



Virginia Center for Diabetes Prevention and Education



VIRGINIA DIABETES PREVENTION PROGRAM NETWORKING MEETING 2019



Virginia Center for Diabetes Prevention and Education



Where are we with Diabetes Prevention in Virginia?

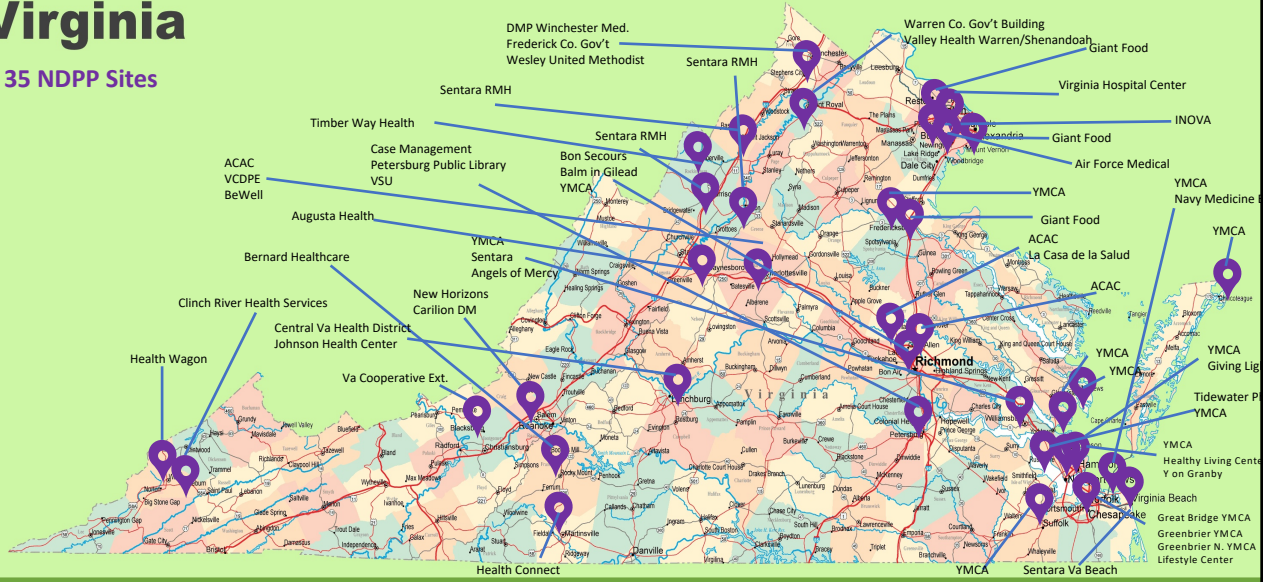
Annual Networking Meeting 2019

Viola Holmes, MS, RD, CDE



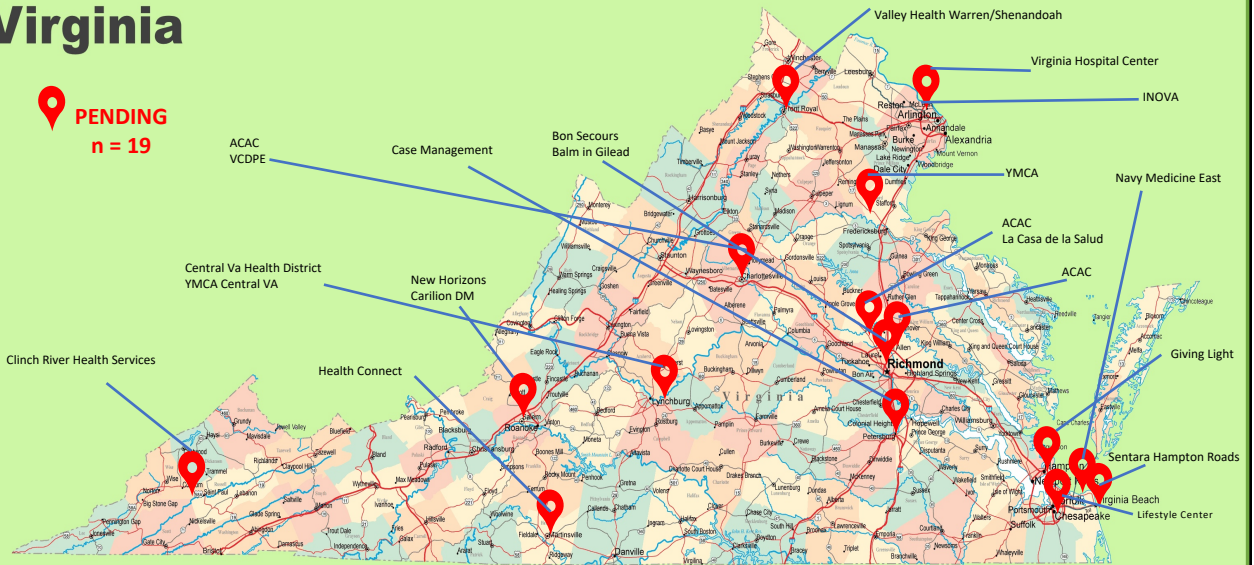
Virginia

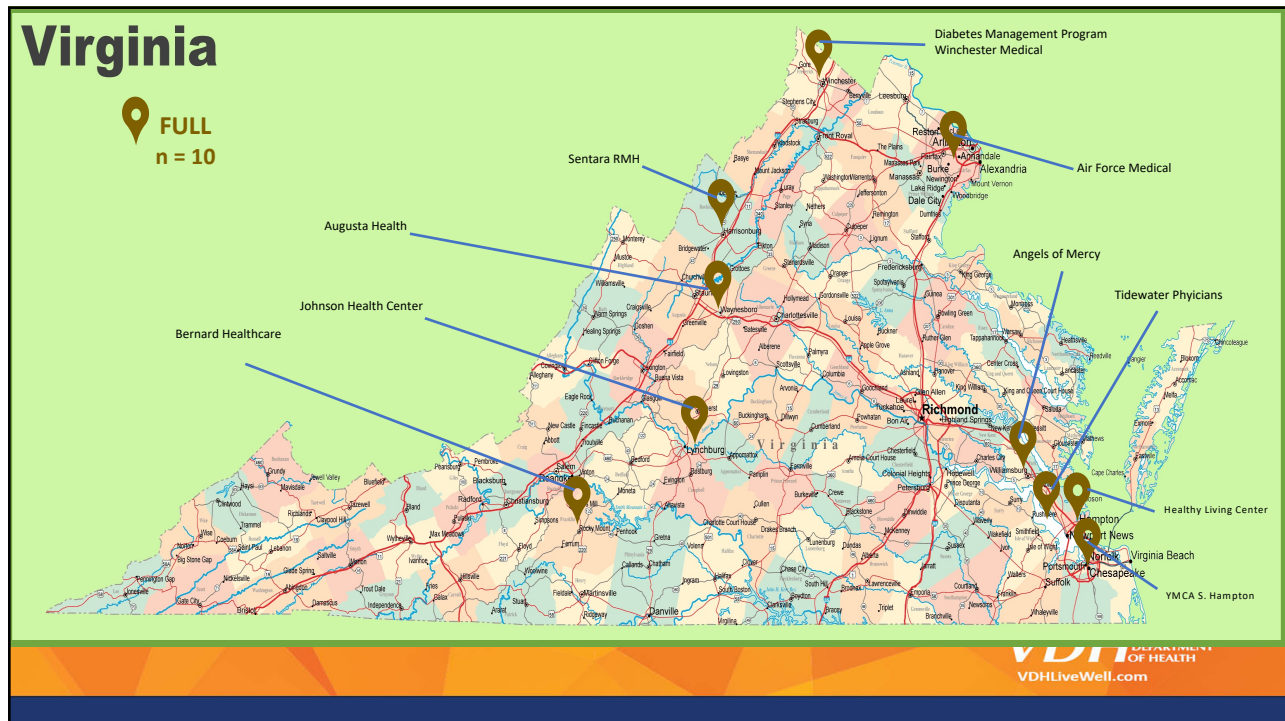
35 NDPP Sites



Virginia

PENDING
n = 19





Comparison of the types and number of sites 2018 to 2019

35 sites in April 2019

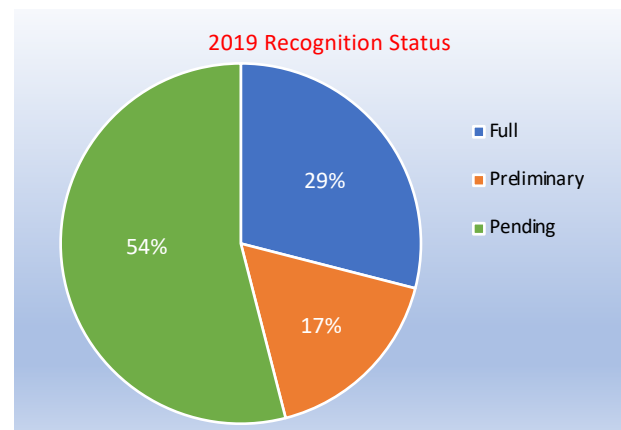
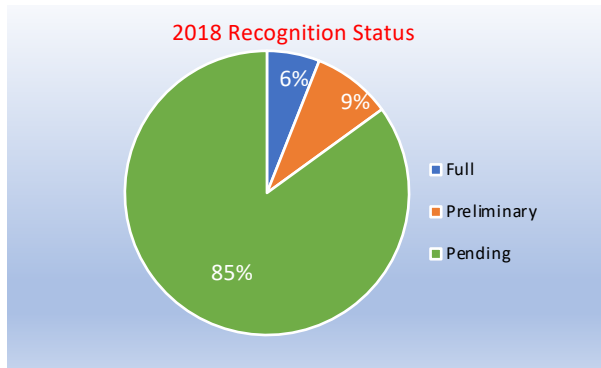
8 sites in January 2016 >> 46 sites in May 2018

13 Health Systems	1 Large Employer
7 regional YMCA's	1 Virginia Cooperative Extension
7 Free Clinics	1 Pharmacy
7 Physician and Nurse Practitioner-Based Practices	1 Church
3 Fitness Center	1 Area Agency of Aging
2 Federally Qualified Health Center (FQHC)	1 Home Health Agency
	1 Military

12 Health Systems
5 regional YMCA's
4 Free Clinics
3 Physician and Nurse Practitioner-Based Practices
1 Fitness Center
3 Federally Qualified Health Center (FQHC)

1 Virginia Cooperative Extension
2 Faith-Based Organizations
1 Hispanic non-profit Organization
2 Military
