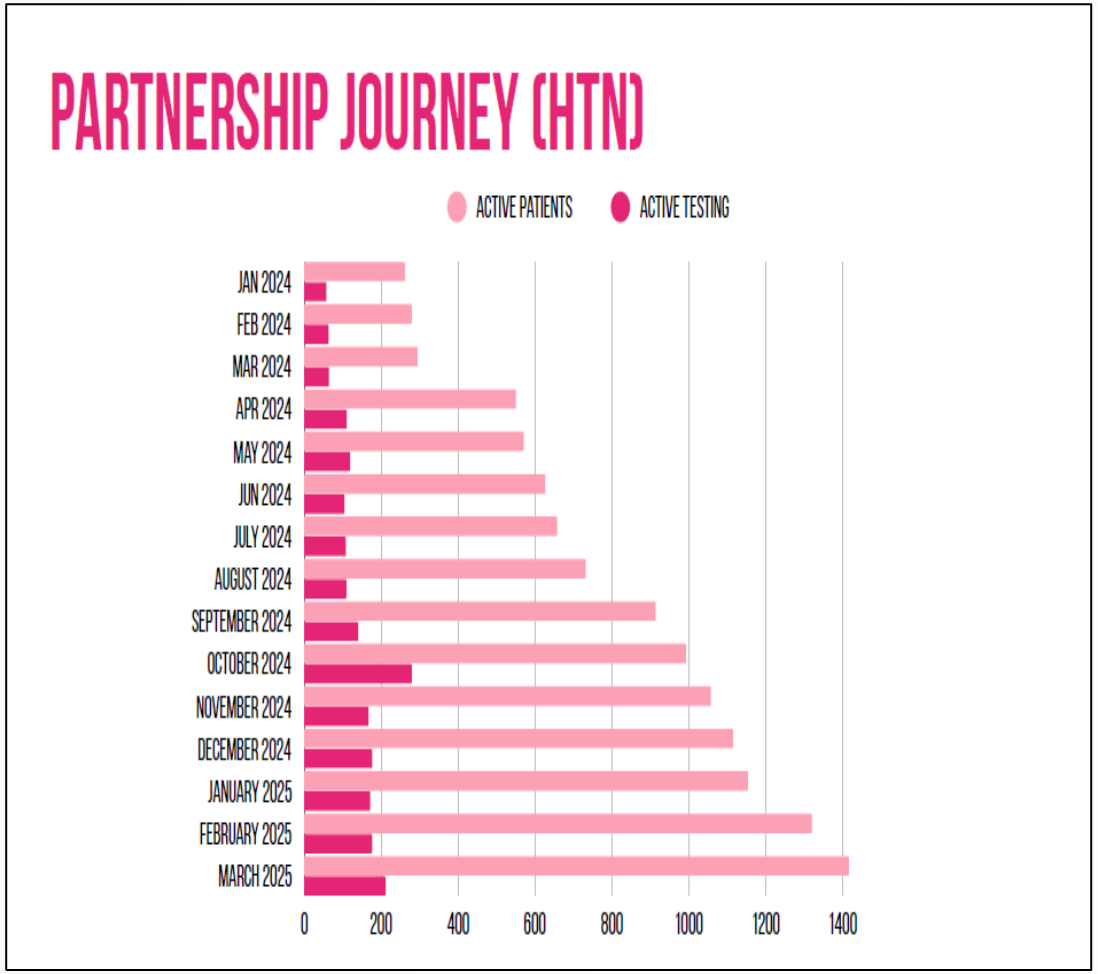
RPM PARTNERSHIP JOURNEY

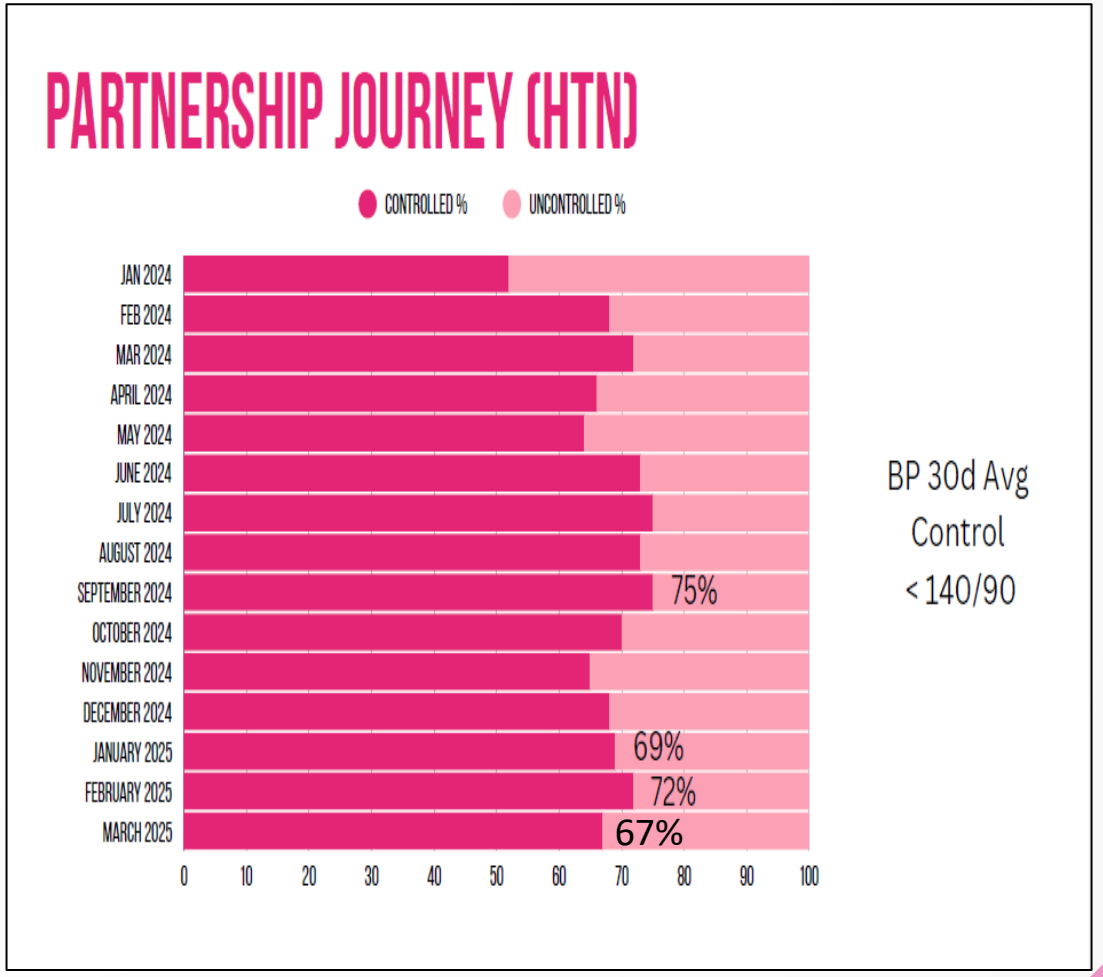


RPM DATA: HTN AND DM

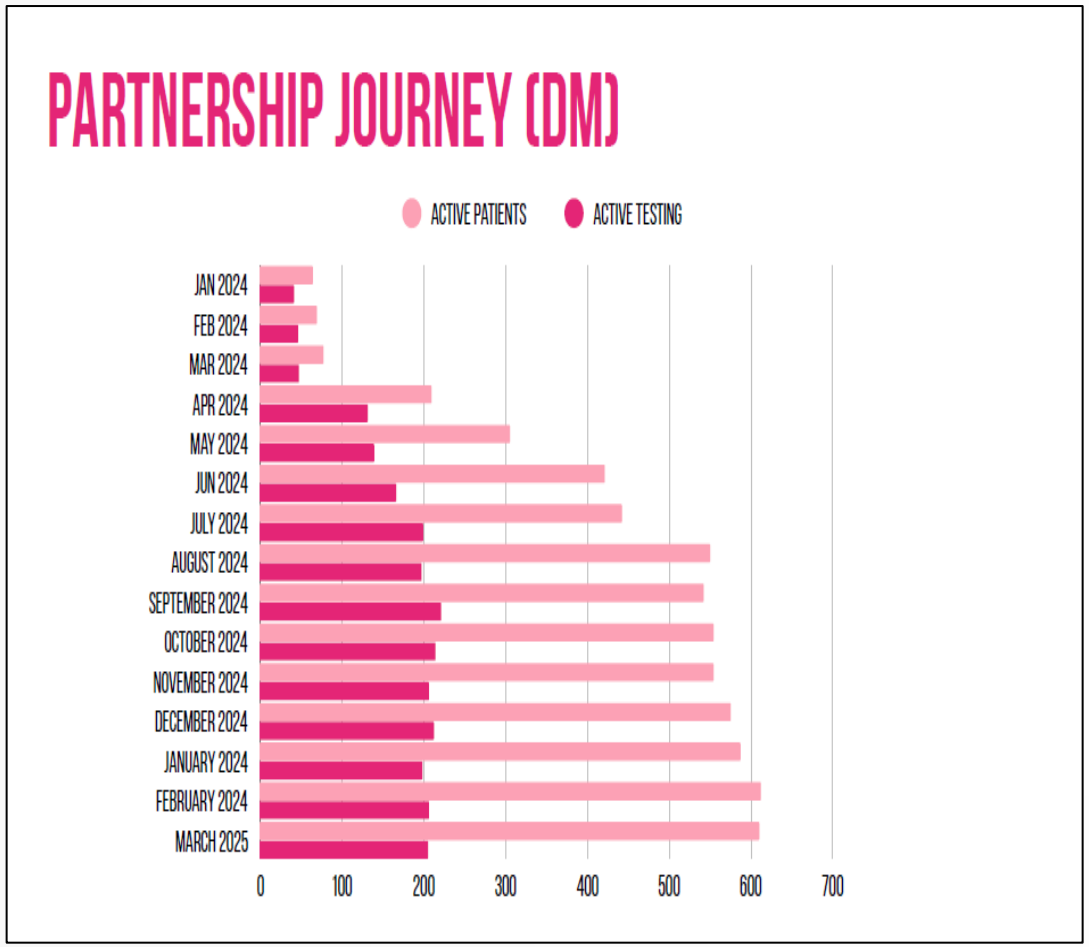
RPM – Gojji Enrollments (June 2023 – March 2025)	HTN: 1,414 DM: 607
Gojji Controlled Definition	HTN: Avg < 140/90 DM: eA1c < 8
% Controlled	HTN: 67% DM: 75%
% Uncontrolled	HTN: 33% DM: 25%

