Diabetes Prevention, Diagnosis and Treatment Guide

NYC Health

Every office visit is an opp

1. Assess Diabetes Risk

Is your patient aged 45 years or older?

No

Is your patient aged 18 years or older and overweight or obese (BMI ≥25 kg/m2 or ≥23 kg/m2 in Asian Americans)?

Yes

Yes

See 2. Determine Diagnosis

Does your patient have one or more additional risk factors?

- Physical inactivity
- First-degree relative with diabetes
- High-risk race/ethnicity (e.g., Black, Latino, Native American, Asian American, Pacific Islander)
- History of gestational diabetes mellitus diagnosis (GDM)
- History of delivering a baby weighing greater than 9 lbs
- Polycystic ovary syndrome
- Hypertension (≥140/90 mmHg or on therapy for hypertension)
- HDL cholesterol level <35 mg/dL and/or a triglyceride level >250 mg/dL
- Hemoglobin A1C 5.7-6.4 percent, impaired glucose tolerance or impaired fasting glucose on previous testing
- History of cardiovascular disease
- Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)

No

Counsel the patient on healthy eating and increasing physical activity.

Yes

See 2. Determine Diagnosis

Create a team-based workflow in your

- **Who will assess the patient's medical chart and/or vital signs for diabetes screening eligibility (front desk team, medical assistant, nurse or other provider)?**

portunity to help your patients p

2. Determine Diagnosis

A. Order one of the following tests:

- Hemoglobin A1C (A1C)
- Fasting plasma glucose (FPG)
- Oral glucose tolerance test (OGTT)

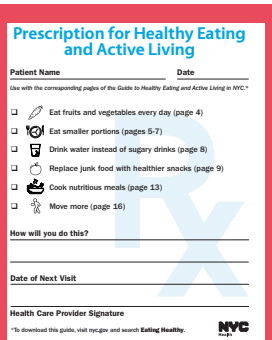
Test Range

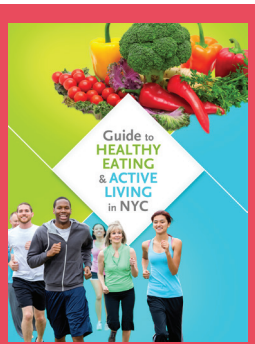
Diagnostic Test	Normal	Prediabetes	Diabetes*
A1C (%)	<5.7	5.7-6.4	≥6.5
FPG (mg/dL)	<100	100-125	≥126
OGTT (mg/dL)	<140	140-199	≥200

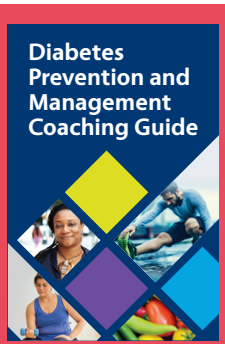
*Confirm patient's diagnosis with retesting

B. Document patients' lab results in their medical record.

Refer to the ***Prescription for Healthy Eating and Active Living***, the ***Guide to Healthy Eating & Active Living in NYC***, and the ***Diabetes Prevention and Management Coaching Guide*** for ways to reframe this issue and help your patients make positive changes to improve their health.







practice to optimize diabetes prevention.

- **Who will counsel and discuss the importance of screening?**
- **Who will acknowledge an abnormal test result and address it with the patient?**

prevent or delay diabetes.

3a. Counsel and Refer Patients

Normal Range

- Counsel patients on the importance of a healthy diet and physical activity.
- Retest asymptomatic patients every three years. More frequent testing may be considered based on risk factors.

Prediabetes Range

- Counsel patients on the importance of a healthy diet and physical activity.
- Refer patients to a local CDC-recognized National Diabetes Prevention Program (NDPP). For referral instructions, see the Refer Your Patients to an Evidence-Based Intervention: Type 2 Diabetes Prevention and Self-Management Services fact sheet.
- Consider annual retesting of patients in this range.

NDPP Eligibility Exception for Women with History of GDM

If a patient is 18 years or older and has a BMI per NDPP eligibility criteria and has a history of GDM, she is eligible for NDPP even if she has a normal range glycemic test result.

NDPP Eligibility Considerations†

In addition to a positive screening test, participants must be 18 years or older *and* have a BMI ≥24 kg/m2 (≥22 kg/m2 in Asian Americans) *and* no previous history of diabetes mellitus type 1 or 2.‡

- Document the referral in the patient's medical record.
- Consider retesting annually to check for diabetes onset.

†Eligibility as per CDC NDPP program eligibility guidelines: visit cdc.gov and search **NDPP program eligibility**.

‡Note: The BMI criteria for NDPP enrollment is set lower than ADA diabetes screening criteria.