1 Health Department (CVHD - Lynchburg)

Comparison CDC- NDPP Recognition Status



Findings for the decrease in the number of recognized sites:

- Organizational re-structuring
- Medicaid Expansion
- Coach Turnover
- Per data evaluation and recommendations from CDC
- Challenges with recruitment & retention
- Lack of funding & reimbursement to sustain the program
- Not a good fit for the organization

Summary

- Significant progress has been made in organizations obtaining preliminary and full CDC recognition
- Reimbursement and sustainability are still a challenge; the more we work together the more feasible it will be for organizations to achieve these goals.
- VCDPE to focus on supporting organizations in the areas of Virginia that have few to no NDPP programs.

Let's keep moving forward and working together!

Strategies to Sustain Weight Loss

Speaker: Linda Delahanty, MS, RD

Diabetes Prevention Program Research Trial
Massachusetts General Hospital, Boston, MA

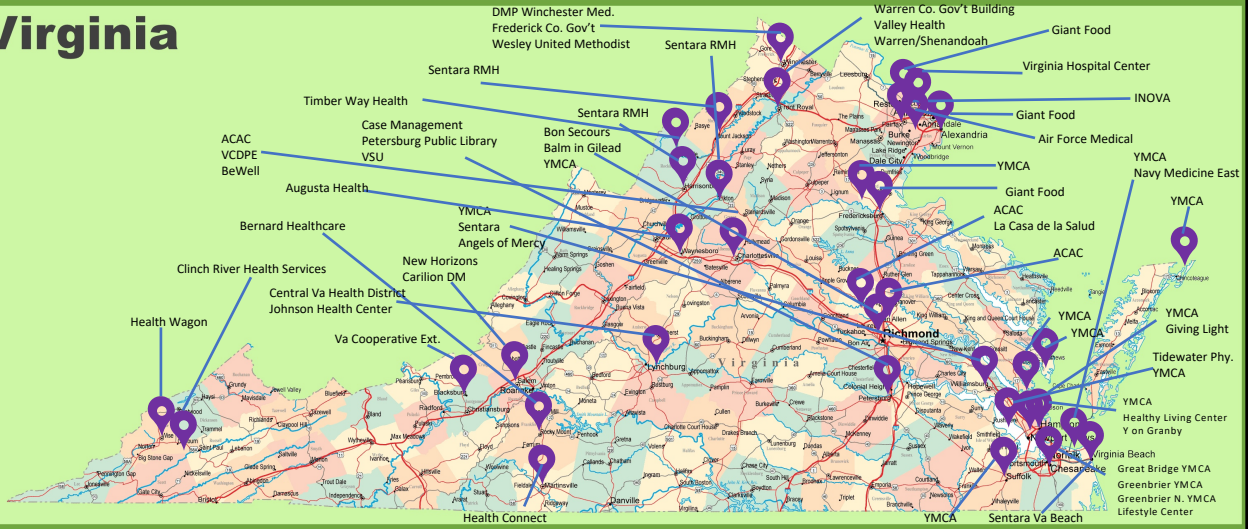
The slides from this presentation will be available via the webinar that Linda will be recording for us later this month. Once the recording and materials are available for viewing, we will send a message to the Networking group.

