



American Heart Association®
Outpace CVD



Ready



Set



Go!

Standardizing Type 2 Diabetes Management for
the Reduction of Cardiovascular Disease:

IMPLEMENTATION GUIDE

Ready, Set, Go!



Standardizing Type 2 Diabetes Management for the Reduction of Cardiovascular Disease: **IMPLEMENTATION GUIDE**

More than 38 million Americans have diagnosed and undiagnosed diabetes, and cardiovascular disease is the leading cause of death for people living with Type 2 diabetes¹. This chronic condition comes with a host of other health risks, but there's hope! We know that people living with Type 2 diabetes can make practical, meaningful changes to reduce their risk of cardiovascular disease – heart attacks, strokes, and heart failure are not inevitable. **This is why the American Heart Association is prioritizing managing both diabetes and other risk factors to help people live longer, healthier lives.**

The Target: Type 2 DiabetesSM program, as part of [Outpace CVD's](#) suite of resources, has developed this easy-to-use guide to **evaluate** your organization's current practices, **develop** an effective diabetes management plan, and seamlessly **integrate** a diabetes management policy into your current care practices.

How to use...



Ready
EVALUATE

Ready - Get ready for success:

Get ready for success! This section will provide tools for self-evaluation, a model share for peer review, and information on connecting with AHA quality improvement (QI) support.



Set
DEVELOP

Set - Learn AHA standards:

Prepare your teams and set the standard. This section will help inform the building of a standardized diabetes management plan including treatment algorithm examples, diabetes comorbidities, and tips to incorporate a team-based care approach.



Go!
INTEGRATE

Go - Integrate your plan:

Implement your well-organized diabetes management plan aligning your system's goals to reaching guideline-directed targets. This section will include ways to leverage technology, tools for shared decision making, and resources to assist in overcoming barriers to implementation.



Ready

> EVALUATE

The [2025 American Diabetes Association's \(ADA\) Standards of Care in Diabetes](#)² provides compelling evidence that standardized management of patients with diabetes is critical. Diabetes is a chronic condition that requires a complex range of risk-reduction strategies including and beyond glycemic management.

Developing a systemwide diabetes management plan is essential to ensure your patients receive appropriate screening, treatment, and follow-up care. Standardizing the process for identifying, evaluating, monitoring, and managing high-risk patients improves outcomes and quality of care across your entire patient population.

Self-Assessment

The first step in building a standardized care plan is to evaluate your current practices and identify areas for improvement. Begin by auditing a sample (10% or one month of patient volume) of diabetes patient charts to determine how well your clinicians are following clinical guidelines for screening, goal setting, and medication management.

Key considerations to include:

- Are the correct labs being ordered and documented at appropriate intervals?
- Are patients being prescribed guideline-directed pharmacotherapies?
- Are patients being referred to the appropriate specialty providers when indicated?

Check it Out:

NEW! SELF-ASSESSMENT CHECKLIST

Start the conversation with your care teams using the comprehensive checklist provided.

Diabetes Management Self-Assessment Checklist

Evaluate your current policies, care practices, and patient pathways for guideline-directed diabetes care. This checklist assesses where you are meeting, gaps in care and opportunities for improvement when building and implementing your standardized diabetes management plan.

These questions are designed to generate conversations with your internal teams to create a model for how your system will approach managing patients with diabetes. Each question is linked to a location in this guide to help support you on your journey.

<input type="checkbox"/> Do you regularly monitor your diabetes control rates?	<input type="checkbox"/> Do you regularly use health agents, dashboards, or other population health tools to assist in clinical decision making?
<input type="checkbox"/> Is your staff trained on current diabetes guidelines and regular updates?	<input type="checkbox"/> Do you have a process for identifying patients who would benefit from diabetes self-management education and support (DSMES)?
<input type="checkbox"/> Does your organization assess health care professional adherence to current guidelines?	<input type="checkbox"/> Can shared management of patients with diabetes be improved, especially between primary care doctors and specialists?
<input type="checkbox"/> Does your diabetes management plan include addressing comorbidities including hypertension, cholesterol and kidney disease?	<input type="checkbox"/> Do you currently use tools and/or patient aids for shared decision making?
<input type="checkbox"/> Is your organization routinely assessing kidney health of patients with diabetes, including annual assessment of eGFR and uACR?	<input type="checkbox"/> Are barriers to medication adherence and lifestyle changes assessed?

