Prediabetes Roadmap



Goals

Define goals for a prediabetes program using evidence-based guidelines

Documentation

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

Population Health

Identify and effectively manage your prediabetic patient population

Managing Disparities

Know and address the challenges of patients with prediabetes

Federal & State Initiatives

Federal and state programs to increase diabetes prevention



CQMs

Utilize appropriate clinical quality measures to track prediabetes

Optimizing

Implement best practices for managing prediabetes within the practice

Provider Tips

Tips and tricks to better manage your prediabetic population

Coding Considerations

Document
Prediabetes and
social determinants
of health

Resources

Available prediabetes 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.

Prediabetes Roadmap



GOALS

- To reduce risks factors causing Prediabetes
- To improve preventive services regarding Prediabetes
- To improve patient's health literacy about Prediabetes

Documentation

Document lab tests as structured data

Create templates for use with patients who

Population Health

Clinical Information Systems (e.g. registries)

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

that can provide patient-specific and

gestational diabetes

are pre-diabetic

Document medical risk factors such as family history of diabetes, obesity, or history of



*CQMs



- Screening for Abnormal Blood Glucose in Overweight/Obese Patients
- Screening for Abnormal Blood Glucose in High Risk Patients
- Intervention for Prediabetes
- Retesting of Abnormal Blood Glucose in Patients with Prediabetes



Optimizing

- Identify barriers in the EHR system
- Optimize health literacy/education
- Patient portal access
- Develop EHR templates/Order sets

-• Q

Provider Tips

Personal Care Plan addressing personal goals, clinical goals, including exercise plan, diet plan, medication adherence, and modifying habits such as smoking cessation and reducing use of alcohol and colt



Coding Considerations

- Document code R73.03 for Prediabetes
- Use Z codes for family history & social determinants of health

Managing Disparities

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

cultural barriers to care



Resources



- Prevent Diabetes STAT https://preventdiabetesstat.org/
- NDPP Coverage Toolkit https://coveragetoolkit.org
- NCQA: Diabetes Recognition Program (DRP). https://www.ncqa.org/programs/health-care-providers-practices/diabetes-recognition-program-drp/



Federal & State Initiatives

- National Diabetes Prevention Program (DPP)
- ADA recognized/AADE accredited Diabetes Self-Management Education and Support
- 6|18 Initiatives Diabetes
- * Measures developed and proposed by the American Medical Association's (AMA) Prediabetes Quality Measures Technical Expert Panel.

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