Break through Recruitment and Referral Barriers

Tanya Henderson, PhD Balm in Gilead
Lauren Palmer, RN ACAC Health and Wellness
Anne Wolf, MS,RD University of Virginia

National DPPs in Virginia, 2019

Virginia



DPPs in Virginia Open to Public

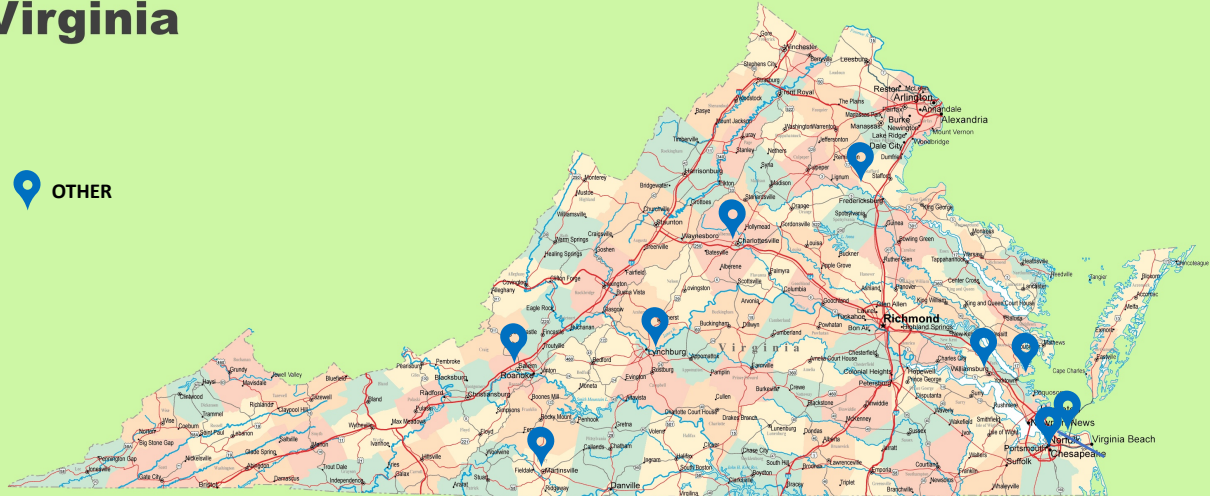
Virginia

 PUBLIC



DPPs in Virginia, Private (employer, Internal Clinic)