[Click to open](#)

Ready

Peer Review Model Share

A key part of assessment is evaluating how clinical practices are currently implemented on a patient level. A process such as peer review can be helpful to understand how clinicians are practicing to inform opportunities for standardization and clinician education.

An example peer review process is provided below.

Insights from an AHA-led diabetes learning collaborative regarding their self-assessment and peer review process:

1	2	3	4	5
Each provider is assigned 10 charts to peer review	Once complete, the peer review results are reviewed by the CMO and Quality Management Council	Any patterns that are identified as outside of the recommendations are addressed as a part of the organizational quality improvement process	Clinical concerns are sent to the peer review committee for additional review	Repeat the process on an ongoing basis

Elements Assessed in each Chart Review

1. Medication reconciliation
2. Are the labs current per guidelines?
3. Medication changes made at the visit are within guideline recommendations
4. Is there an appropriate follow-up plan? <ul style="list-style-type: none"> • Rationale for follow up in 3 months vs. 6 months
5. Retinal exams completed?
6. Foot exams completed?
7. Kidney health labs ordered? <ul style="list-style-type: none"> • uACR within the past year • eGFR within the past year
8. Pneumonia shot offered?
9. Is a statin prescribed?

Ready

Evaluate your Data with our QI Support

Understanding your organization's gaps in care involves reviewing relevant clinical data insights. We can help you with that! [Contact us](#) to be connected with a local AHA representative.

AHA's Target: Type 2 DiabetesSM program is designed to engage both outpatient and inpatient clinicians to promote guideline-directed recommendations and allow your organization to receive recognition for your efforts.

Outpatient health care organizations managing patients with diabetes can access quality improvement resources, use benchmarking tools, and submit their data for an achievement award in Target: Type 2 DiabetesSM.

Hospital participants of Get With The Guidelines[®]-Heart Failure (GWTG-HF), Get With The Guidelines[®]-Stroke (GWTG-Stroke) and/or Get With The Guidelines[®]-Coronary Artery Disease (GWTG-CAD) that meet specific diabetes measure thresholds may be eligible for Target: Type 2 DiabetesSM Honor Roll recognition.

For information about Target: Type 2 DiabetesSM, please visit the links to the right.



[Outpatient](#)
[Inpatient](#)

Health Care for Everyone, Everywhere

Social drivers of health play an important role in the care and management of patients with diabetes. There is a growing need for renewed focus and concerted effort to ensure health care for patients, particularly those from under resourced communities.

Addressing social drivers that impact access to quality care, medication adherence, and lifestyle changes could help reduce disparities and improve health for everyone.



A Panel Discussion on Health Care for Everyone, Everywhere

A panel discussion on what this could do to lower cardiovascular disease risk.

The American Heart Association equips professionals with the tools, resources, and knowledge to improve your institution with CME course offerings. Visit AHA's [website](#) to learn more.

AHA'S COMMITMENT TO HEALTH CARE FOR EVERYONE, EVERYWHERE

Improve Health Outcomes:

Ensuring health care to everyone, everywhere is one of the main key drivers of AHA's commitments as a solution for clinicians, health professionals and scientists to remove barriers that affect health outcomes..

Be on the look out

Look out for these bubbles for tips on how to approach incorporating health care for everyone, everywhere into all aspects of your care.



Set > DEVELOP

Now that you have assessed your team's care and identified the gaps in your process, **Set** is intended to prepare your team and set the standard. This section will help inform the building of a standardized diabetes management plan using a team-based approach, provide tips for addressing comorbidities, and provide resources to familiarize your care teams with current diabetes guidelines and best practices.

Professional Education

Keeping staff knowledge up to date with the most current guidelines and recommendations ensures patients receive evidence-based care. Trainings for staff can be implemented in regularly scheduled meetings such as through organization-wide lunch and learn programs or can be provided for self-study.

DID YOU KNOW?