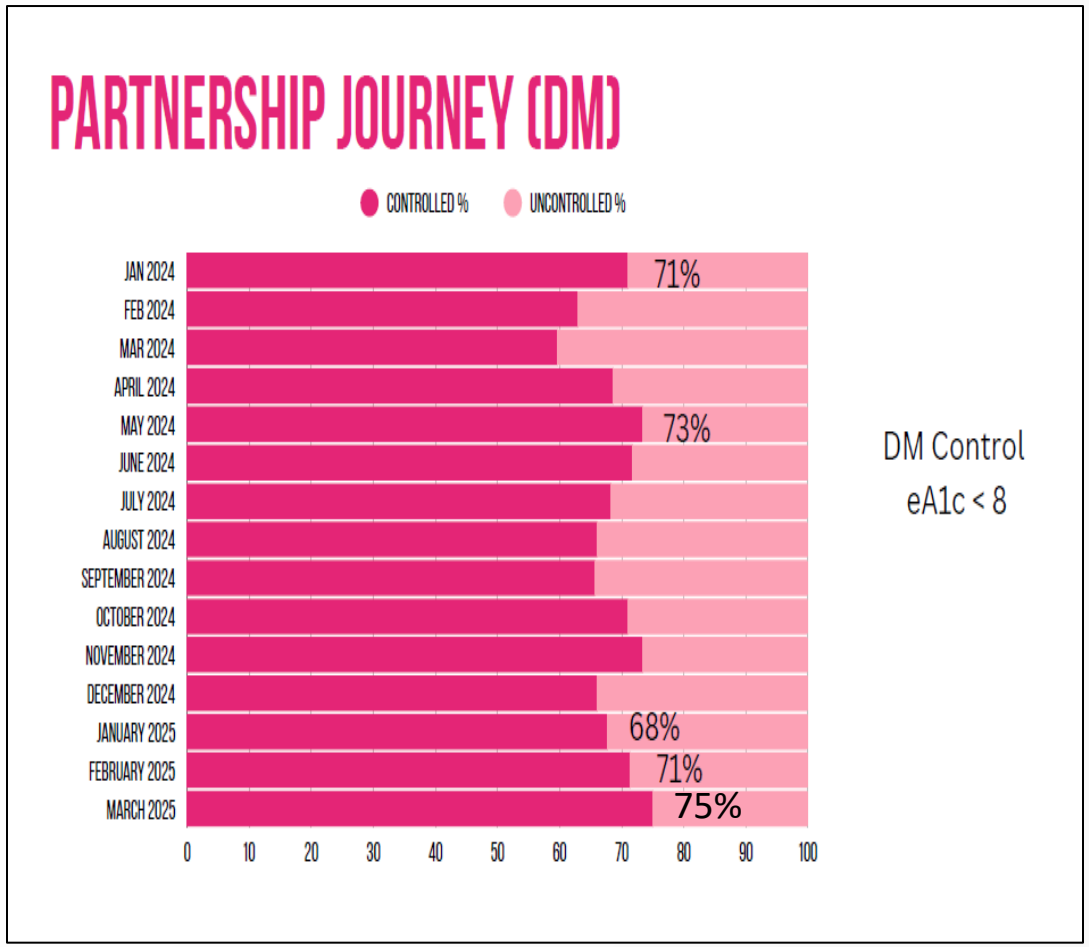
RPM DATA: HYPERTENSION



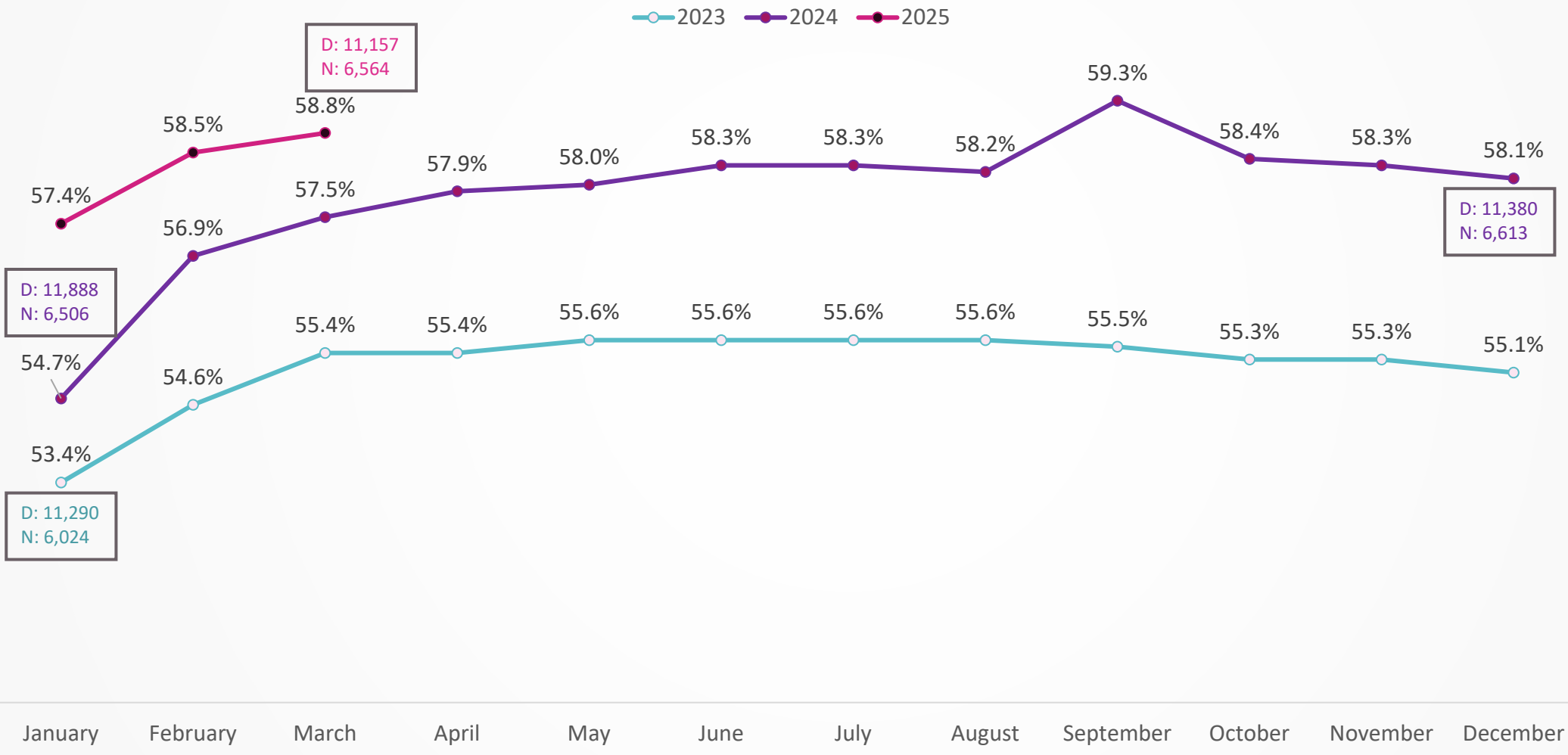


RPM DATA: DIABETES

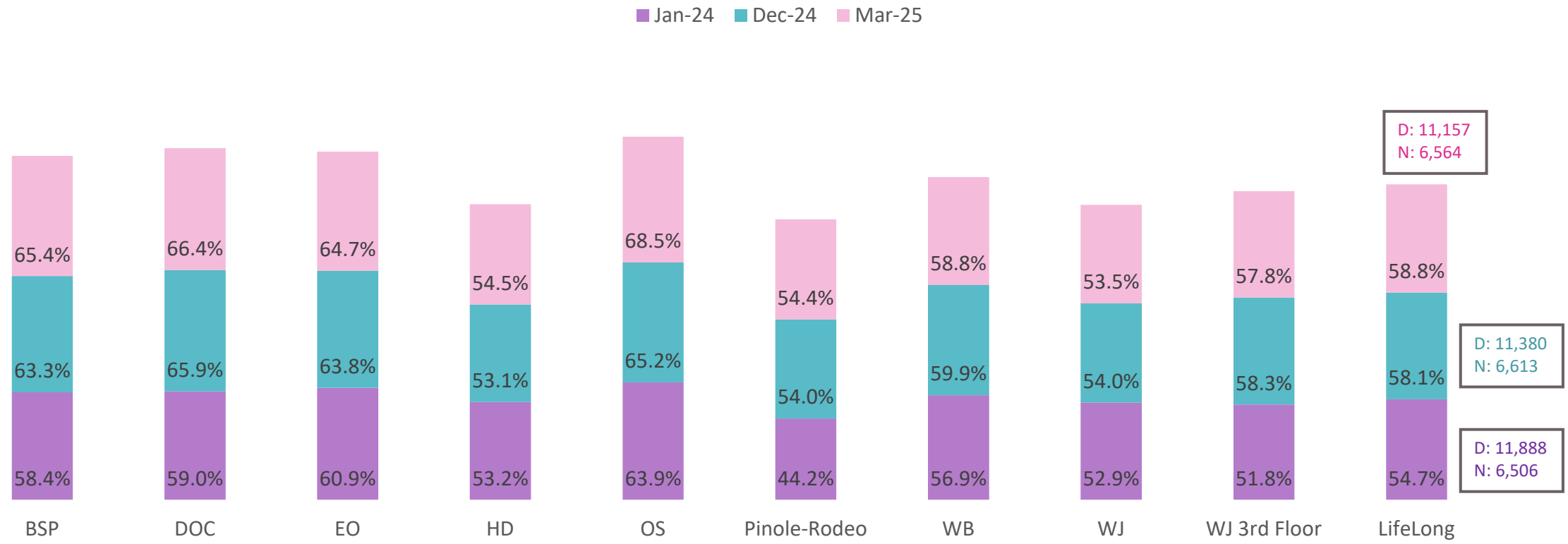




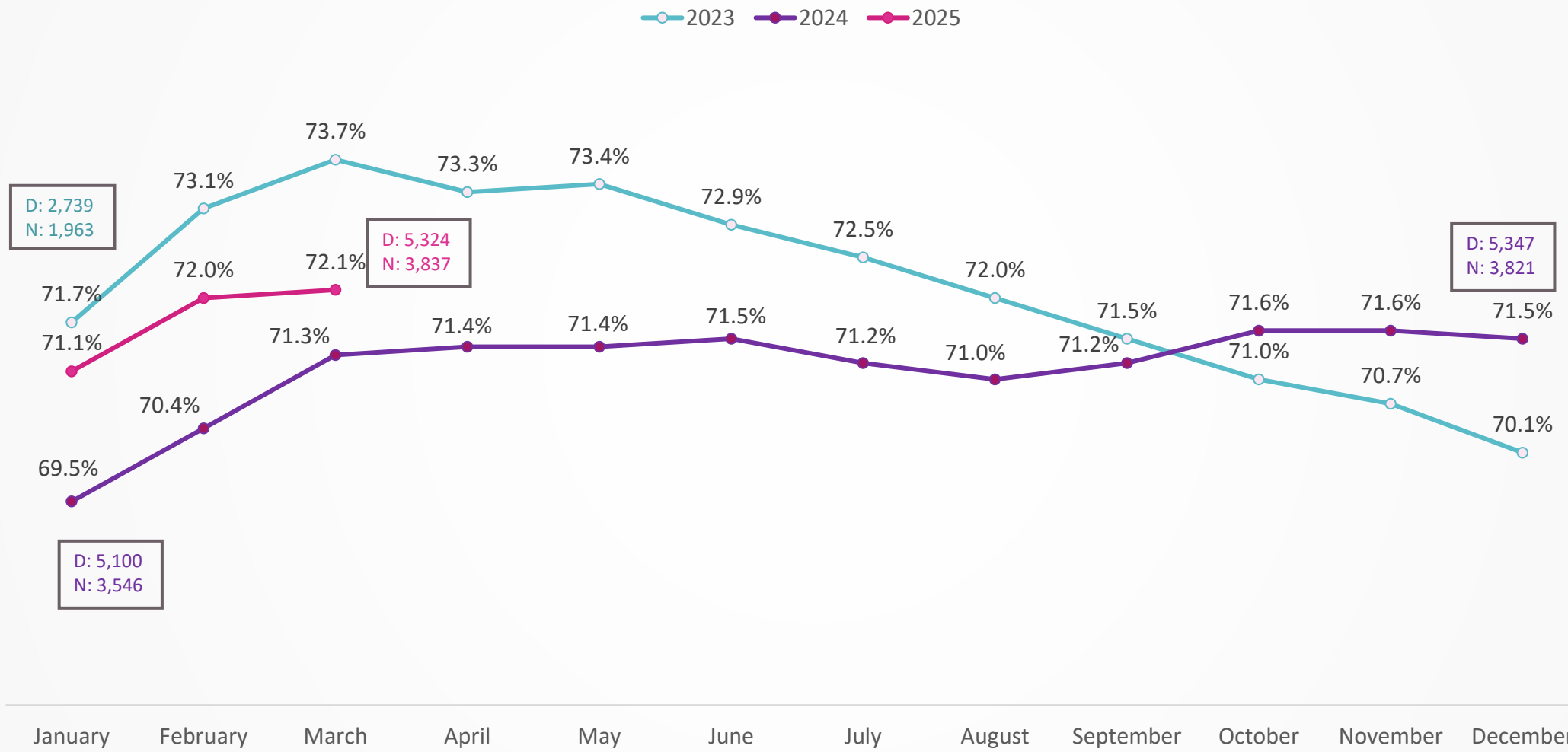
PERFORMANCE RATE: HYPERTENSION