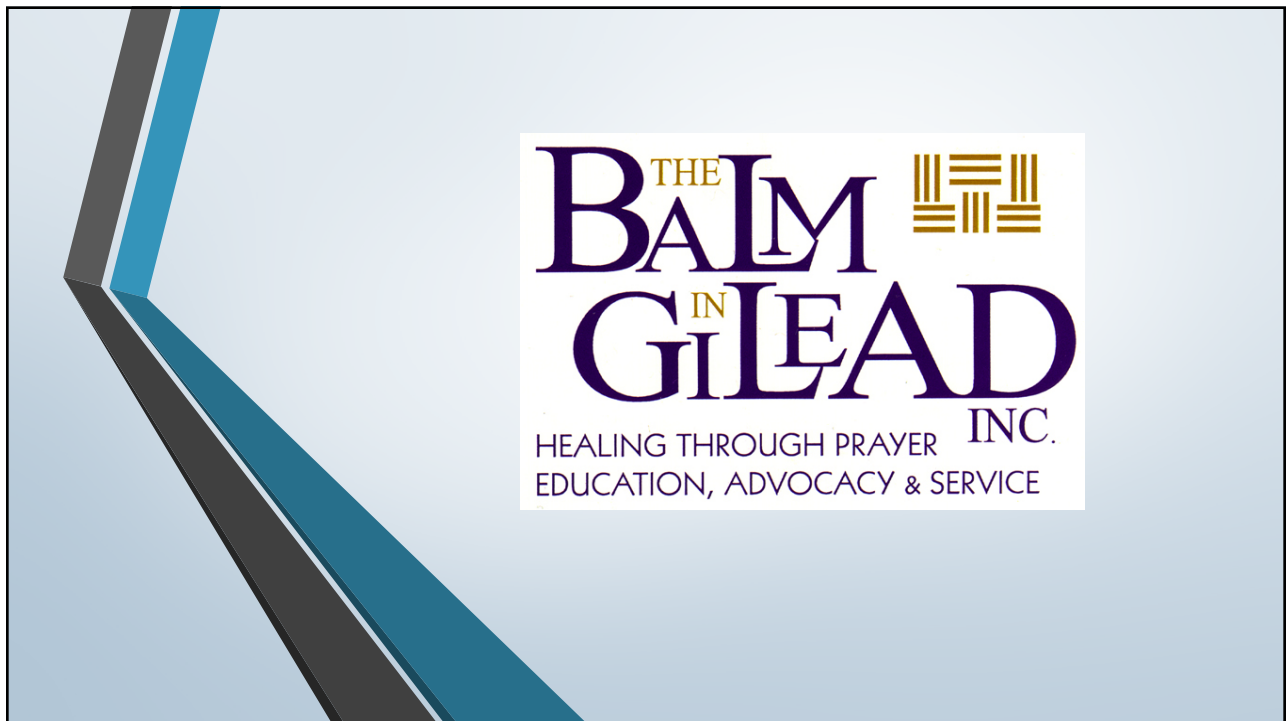
Virginia



Objectives

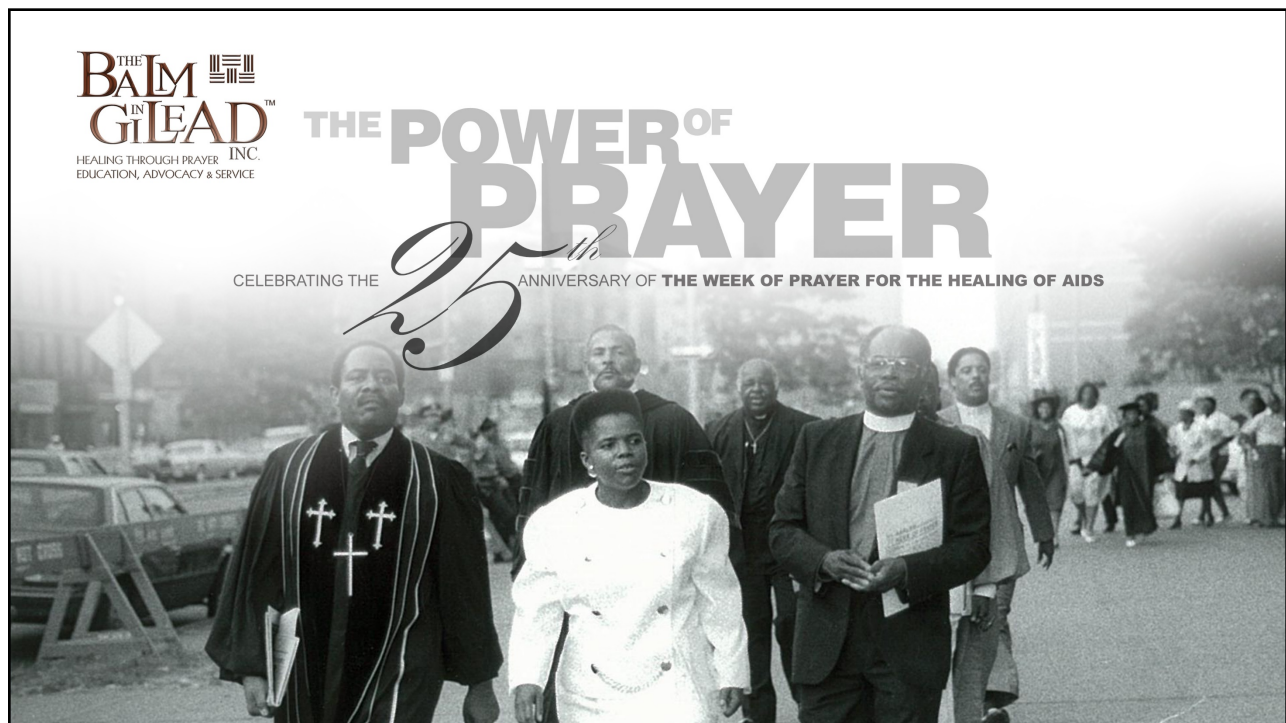
By the end of this session, participants will be able to

- Discuss Key marketing strategies when recruiting participants into the National DPP from the community and faith-based organizations.
- Learn strategies to overcome challenges and build healthy relationships with physician offices to increase your referral stream for the National DPP
- Identify at least three ways a clinic or hospital system can use their Electronic Health Record to identify, screen or refer patients to a National diabetes prevention program.



The Balm In Gilead, Inc.

- The Balm In Gilead, Inc. builds and strengthens the capacity of faith communities in the United States and in the United Republic of Tanzania (East Africa) to deliver programs and services that contribute to the elimination of health disparities.
- The organization develops educational and training programs specifically designed to establish **sustainable, integrated systems of public health and faith principles**, which helps to improve health outcomes of individuals living in urban, rural and remote communities.



The Balm In Gilead, Inc.

- The *Southeast Diabetes Faith Initiative*, The *National Brain Health Center for African Americans* and The *Healthy Churches 2020 National Campaign* are **three unique national programs** of The Balm In Gilead, which deliver science-based, health awareness, understanding and interventions through the tenets of cultural competence to a broad spectrum of African Americans across the United States.



The **Southeast Diabetes Faith Initiative (SDFI)** is a national program of The Balm In Gilead.

It is a 5-state faith-based project designed to expand access and utilization of the Centers of Disease Control (CDC)'s **PREVENT T2 Program**.

In partnership with *local faith partners*, **SDFI** supports and encourages communities and individuals to live healthier in mind, body and spirit.

SDFI Virginia Sites

City of Colonial Heights

Bethesda Baptist Church
15800 Woods Edge Road
Colonial Heights, VA 23834
Rev. Bernice Harrison, Pastor

Fairfax County

First Baptist Church of Vienna
450 Orchard Street, NW
Vienna, VA 22180
Rev. Vernon C. Walton, Pastor

City of Hampton

Sixth Mount Zion Baptist Temple/Six House Inc.
2003 Kecoughan Road
Hampton, VA 23661
Rev. Jerome Barber, Pastor

City of Hopewell

Friendship Baptist Church
1305 Arlington Road
Hopewell, VA 23860
Rev. Dr. Norwood Carson, Pastor

Sussex County

Mars Hill AME Zion Church
401 Main Street
Wakefield, VA 23888
Rev. Willie Dixon, Pastor

Virginia Staff

Program Coordinator
Sharon Napper

Colonial Heights
Shirl Isley
Jackie Briggs

Fairfax County
Robin Williams
Dale Wallace

Hampton
Michelle McRae
Phyllis Richardson

Hopewell
Lawana Simpson

Sussex County
Claessa Strawn

For more information about SDFI



Contact ME!!!

Tanya Bender Henderson, PhD
Virginia State Manager
thenderson@balmingilead.org
202.277.5872

**Establishing a reliable stream of
medical referrals**

Lauren Palmer, RN
acac Fitness and Wellness Centers

Using the P.R.E.P. Model

What is P.R.E.P.?

Key P.R.E.P. team members

- ❑ Director, Nurse, Medical Fitness Team Member
- ❑ Physician Liason
 - ❑ Builds and sustains business relationships with physicians and their teams
 - ❑ Distributes info about P.R.E.P. and educates physicians about the program
 - ❑ Organizes physician dinners or other events
 - ❑ Lunches, breakfasts, other appointments and office visits
- ❑ Corporate outreach

First...A Faulty Assumption:

- ❑ P.R.E.P. medical outreach would have an easy time adding DPP message to their usual routine

What Can DPP Steal (ahem...learn) From P.R.E.P.?

- ❑ Craft a message that conveys the value of our program to physicians...and their patients
- ❑ Build strong relationships with physicians and their staff
- ❑ Effective communication and follow up is key

National DPP | acac
national diabetes prevention program

PROVEN TO REDUCE THE INCIDENCE OF DIABETES BY 58%*

National Diabetes Prevention Program

The National Diabetes Prevention Program is a year-long intervention based on the CDC-approved PreventT2 curriculum. Participants meet in small groups with trained lifestyle coaches who empower them to develop skills to help them lose weight, be more active, and manage stress to achieve their goals together.

Program Highlights:

- Affordable
- Promotes Healthy Lifestyle
- Provides Social Support
- Evidence-based

Gregory Degnan, MD
Orthopaedic Specialist & Medical Director, acac Fitness & Wellness

Ask your doctor for a DPP referral today. | acac.com/DPP | Live your best.

National DPP | acac
national diabetes prevention program

Refer to p.r.e.p.
p.r.e.p. is available for eligible former back and 401(k) ERISA health & vision plan, P.A. & P.A.A. Membership Coordinator for details.

Recommend National Diabetes Prevention Program based on the following:

Patient must meet **all 4** requirements:

- At least 18 years old
- BMI > 24 (22 if Asian)
- Has no previous diagnosis of type 1 or type 2 diabetes
- Does not suffer from ESRD

AND

Patient must meet **only 1** requirement:

- Previous diagnosis of gestational diabetes
- Hemoglobin A1C: 5.7%-6.4%
- Fasting plasma glucose: 100-125 mg/dL
- 2-hour plasma glucose (after a 75 g glucose): 140-199mg/dL

Patient is cleared for unsupervised exercise. If there are any precautions/special conditions please list here.

.....

.....