ADA's Standards of Care are updated annually. Ensure that your team is up to date with the latest guidelines by including at least one annual training for all staff providing care to patients with diabetes.



[Click to watch \(1 hour.\)](#)

Standards of Care in Diabetes

This webinar highlights important updates from the American Diabetes Association's Standards of Care in Diabetes-2025 with speakers Dr. Dennis Bruemmer, MD, PhD, Cleveland Clinic and Dr. Alexander Chang, MD, MS, Geisinger Health.



[Click to access](#)

Cardiovascular Disease in Type 2 Diabetes for Health Care Professionals

A four-part series designed to help health care professionals stay up to date on guidelines to treat and manage cardiovascular disease and chronic kidney disease in people with Type 2 diabetes.



[Click to access](#)

Assessing the Benefits of GLP-1 RAs

This course covers the underlying mechanisms of cardiorenal benefit, the mechanism of action, glycemic effects, and safety concerns of GLP-1 RA medications.

Set

Want to stay up to date?

Sign up for our [AHA Outpace CVD Quality newsletter](#) and our [Quality News You Can Use newsletter](#) to find out when new courses become available and get alerts about upcoming AHA webinars and events.

Pro Tip:

CREATE AN ALGORITHM!

Evaluate your current patient journey by creating an algorithm informed by your [self-assessment](#). Using a patient algorithm can assist in finding points of care to leverage technology through order sets or best-practice alerts and can streamline workflows to the appropriate managing provider. Utilize diabetes focused peer review of patient charts as a starting point to better understand current processes.

Treatment Algorithms

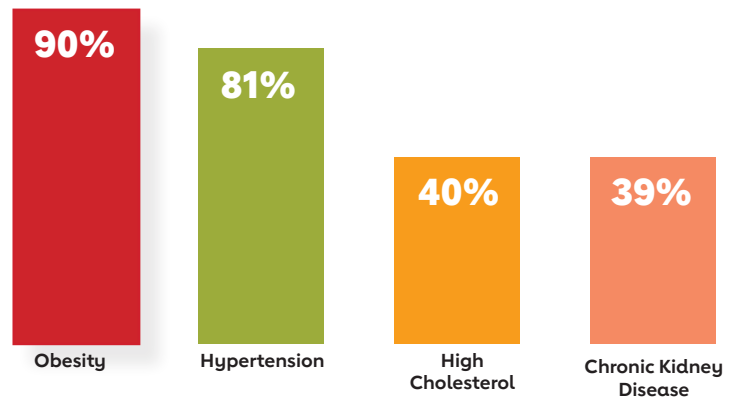
Understanding how your patients move through your system is critical to establishing ownership of the care of patients with diabetes. Oftentimes, there is confusion over who is the “responsible party” for prescribing medications and ordering labs, which can lead to poor patient outcomes and gaps in care. Standardizing the treatment process ensures all patients receive evidence-based interventions. Utilizing an existing algorithm as standard practice in your organization can help clinicians apply current guidelines to their workflows.

Set

Addressing Comorbidities for CVD Risk Reduction

A focus on reducing diabetes complications and comorbidities is essential to optimizing comprehensive care. Outside of glycemic management, it is important that cardiovascular health, kidney health, and weight management are also prioritized.