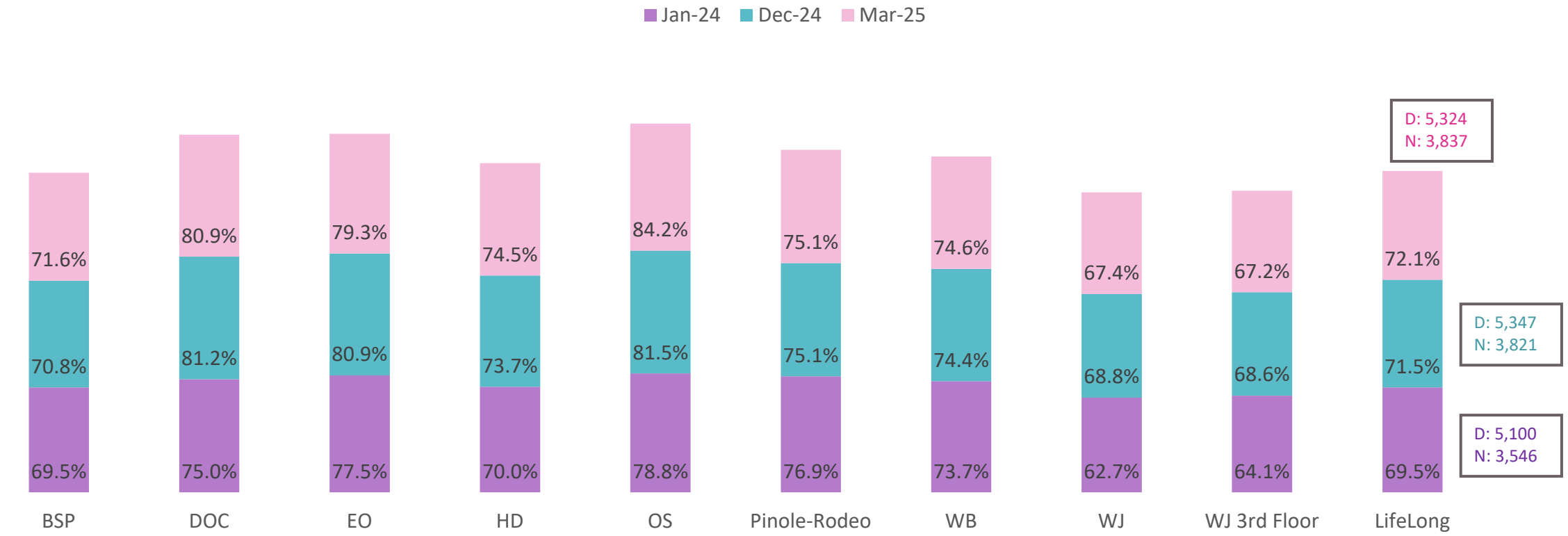
HYPERTENSION PERFORMANCE RATE BY SITES



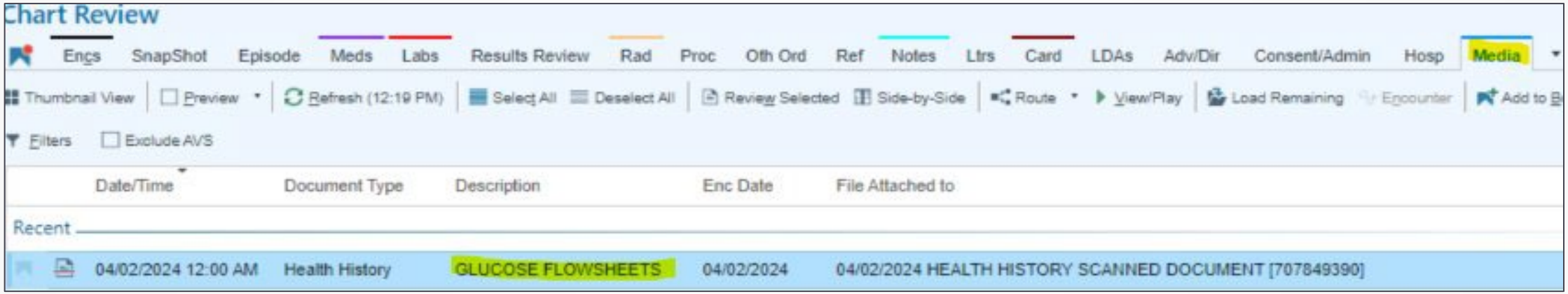
PERFORMANCE RATE: DIABETES

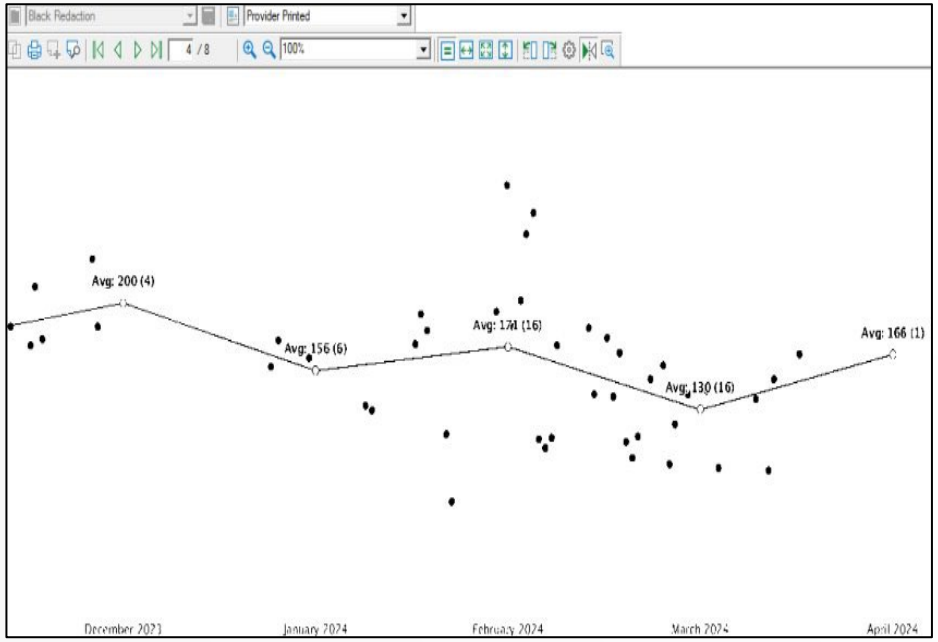


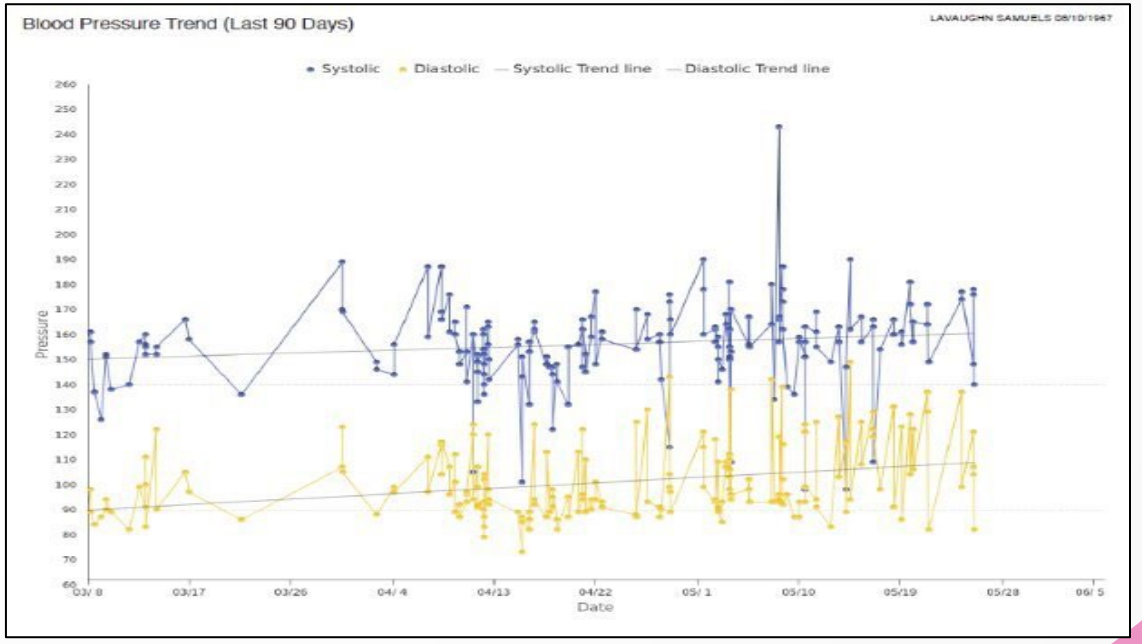
DIABETES PERFORMANCE RATE BY SITES