Diabetes Range

- Counsel patients on their diagnosis and the importance of a healthy diet and physical activity.
- Initiate therapy as indicated.
- Refer to Diabetes Self-Management Program (DSMP). ***(See back panel for additional information.)***

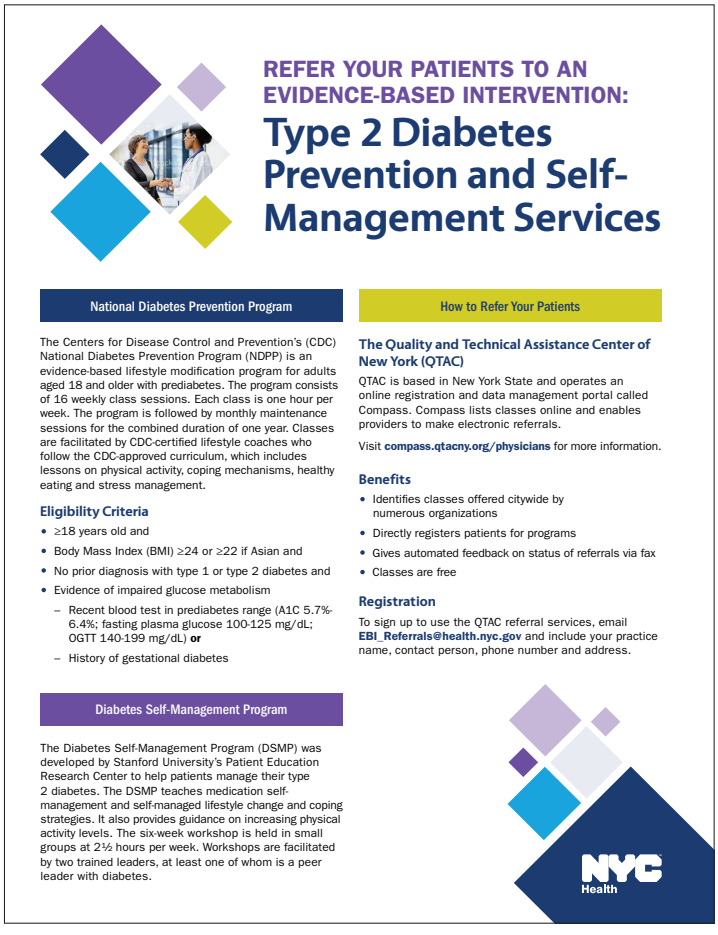
- **Who will discuss lab results with the patient?**
- **Who will provide supportive counseling?**
- **Who will identify patients with NDPP eligibility for a possible referral? When will this happen?**
- **Who will facilitate the NDPP referral?**
- **Who will document and follow up with the patient to confirm enrollment and progress in NDPP classes?**

Help your patients manage their diabetes with additional resources.

3b. Refer Patients

Does your patient have type 2 diabetes mellitus?

If yes, refer the patient to a local Diabetes Self-Management Program (DSMP) to learn more about lifestyle changes (e.g., healthy eating, appropriate use of medication and exercise) and coping strategies to better manage their diabetes. For referral instructions, see the Refer Your Patients to an Evidence-Based Intervention: Type 2 Diabetes Prevention and Self-Management Services fact sheet.



REFER YOUR PATIENTS TO AN EVIDENCE-BASED INTERVENTION:

Type 2 Diabetes Prevention and Self-Management Services

National Diabetes Prevention Program

The Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (NDPP) is an evidence-based lifestyle modification program for adults aged 18 and older with prediabetes. The program consists of 16 weekly class sessions. Each class is one hour per week. The program is followed by monthly maintenance sessions for the combined duration of one year. Classes are facilitated by CDC-certified lifestyle coaches who follow the CDC-approved curriculum, which includes lessons on physical activity, coping mechanisms, healthy eating and stress management.

Eligibility Criteria

- ≥18 years old and
- Body Mass Index (BMI) ≥24 or ≥22 if Asian and
- No prior diagnosis with type 1 or type 2 diabetes and
- Evidence of impaired glucose metabolism
  - Recent blood test in prediabetes range (A1C 5.7%-6.4%; fasting plasma glucose 100-125 mg/dL; OGTT 140-199 mg/dL) **or**
  - History of gestational diabetes

Diabetes Self-Management Program

The Diabetes Self-Management Program (DSMP) was developed by Stanford University's Patient Education Research Center to help patients manage their type 2 diabetes. The DSMP teaches medication self-management and self-managed lifestyle change and coping strategies. It also provides guidance on increasing physical activity levels. The six-week workshop is held in small groups at 2½ hours per week. Workshops are facilitated by two trained leaders, at least one of whom is a peer leader with diabetes.

How to Refer Your Patients

The Quality and Technical Assistance Center of New York (QTAC)

QTAC is based in New York State and operates an online registration and data management portal called Compass. Compass lists classes online and enables providers to make electronic referrals.

Visit **compass.qtacny.org/physicians** for more information.

Benefits

- Identifies classes offered citywide by numerous organizations
- Directly registers patients for programs
- Gives automated feedback on status of referrals via fax
- Classes are free

Registration

To sign up to use the QTAC referral services, email **EBI_Referrals@health.nyc.gov** and include your practice name, contact person, phone number and address.

NYC Health

Create a team-based workflow for patients interested in a DSMP.

- **Who will refer patients to a DSMP class (front desk, medical assistant, nurse or provider)?**
- **Who will follow up with the patient to confirm enrollment in a DSMP class?**
- **Who will discuss the impact of the DSMP class with the patient and integrate it into her or his care plan?**

Resources:

American Diabetes Association. Classification and diagnosis of diabetes. Sec. 2. in Standards of Medical Care in Diabetes-2016. Diabetes Care 2016;39(Suppl. 1):S13-S22.

National Diabetes Prevention Program. Accessed January 2017. cdc.gov/diabetes/prevention

Diabetes Self-Management Program. Accessed January 2017. patienteducation.stanford.edu


NYC
Health