Patient Information

Patient name:

Patient phone:

Date of Birth:

Provider Information

Provider name (print):

Provider signature: **X**
SIGN HERE DEGREE

Date:

Provider phone:

Provider fax:

You will receive progress reports on your patients.

Provider Stamp

.....

Fax completed form to patient's acac Fitness & Wellness Center location:

Charlottesville
email: dcac@acac.com
phone: 434.293.0287
fax: 434.321.3995


Maryland
email: dcac@acac.com
phone: 240.209.4981
fax: 240.366.1395

Pennsylvania
email: dcac@acac.com
phone: 610.632.8047
fax: 484.820.0242

Richmond
email: dcac@acac.com
phone: 804.379.0795
fax: 804.597.0204


Program is FREE for Medicare beneficiaries. Discounted self-pay options available.

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National DPP | acac
national diabetes prevention program

Do NOT Refer to p.r.e.p.
Patient is NOT cleared for exercise.

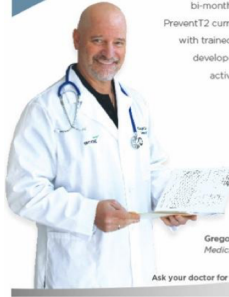


DESIGNED FOR PATIENTS WITH BMI 25 OR OVER

National Diabetes Prevention Program

National DPP is a 16-week intervention program with bi-monthly follow-ups utilizing the CDC-approved PreventT2 curriculum. Participants meet in small groups with trained lifestyle coaches who empower them to develop the skills needed to lose weight, be more active, manage stress and achieve their goals.

- Promote healthier eating & increased physical activity
- Achieve 5-7% weight loss
- Reduce the risk of developing type 2 diabetes by 58%*



Gregory Dagnan, MD
Medical Director, acac Fitness & Wellness

Ask your doctor for a DPP referral today. | acac.com/DPP | Live your best.

Recommend National Diabetes Prevention Program and p.r.e.p.* based on the following:
Available program tracks:

- General Health Track - for patients with BMI 25+ (at higher risk for prediabetes)
- Prediabetes Track - for patients with a diagnosis of prediabetes
- Diabetes Management Track - for patients with a diagnosis of type 2 diabetes
- Women's Health Track - for women seeking weight loss for improved fertility and healthier pregnancies

Patient is cleared for unsupervised exercise. If there are any precautions/special conditions please list here.

.....

.....

.....

Patient Information	Provider Information
Patient name	Provider name (print)
Patient phone	Provider signature, X <small>SIGN HERE</small> DEGREE
Patient email	Date / /
Date of Birth / /	Provider phone
	Provider email
	Provider fax
	You will receive progress reports on your patients.
	Provider Stamp

Fax completed form to patient's acac Fitness & Wellness Center location:

Charlotteville
email: dpncvill@acac.com
phone: 434-215-0287
fax: 434-2113995


Maryland
email: dpnmaryland@acac.com
phone: 240-200-4933
fax: 240-246-1395

Pennsylvania
email: dpnpa@acac.com
phone: 610-612-8047
fax: 610-630-0242

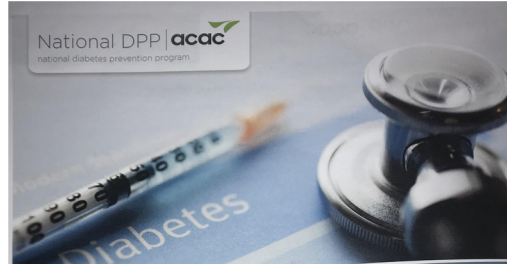
Richmond
email: dpnrchmond@acac.com
phone: 804-275-8755
fax: 804-597-0204

*Insurance not required. Member of acacac. All services provided at participating locations only. Referrals are the responsibility of your physician. Discounted self-pay options available. www.acac.com/dpp

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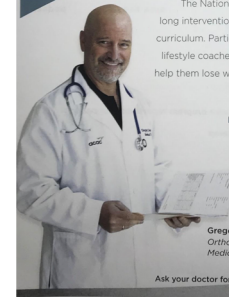
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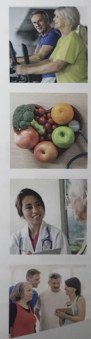
Program Highlights:

- Affordable
- Promotes Healthy Lifestyle
- Provides Social Support
- Evidence-based



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national diabetes prevention program

Refer to p.r.e.p.
Patient must meet all 4 requirements. Ask a p.r.e.p. Member for details.

Recommend National Diabetes Prevention Program based on the following:

Patient must meet all **4** requirements:

<input type="checkbox"/> At least 18 years old	AND	<input type="checkbox"/> Previous diagnosis of gestational diabetes
<input type="checkbox"/> BMI > 24 (22 if Asian)		<input type="checkbox"/> Hemoglobin A1C: 5.7%-6.4%
<input type="checkbox"/> Has no previous diagnosis of type 1 or type 2 diabetes		<input type="checkbox"/> Fasting plasma glucose: 100-125 mg/dL
<input type="checkbox"/> Does not suffer from ESRD		<input type="checkbox"/> 2-hour plasma glucose (after a 75 g glucose): 140-199mg/dL

Patient is cleared for unsupervised exercise. If there are any precautions/special conditions please list here.

Patient Information

Patient name:

Patient phone:

Date of Birth:

Provider Information

Provider name (print):

Provider signature: **X** **SIGN HERE** **DEGREE**

Date:

Provider phone:

Provider fax:

Provider Stamp

You will receive progress reports on your patients.

Fax completed form to patient's acac Fitness & Wellness Center location:

Charlottesville
email: dppcvilla@acac.com
phone: 434.225.0287
fax: 434.321.1995

Maryland
email: dppmaryland@acac.com
phone: 240.356.4881
fax: 240.356.1395

Pennsylvania
email: dpppa@acac.com
phone: 610.632.8047
fax: 484.930.0242

Richmond
email: dpprichmond@acac.com
phone: 804.597.8755
fax: 804.597.0204

Program is FREE for Medicare beneficiaries. Discounted self-pay options available.

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National DPP | acac
national diabetes prevention program

Do NOT Refer to p.r.e.p.
Patient is NOT cleared for exercise.

Recommend National Diabetes Prevention Program and p.r.e.p. based on the following:

Available program tracks:

- General Health Track - for patients with BMI 25+ (at higher risk for prediabetes)
- Prediabetes Track - for patients with a diagnosis of prediabetes
- Diabetes Management Track - for patients with a diagnosis of type 2 diabetes
- Women's Health Track - for women seeking weight loss for improved fertility and healthier pregnancies

Patient is cleared for unsupervised exercise. If there are any precautions/special conditions please list here.

