Prediabetes Fact Sheet and Roadmap

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

Goals

- Identify interventions to modify risk factors to preventing type 2 diabetes
- Establish policies to increase implementation of standardized quality improvement procedures to screen patients for diabetes and refer them to appropriate diabetes prevention interventions
- Maximize electronic health record (EHR) technology through use of trackable and reportable quality measures
- Establish targets and benchmarks to evaluate improvement efforts and outcomes routinely
- Increase value-based reimbursement through improved performance on quality improvement activities
- Use evidence-based practices to address and reduce health disparities in prediabetes

***CQMs**

- Screening for Abnormal Blood Glucose in Overweight/Obese Patients
  - Percentage of patients aged 40 to 70 years who are overweight or obese who are seen for at least two visits or at least one preventive visit during the 12-month measurement period who were screened or have documented previous results for abnormal blood glucose at least once in the last 3 years
- Screening for Abnormal Blood Glucose in High Risk Patients
  - Percentage of patients aged 18 years and older who have risk factors for diabetes who were seen for at least two office visits or one preventive visit in the 12-month measurement period who were screened or have documented previous results for abnormal blood glucose at least once in the last 3 years
- Intervention for Prediabetes
  - Percentage of patients aged 18 years and older with identified abnormal lab result in the range of prediabetes during the 12-month measurement period who were provided an intervention
- Retesting of Abnormal Blood Glucose in Patients with Prediabetes
  - Percentage of patients aged 18 years and older who had an abnormal fasting plasma glucose, oral glucose tolerance test, or hemoglobin A1c result in the range of prediabetes in the previous year who have a blood glucose test performed in the one-year measurement period

**Measures developed and proposed by the American Medical Association's (AMA) Prediabetes Quality Measures Technical Expert Panel. There are currently no relevant quality measures for Merit-based Incentive Payment System (MIPS) for Prediabetes.*

Documentation

- Document risk factors (such as family history, race, ethnicity), environmental factors, and clinical signs (i.e. weight, age) in individuals at risk for diabetes
- Document social determinants of health such as potential food insecurity, housing stability, and financial situation
- Evaluate for prediabetes-related complications and comorbidities

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Optimizing

- Clinical practice workflows
- Organize your practice for efficiency
- Optimize use of your EHR and health IT to determine who needs to be screened/rescreened
- Empower patients through proactive reminders/outreach, patient education, and patient portal access
- Discuss the benefits of a team-based approach to assist individuals with prediabetes to achieve their target goals and objectives

Population Health

- 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

- Better understanding needed regarding variables that influence behaviors that lead to obesity, prediabetes and diabetes
- Identify or develop community resources to support healthy lifestyles
- Refer patients to local community resources when available
- Develop or offer prediabetes educational programs and materials in multiple languages to facilitate the knowledge and skills necessary for diabetes prevention
- Utilize health IT (EHR) to outreach to vulnerable populations needing preventative care services

Provider Tips

- Be proactive in an effort to improve outcomes (screen/rescreen)
- Use shared decision-making tools to create a management plan
- Management plan to include personal goals (changes in lifestyle), clinical goals, and medication adherence
- Provide patients with prediabetes self-management education and support
- Continually screen for modifiable risk factors (i.e. physical inactivity, obesity, hypertension, and smoking) at each interaction
- Increase use of pharmacist-patient care processes that help people with prediabetes manage their medication

Coding Considerations

- Document diagnosis code R73.03 for prediabetes
- Use a Healthcare Common Procedure Coding System (HCPCS) code for A1c Levels
- Use Z codes for family history and social determinants of health

Federal & State Initiatives

- National Diabetes Prevention Program (DPP) – https://www.cdc.gov/diabetes/prevention/index.html
- ADA recognized/AADE accredited Diabetes Self-Management Education and Support Programs – https://www.cdc.gov/diabetes/programs/stateandlocal/resources/self-management-education-support.html
- Centers for Disease Control and Prevention's 6 |18 Initiative: Prevent Type 2 Diabetes – https://www.cdc.gov/sixeighteen/diabetes/index.htm

Resources

- Prevent Diabetes STAT – https://preventdiabetesstat.org/
- NDPP Coverage Toolkit – https://coveragetoolkit.org/
- NCQA Diabetes Recognition – https://www.ncqa.org/programs/health-care-providers-%20practices/diabetes-recognition-program-drp/