Strategies to Reduce Obesity, Diabetes and the Burden of Chronic Disease

III. Clinical Prevention

III.A. Increase screening of high risk group (African Americans, Latinos, Asian-Pacific Islanders)

III.A.1. Increase screening of high risk group
III.A.1.a) Annual fundoscopic and extremity exam
III.A.1.b) BP @ every visit
III.A.1.c) Monitor lipid profile and treatment as per guidelines
III.A.1.d) Maintain HbA1C below 6.5%
III.A.1.e) Maintain glucose for microalbuminures

III.B. Institute model practice guidelines as standards for reimbursement

III.B.1. Institute model practice guidelines
III.B.1.a) Use HEDIS reporting measures to monitor performance
III.B.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

III.C. Anthropometrics at every visit

III.C.1. Measure waist/hip circumference, calculate ratio, educate patients about importance
III.C.2. Record blood pressure
III.C.3. Record random BG fingerstick
III.C.4. Record weight, calculate BMI

III.D. Maximize use of IT and other technologies to identify high risk individuals and provide anticipatory guidance

III.D.1. Pre-conception & post-partum counseling & referral to community based programs for women of childbearing age
III.D.2. Use Registries to follow gestational diabetic offspring

III.E. Research Primary and Secondary prevention strategies

III.E.1. Research Primary and Secondary prevention strategies
III.E.2. Research Environmental factors
III.E.3. Research the psychosocial aspects/predictors of care and patient compliance

IV. Clinical Management

IV.A. Increase access to health care

IV.A.1. Support health reform strategies to increase access

IV.B. Increase provider capacity to provide quality outpatient services

IV.B.1. (Diabetes) Institute model practice guidelines and emphasize consistent use of treatment guidelines
IV.B.1.a) Pre-conception & post-partum counseling & referral to community based resources for women of childbearing age
IV.B.1.a)a) Annual fundoscopic and extremity exam
IV.B.1.a)b) BP @ every visit
IV.B.1.a)c) Monitor lipid profile and treat as per guidelines
IV.B.1.a)d) Maintain HbA1C below 6.5%
IV.B.1.a)e) Maintain vigilance for microalbuminures
IV.B.1.b) Track effectiveness of disease management efforts
IV.B.1.c) Institute model practice guidelines as standards for reimbursement
IV.B.1.d) Risk stratify patients to maximize use of resources
IV.B.1.e) Institute group appointments
IV.B.1.f) Support access to care, including Specialty Care

IV.B.2. Institute model practice guidelines as standards for reimbursement

IV.B.2.1. Institute model practice guidelines
IV.B.2.1.a) Use HEDIS reporting measures to monitor performance
IV.B.2.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.B.3. Institute model practice guidelines as standards for reimbursement

IV.B.3.1. Institute model practice guidelines
IV.B.3.1.a) Use HEDIS reporting measures to monitor performance
IV.B.3.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.B.4. Institute model practice guidelines as standards for reimbursement

IV.B.4.1. Institute model practice guidelines
IV.B.4.1.a) Use HEDIS reporting measures to monitor performance
IV.B.4.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.B.5. Institute model practice guidelines as standards for reimbursement

IV.B.5.1. Institute model practice guidelines
IV.B.5.1.a) Use HEDIS reporting measures to monitor performance
IV.B.5.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.B.6. Institute model practice guidelines as standards for reimbursement

IV.B.6.1. Institute model practice guidelines
IV.B.6.1.a) Use HEDIS reporting measures to monitor performance
IV.B.6.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.B.7. Institute model practice guidelines as standards for reimbursement

IV.B.7.1. Institute model practice guidelines
IV.B.7.1.a) Use HEDIS reporting measures to monitor performance
IV.B.7.1.b) Diabetes: Institute model practice guidelines and emphasize consistent use of treatment guidelines

IV.C. Increase provider capacity to provide quality outpatient services

IV.C.1. Increase provider capacity to provide quality outpatient services
IV.C.2. Support provider inclusion in home education tools such as CDs/DVDs & computer-based programs

IV.D. Increase provider capacity to provide quality outpatient services

IV.D.1. Increase provider capacity to provide quality outpatient services
IV.D.2. Support provider education through home education tools such as CDs/DVDs & computer-based programs

IV.E. Increase provider capacity to provide quality outpatient services

IV.E.1. Increase provider capacity to provide quality outpatient services
IV.E.2. Support provider education through home education tools such as CDs/DVDs & computer-based programs

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