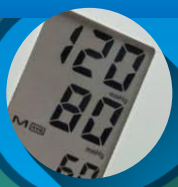
Diabetes Roadmap

HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE
A Division of the UCF College of Medicine

Goals
Define goals for a diabetes management program using evidence-based guidelines



CQMs
Utilize the appropriate CQM measures needed to track diabetes

Documentation
Define the key types of documentation required in the EHR and claims

Optimizing
Implement best practices for managing diabetes within the practice

Population Health
Identify and effectively manage your diabetic patient population

Provider Tips
Tips and tricks to better manage your diabetic population

Managing Disparities
Know and address the challenges of patients with or at risk of diabetes

Coding Considerations
Document social determinants of health and use combination codes

Federal & State Initiatives
Federal and state programs to increase diabetes prevention and management

Resources
Available diabetes resources for providers and patients

This project is supported by the Improving the Health of Floridians through Prevention and Management of Diabetes, Heart Disease, and Stroke Cooperative Agreement number NU58DP006550, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Diabetes Roadmap

HealthARCH
ADVANCING RESOURCES TO CHANGE HEALTHCARE
A Division of the UCF College of Medicine

Goals

- Reduce risks factors causing Type 2 diabetes
- Improve preventive services regarding diabetes
- Improve patient's health literacy about diabetes

Documentation

- Document medical risk factors such as family history, obesity, or history of gestational diabetes
- Document lab tests as structured data
- Enter care plans and documents received from other specialists
- Document results of yearly retinopathy exam

Population Health

- Consider Clinical Information Systems (e.g. registries) that can provide patient-specific and population-based support to the care team
- Assess social context (i.e. food insecurities, housing stability, and financial barriers) and apply that information to treatment decisions
- Adopt a patient-centered communication style that includes patient preferences, assesses health literacy, and addresses cultural barriers to care

Managing Disparities

- Address specific groups in the community
- Wellness programs
- Educational programs
- Preventive care services

Federal & State Initiatives

- National Diabetes Prevention Program
- ADA recognized/AADE accredited Diabetes Self-Management Education and Support (DSMES) Programs
- 6|18 Initiatives Diabetes

CQMs

- CMS122v7 (NQF 0059)
- Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

Optimizing

- Identify barriers in the EHR system
- Optimize health literacy/education
- Provide patient portal access
- Develop EHR templates

Provider Tips

- Personal Care Plan addressing personal and clinical goals, including exercise plan, diet plan, medication adherence, smoking cessation, and reducing use of alcohol and salt

Coding Considerations

- Use Z codes for family history & social determinants
- Use combination codes for diabetes with complications
- Use additional codes to document site and stage of skin ulcer, and stage of CKD

Resources

- Prevent Diabetes STAT – https://preventdiabetesstat.org/
- NDPP Coverage Toolkit – https://coveragetoolkit.org/
- DSMES Toolkit – https://www.cdc.gov/diabetes/dsmes-toolkit/index.html

For more information on the project and additional resources, please visit the HealthARCH project website at: www.healtharch.org/improvingthehealthoffloridians