DOCUMENTATION: EPIC

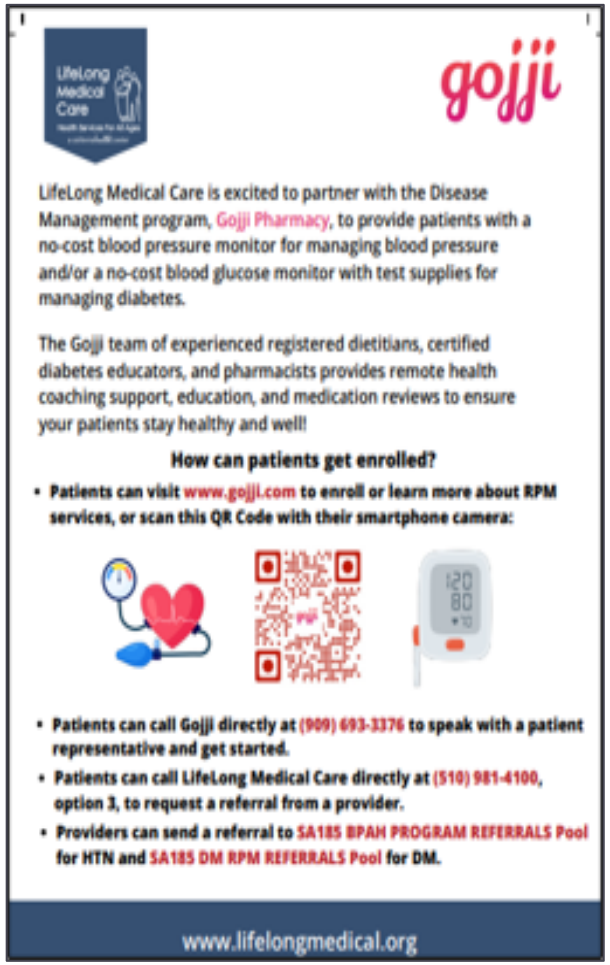






PATIENT AND PROVIDER FLYERS: GOJJI

- Flyers created in English and Spanish
  - Information about Gojji
  - Frequently Asked Questions for Patients and Providers



LifeLong Medical Care is excited to partner with the Disease Management program, Gojji Pharmacy, to provide patients with a no-cost blood pressure monitor for managing blood pressure and/or a no-cost blood glucose monitor with test supplies for managing diabetes.