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Patient phone:

Patient email:

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phone: 240.205.4981
fax: 240.364.1395

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phone: 610.632.8047
fax: 484.930.0242

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email: dpprichmond@acac.com
phone: 804.597.8755
fax: 804.597.0204

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Build strong relationships

- ❑ Consistency is key
 - ❑ Might take many visits to an office to achieve any progress
 - ❑ Always have something to drop off!
- ❑ Target your efforts
 - ❑ Start with physicians who already have a good relationship with your organization, or are leaders in the community
 - ❑ Give more attention to physicians with a record of being good referral sources
 - ❑ Be mindful of physician's patient population
 - ❑ Prefer PCP offices, but don't rule out specialty practices
- ❑ Have a clear message
 - ❑ Physician time is limited...know your elevator pitch!

Communicate and Follow Up

Opportunities to reach out to physicians:

- ❑ Physician refers a patient
 - ❑ Patient enrolls
 - ❑ Patient decides NOT to enroll
- ❑ Patient self-refers to DPP
 - ❑ Opportunity to inform physician of patient's enrollment AND provide information about the program
- ❑ Obtain lab results to establish patient eligibility
- ❑ Progress reports

Your patient has elected to enroll in the National Diabetes Prevention Program at acac Fitness & Wellness Centers. The NDPP is an evidence-based program recognized by the CDC, which provides lifestyle and wellness coaching in a small group setting over the course of one year. Participants who enroll in our program are seeking to improve their health through modest weight loss and increased physical activity.

[Patient] attended an Intake and Health Assessment appointment on 3/11/19. At this appointment we discussed her goals for the program, previous weight loss efforts, and determined how best to support her over the next year.

We also reviewed her medical history, current medical status, and current medications. Her elevated A1c lab result qualifies her for complete coverage of this program through her Medicare insurance policy.

[Patient] is a lovely woman, and I am so pleased she is participating in the National DPP. She will be joining a group already in progress which began meeting in February, and will receive make-up sessions from her coach for any content they have already covered. I look forward to apprising you of changes in her biometric data and progress toward her goals following routine periodic assessments. In the meantime, if you have any questions please feel free to reach out to me.

Thank you so much for recommending [patient] for the National Diabetes Prevention Program at **acac** Fitness & Wellness Centers. She has elected to enroll in the program as of today, and will be joining my Tuesday 11:45 cohort effective next week.

I had a chance to talk at length with [patient] this morning. We briefly reviewed her medical history and current medical status. Based on the results of her A1C lab result, she will qualify for complete coverage of this program through her Medicare insurance policy

[Patient] is a delightful woman, and I am so pleased she will be joining my group. Both she and her husband are also enrolling in our P.R.E.P program. I look forward to apprising you of changes in her biometric data and progress toward her goals following routine periodic assessments. In the meantime, if you have any questions please feel free to reach out to me.

Last summer your patient elected to enroll in **acac** Fitness & Wellness Center's National Diabetes Prevention Program, a year-long lifestyle change program providing nutrition, exercise and wellness counselling. At this time, I am pleased to provide you with an update on her progress.

Upon enrollment in the National DPP, each patient is provided with an InBody analysis, which gives a complete assessment of body composition. This data, along with weight, hip and waist measurements, allows us to track participants as they progress toward their goals. Within the program, our goal for every patient is to reduce his/her initial weight by 5-10% and establish a habit of 150 minutes of moderate exercise each week.

Below you will find intake data for [patient] as well as data collected today at her 6 month follow up. As you can see, she has already exceeded the program goal of 10% weight loss, with corresponding decrease in her BMI, body fat percentage, and waist and hip circumference.

<u>Intake</u> (6/18/18)		<u>6-Month F/U</u> (2/7/19)	
Weight	163.7	Weight	144.4
BMI	24.8	BMI	28.1
Waist	35"	Waist	37"
Hip	39"	Hip	43"
% Body Fat	36.8	% Body Fat	42.3

[Patient] clearly takes great pride in the progress she has made. My next formal follow up to reassess her biometric data will occur at the 12-month mark. In the meantime, if you have any questions or would like to learn more about our program, please feel free to reach out to me. We would appreciate the opportunity to assist more of your patients in developing a healthier lifestyle!

In summary....

- ❑ Develop a clear message about how NDPP is good for physicians' patients
- ❑ Build strong relationships
- ❑ Regular communication and follow up is key

BREAKING THROUGH RECRUITMENT AND REFERRAL BARRIERS USING THE EHR

**ANNE WOLF, MS,RD
VIRGINIA CENTER FOR DIABETES PREVENTION AND EDUCATION**

Focus

Hospitals

+

Clinics



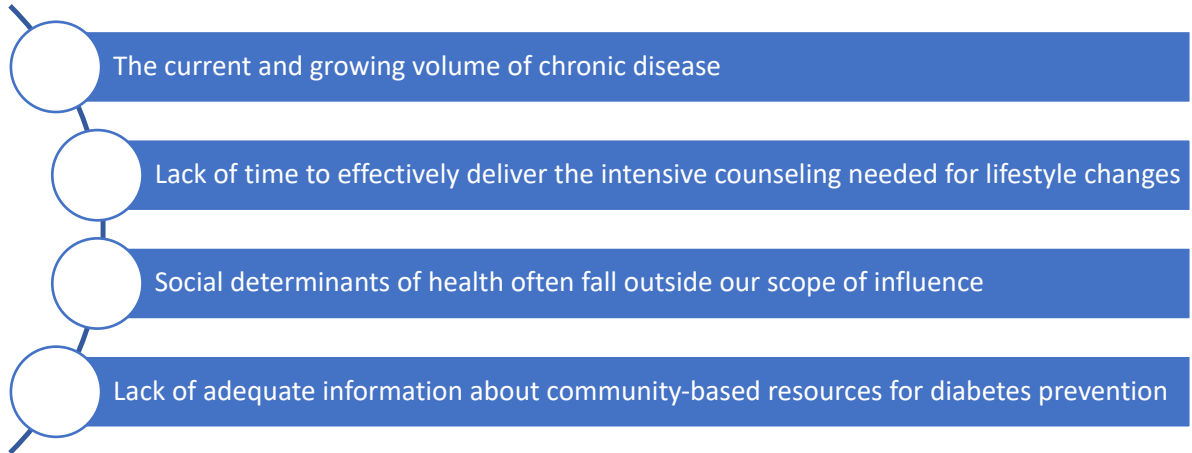
Referrals

QUESTION

Please stand *if your facility*

- Uses an Electronic Health Record (EHR)?
- Uses the EHR to identify people with prediabetes?
 - Uses a patient registry to identify prediabetes
 - Uses Best Practice Alerts to id and screen high risk people
- Uses the EHR to provide information about prediabetes
- Uses the EHR to refer to your program

Challenges faced by practicing physicians and care teams

- 
- The current and growing volume of chronic disease
 - Lack of time to effectively deliver the intensive counseling needed for lifestyle changes
 - Social determinants of health often fall outside our scope of influence
 - Lack of adequate information about community-based resources for diabetes prevention