The Gojji team of experienced registered dietitians, certified diabetes educators, and pharmacists provides remote health coaching support, education, and medication reviews to ensure your patients stay healthy and well!

How can patients get enrolled?

- **Patients can visit www.gojji.com to enroll or learn more about RPM services, or scan this QR Code with their smartphone camera:**
- **Patients can call Gojji directly at (909) 693-3376 to speak with a patient representative and get started.**
- **Patients can call LifeLong Medical Care directly at (510) 981-4100, option 3, to request a referral from a provider.**
- **Providers can send a referral to SA185 BPAH PROGRAM REFERRALS Pool for HTN and SA185 DM RPM REFERRALS Pool for DM.**

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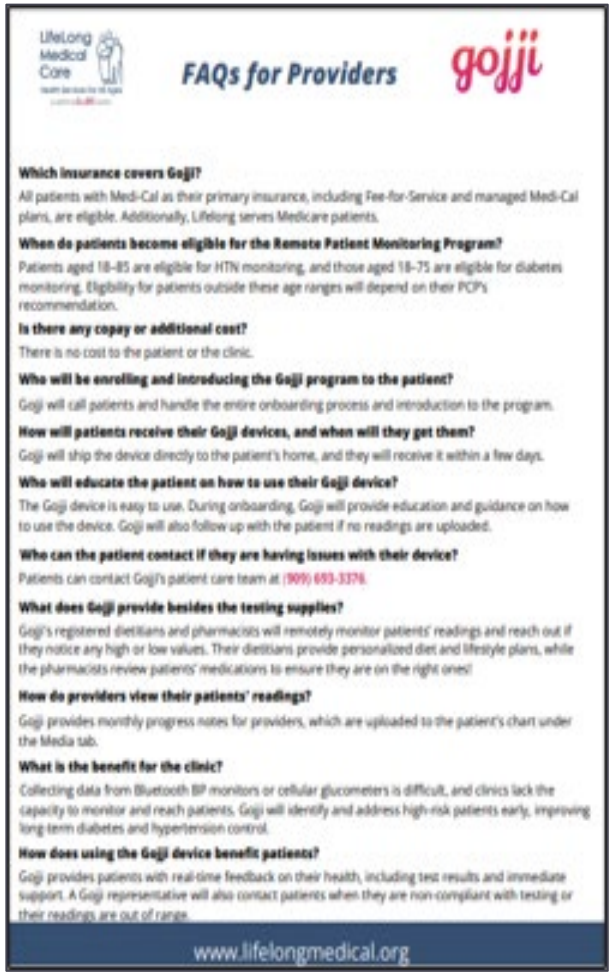

FAQs for Providers

Which insurance covers Gojji?
All patients with Medi-Cal as their primary insurance, including Fee-for-Service and managed Medi-Cal plans, are eligible. Additionally, Lifelong serves Medicare patients.

When do patients become eligible for the Remote Patient Monitoring Program?
Patients aged 18–85 are eligible for HTN monitoring, and those aged 18–75 are eligible for diabetes monitoring. Eligibility for patients outside these age ranges will depend on their PCP's recommendation.

Is there any copay or additional cost?
There is no cost to the patient or the clinic.

Who will be enrolling and introducing the Gojji program to the patient?
Gojji will call patients and handle the entire onboarding process and introduction to the program.

How will patients receive their Gojji devices, and when will they get them?
Gojji will ship the device directly to the patient's home, and they will receive it within a few days.

Who will educate the patient on how to use their Gojji device?
The Gojji device is easy to use. During onboarding, Gojji will provide education and guidance on how to use the device. Gojji will also follow up with the patient if no readings are uploaded.

Who can the patient contact if they are having issues with their device?
Patients can contact Gojji's patient care team at (909) 693-3376.

What does Gojji provide besides the testing supplies?
Gojji's registered dietitians and pharmacists will remotely monitor patients' readings and reach out if they notice any high or low values. Their dietitians provide personalized diet and lifestyle plans, while the pharmacists review patients' medications to ensure they are on the right ones!

How do providers view their patients' readings?
Gojji provides monthly progress notes for providers, which are uploaded to the patient's chart under the Media tab.

What is the benefit for the clinic?
Collecting data from Bluetooth BP monitors or cellular glucometers is difficult, and clinics lack the capacity to monitor and reach patients. Gojji will identify and address high-risk patients early, improving long-term diabetes and hypertension control.

How does using the Gojji device benefit patients?
Gojji provides patients with real-time feedback on their health, including test results and immediate support. A Gojji representative will also contact patients when they are non-compliant with testing or their readings are out of range.

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LifeLong Medical Care is thrilled to partner with Gojji Pharmacy's Disease Management program! Receive a no-cost blood pressure monitor or blood glucose monitor with test supplies for managing blood pressure and/or diabetes. Gojji's team of dietitians, diabetes educators, and pharmacists offer remote health coaching, education, and medication reviews to keep you healthy and well.

How to Enroll?

Call Gojji directly at (909) 693-3376.
Call LifeLong Medical Care directly at (510) 981-4100, option 3, to request a referral from your provider.
Scan this QR Code with your smartphone camera

Frequently Asked Questions:

Which insurance covers Gojji?
All patients with Medi-Cal as their primary insurance, including Fee-for-Service and managed Medi-Cal plans, are eligible. Additionally, Lifelong serves Medicare patients.

When do I become eligible for the Remote Patient Monitoring Program?
Patients aged 18–85 are eligible for hypertension monitoring, and those aged 18–75 are eligible for diabetes monitoring. Eligibility for patients outside these age ranges will depend on their PCP's recommendation.

Who will provide instructions on how to use the Gojji device?
The Gojji device is easy to use. During onboarding, Gojji will provide education and guidance on how to use the device. Gojji will also follow up with you if no readings are uploaded.

How do I receive the Gojji devices? When can I expect to get them?
Gojji will ship the device directly to your home, and you should receive it within a few days.