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QUESTION

Please stand *if your facility's EHR is:*

- EPIC
- Cerner
- EClinicalWorks
- Allscripts
- Other

Approaches for Patient Referral in EHR

- Care Management IDs patients who meet criteria for prediabetes and are eligible for referral
 - ID patients at risk
 - Prediabetes Registry
 - Batch referrals
 - Batch Education and communication through patient portal
- Point of Care Uses patient routine office visit to id, screen and refer

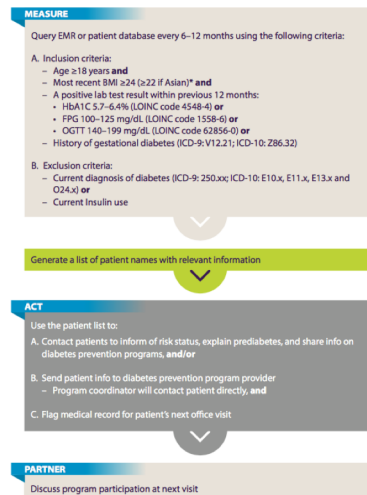
EHR Patient Identification

Query in EHR, Registry

- BMI* ≥ 25 (≥ 23 kg/m² for Asian Americans), and
- Blood glucose/HbA1C levels in prediabetes range, or
- History of Gestational Diabetes
- No history of Diabetes

<https://assets.ama-assn.org/sub/prevent-diabetes-stat/downloads/retrospective-prediabetes-identification-algorithm.pdf>

Retrospective prediabetes identification



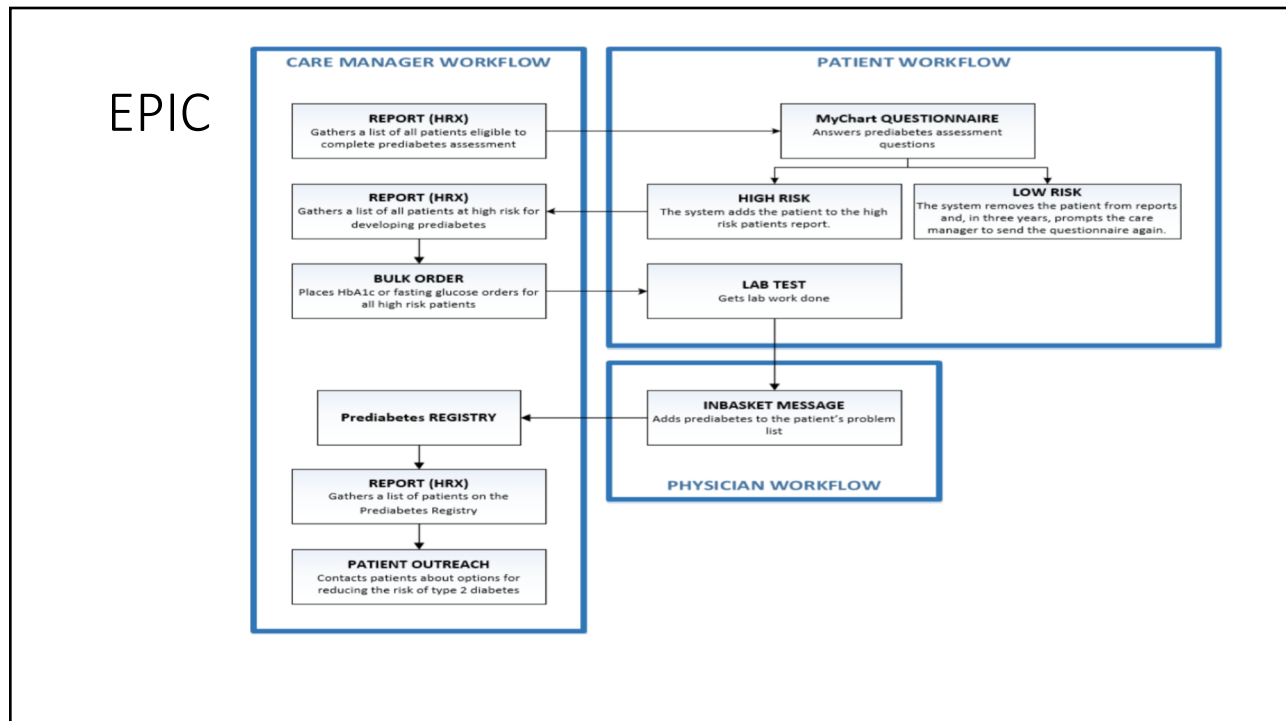
* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans and ≥ 25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.



Prevent Diabetes **STAT** | Screen / Test / Act Today™



The American Medical Association and the Centers for Disease Control are supporting physicians, care teams and patients to prevent diabetes.



Point of Care Management with EHR

Patient ID

- Embed CDC/ADA questionnaire into EHR

Alert Provider of Risk

- EHR Best Practice Alert (BPA) → Cues to order HbA1c lab test

Alert Provider of Prediabetes lab value

- EHR BPA → Cues provider to take action

Patient Management

- Prediabetes Registry – Puts people with prediabetes in one dataset. Easy ID
- Prediabetes SmartSet - One order set for patient management (labs, education, fu)
- Refer to your National DPP

EHR Patient Identification

Best Practice Alerts

- BPA fires if patient is
 - > 45 years and
 - BMI \geq 25 (\geq 23 if Asian)
- Or
- Has history of GDM, + Family Hx
- Use with caution



BPA automatically screens EPIC at visit then fires if patient >age 45 and BMI > 24 or family hx diabetes or GDM. Exclusions: personal hx of T1DM or T2DM or A1c resulted in last year.

Provider can dismiss alert or choose to order labs (Medicare requires FBS>100 before A1C ordered)

BestPractice Advisories

This patient has screened at risk for prediabetes. Would you like to order an A1C? ✓ Accept (2) ✕

Order Do Not Order HGB A1C WITH EST AVG GLUCOSE

Order Do Not Order BASIC METABOLIC PANEL

Acknowledge Reason _____

Alert Inappropriate

✓ Accept (2)

RMH Sentara EHR Referral

REFERRAL TO DIABETES PREVENTION PROGRAM ✓ Accept ✕ Cancel

Priority: Non-Urgent | Non-Urgent | 5-7 Days | 2 Weeks | 4 Weeks | Urgent

Class: Outgoing

Referral: Location/POS: _____ From: _____
 To: _____ # of visits: _____

Expiration Date: _____

Provider: _____
 Specialty: _____
 Department: _____

RefType: Consult, Te | Consult, Test & Treat

Referral Reason: Specialty Services Required | Second Opinion

Reason for Referral: BMI: \geq 24; \geq 22, if Asian | No Hx T1DM or T2DM | A1C: 5.7-6.4% | FBS (plasma): 100-125 mg/dL
 2 Hr GTT: 140-199 mg/dL | + Hx Gestational DM

Barriers: 1:1 Insulin Teaching | 1:1 Management for DM Type 1 or 2 | Eating Disorder | Impaired Cognition
 Impaired Dexterity | Impaired Hearing | Impaired Mobility | Impaired Psychosocial Status
 Language Barrier | Learning Disability | Low Literacy | Morbid Obesity | Visual Impaired | Other

Comments: _____
 Labs must be within the past year.
 BMI: Data Unavailable
 HEMOGLOBIN A1C

Assoc	Encounter	Diagnoses	Codes	Qualifier	Comment
1					

Next Required ✓ Accept ✕ Cancel

Prescription for DPP

Diabetes Prevention Program (DPP) Recommendation

This is a recommendation for an adult patient to participate in Sentara RMH Medical Center's Diabetes Prevention Program (DPP). Please provide the completed form to the patient, who may enroll at 1-800-SENTARA or online at Sentara.com.

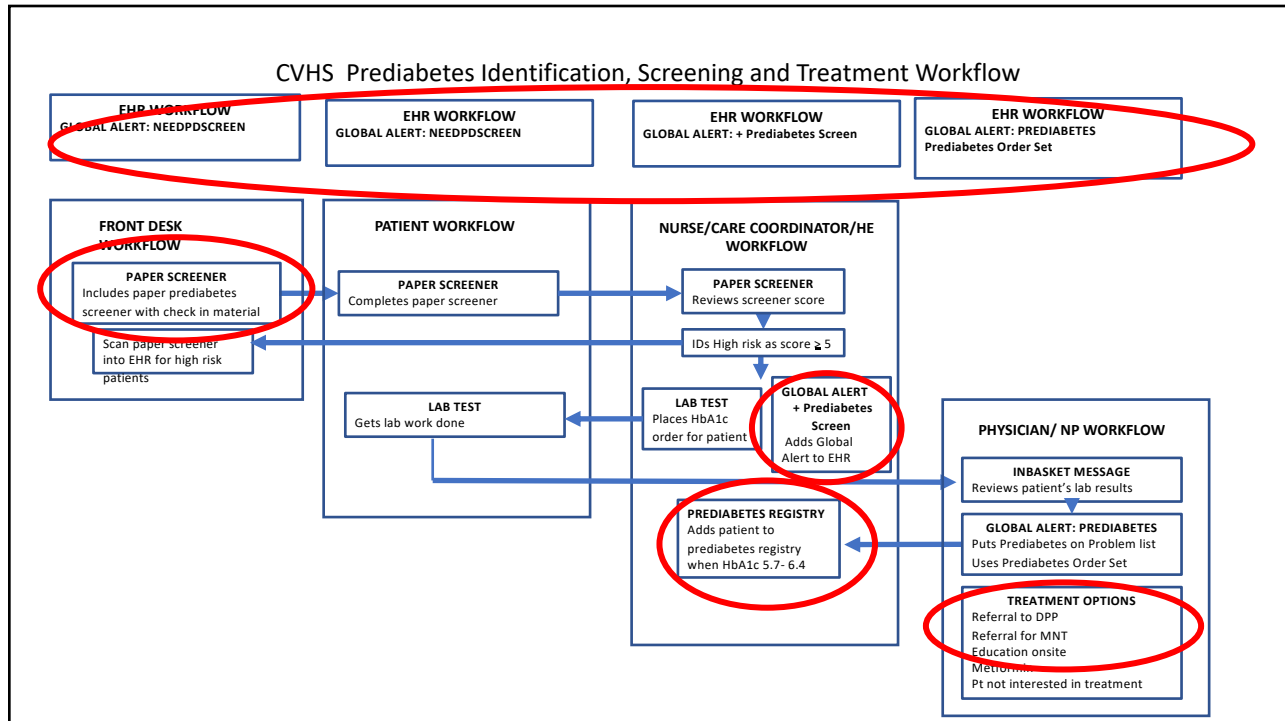
(First Name) _____ (M) _____ (Last Name) _____

The above person is recommended for enrollment in the DPP based on the following eligibility criteria:

- Be at least 18 years old, and
- Be overweight (body mass index \geq 28.2 for Asian), and
- Have no previous diagnosis of Type 1 or Type 2 diabetes, and
- Have a blood test result in the prediabetes range within the past year:
 - o Hemoglobin A1C: 5.7% - 6.4%, or
 - o Fasting plasma glucose: 100-125 mg/dL, or
 - o 2-hour plasma glucose (after a 75 gm glucose load): 140-199 mg/dL, or
 - o Be previously diagnosed with gestational diabetes

Healthcare provider _____ Date _____
 To register, call 1-800-SENTARA. For questions or for more information, contact Julie Perrotton, Diabetes Program Coordinator, 540-698-1102 or jperrot@sentara.com. This program is free.





EclinicalWorks Prediabetes Order set – CVHS

ORDER SET: PRE DIABETES

MEASURE: QUICK ORDER SET: YES

Rx	Name	Strength	Take	Freq	Duration	Refills	Route	Formulation	Dispense	Del
•	Metformin HCl	500 MG	1 tablet with a meal	Once a day	30 day(s)		Orally	Tablet	30	

Labs	Description	Lab Company	Delete
•	Hemoglobin A1c 001453	LabcorpOG	
•	Hemoglobin A1c with eAG Estimation 102525	LabcorpOG	
•	Hemoglobin A1C	-	
•	Glucose, Serum 001032	LabcorpOG	

PDF	Name	Add	Save
•	Prediabetes_PrintableRiskTest(English).pdf		
•	Prediabetes English.pdf		

CVHS Order set: Educational Material

The screenshot shows a web reference management interface. On the left, there is a header 'WEB REFERENCE' and two buttons: 'Add' and 'Save'. The main area contains a list of four items, each with a red document icon, a text input field, a location pin icon, and a red trash icon. The items are:

- Prediabetes Spanish.pdf
- so-you-have-prediabetes-now-what.pdf
- entonces-usted-tiene-prediabetes-y-ahora-que.pdf
- Provider Resource_What is Prediabetes_VDC.pdf

At the bottom right, there is another 'WEB REFERENCE' header and 'Add' and 'Save' buttons.

Bidirectional Referral: Closing Feedback Loop

- National DPPs can close loop in referral process and provide feedback to provider
- Information to provider: Patient enrollment, attendance, % weight loss
 - Internal DPP/Access to EHR
 - Progress documented
 - Patient enrollment & progress at 1-, 6- & 12-month
 - External NDPP to health system/clinic/Non access to EHR
 - Patient enrollment and progress at 12 months

Summary

If you have an EHR, use it to...

- Screen your population automatically
 - Alert providers to order blood test
 - Provide standardized educational material
 - Refer to your program
-
- In any new process, important to develop a workflow for your clinic and health system

Q & A





Virginia Center for Diabetes Prevention and Education



THANK YOU
ON BEHALF OF
VCDPE, VDH, & VDC

<https://med.virginia.edu/vcdpe/>