What does Gojji provide besides the testing supplies?
Gojji's registered dietitians and pharmacists will remotely monitor your readings and contact you if they notice any high or low readings. Their dietitians provide diet and lifestyle plans and their pharmacist review your medications to make sure you are on the right ones!

Who should I contact if I have issues with the Gojji device?
You can reach Gojji's care team at (909) 693-3376.

Is there a cost?
There is no cost to the patient.

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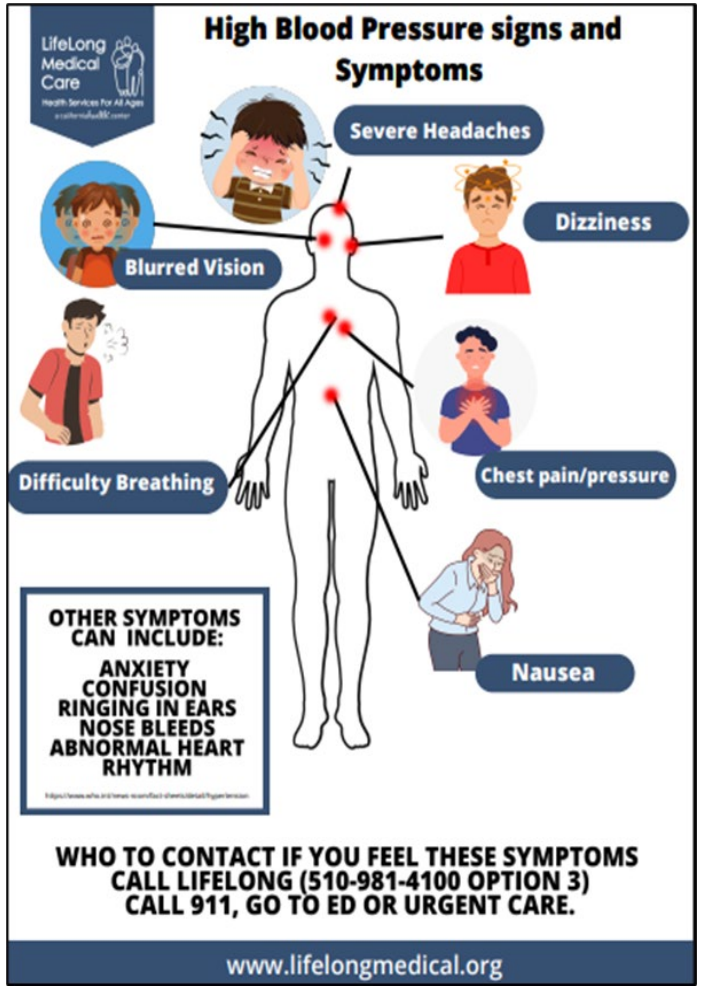
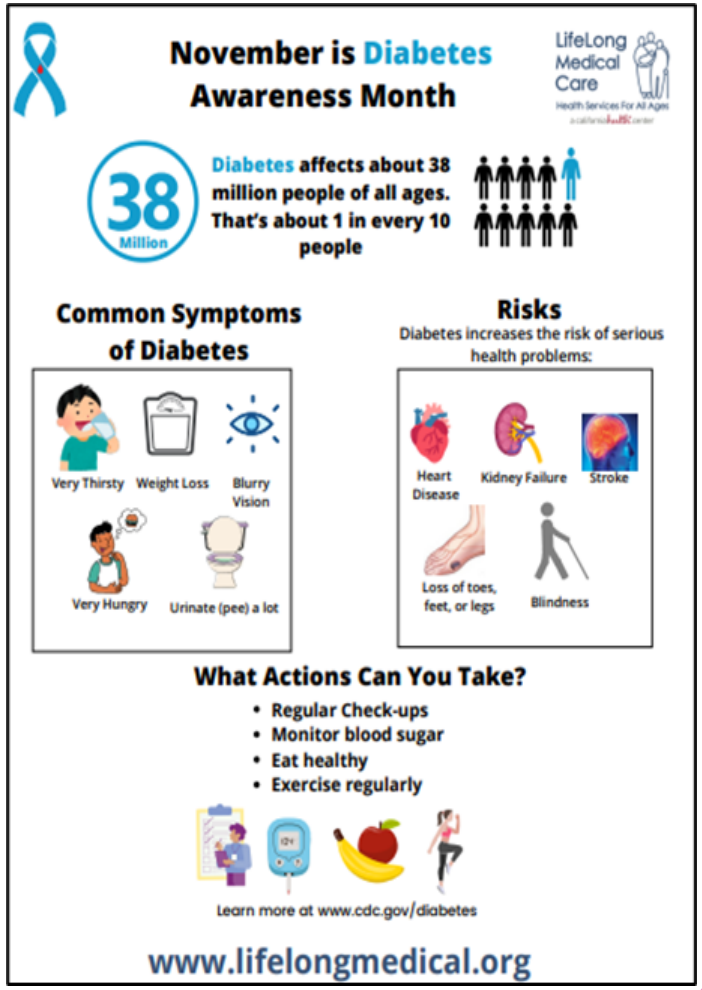
PATIENT EDUCATION MATERIALS





2025 QUALITY IMPROVEMENT INITIATIVES

- Reengagement through targeted outreach for Gojji enrolled patients (HTN/DM Program):
  - Stratify patients into 3 categories for outreach (patient incentives)
    - Not actively testing for 3 months: BP readings or BG readings or eA1C readings
    - Not actively testing for 6 months: BP readings or BG readings or eA1C readings
    - Not actively testing for >6 months: BP readings or BG readings or eA1C readings
- Educational awareness campaigns using flyers
  - Reminders to patients to send their blood pressure readings/blood glucose readings
  - Patient enrollment to RPM programs and about the benefits of timely health checks.
- OCHIN EPIC Integration

CONTACT INFORMATION

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LifeLong Medical Care
Health Services For All Ages
a california health center

THANK YOU!