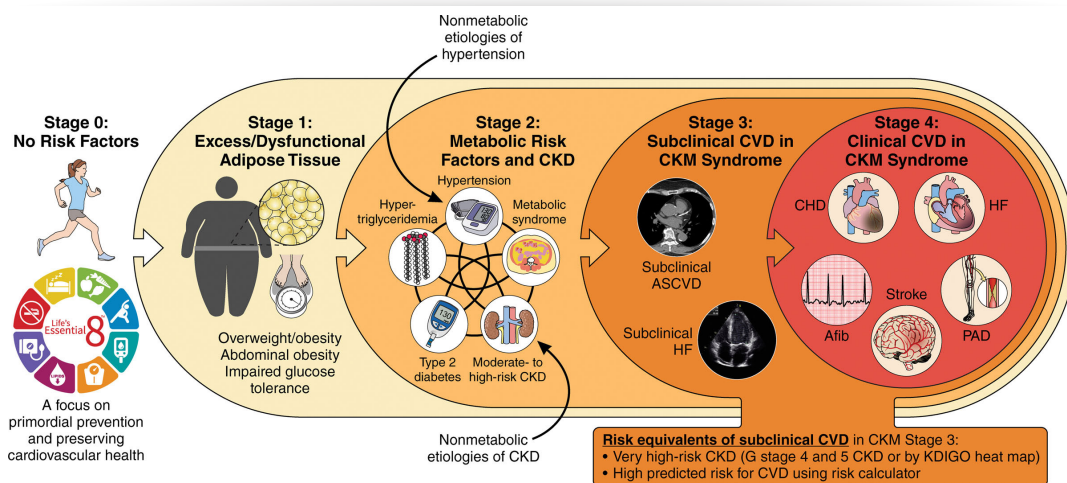
% of Patients with Diabetes and...³



Obesity and Weight Management

Obesity is an extremely prevalent comorbidity of diabetes and is also a major driver of the disease pathophysiology. Thus, a focus on obesity management in individuals with diabetes is important to control this critical comorbidity of diabetes. Weight loss, even just 3–7%, can provide the clinical benefits of better glucose control and reduction of cardiovascular risk⁴.

Medications such as glucagon-like peptide 1 (GLP-1) receptor agonists are the preferred pharmacotherapy for individuals with obesity and diabetes because of their proven weight loss and CVD benefits⁵. The [AHA's Presidential Advisory on Cardiovascular-Kidney Metabolic Health](#) recognized obesity as the key driver for the risk of development of CVD, diabetes, and kidney disease.



3 [National Diabetes Statistics Report | Diabetes | CDC](#)

4 American Diabetes Association Professional Practice Committee; 8. Obesity and Weight Management for the Prevention and Treatment of Type 2 Diabetes: Standards of Care in Diabetes-2025. *Diabetes Care* 1 January 2025; 48 (Supplement_1): S167–S180. <https://doi.org/10.2337/dc25-S008>

5 [Compare and Contrast the Glucagon-Like Peptide-1 Receptor Agonists \(GLP1RAs\) - StatPearls - NCBI Bookshelf](#)

Set

Obesity and Weight Management continued...

Weight should be addressed as a part of a comprehensive diabetes management plan to reduce comorbidity burden. Recommendations for implementation include:

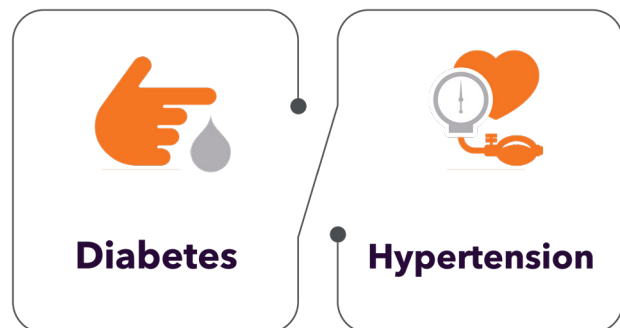
- Assessment of anthropometric measurements at least annually, including measurement of height, weight, waist circumference and waist-to-hip ratio.
- Programs inclusive of medications and bariatric surgery in addition to lifestyle interventions to reduce weight.
- Create individualized plans for patients that utilize team-based care, inclusive of pharmacists, dietitians and mental health clinicians.

Hypertension

Addressing hypertension in patients with diabetes is crucial due to the significant overlap and compounded health risks associated with these conditions. According to the CDC, nearly 80% of people with diabetes also have hypertension⁶. This dual diagnosis increases the risk of cardiovascular diseases, kidney disease, and stroke. Managing both conditions together is essential because high blood pressure can exacerbate the complications of diabetes, leading to more severe outcomes⁷.

Target: BP™, is a national initiative created by the AHA and the American Medical Association (AMA) in response to the high prevalence of uncontrolled blood pressure (BP). This initiative supports health care organizations and communities to improve BP control for the patients they serve with the latest scientific evidence from the AHA, AMA, and other experts.

Learn more about [Target:BP™](#).



Blood Pressure Categories



BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (top/upper number)		DIASTOLIC mm Hg (bottom/lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120-129	and	LESS THAN 80
STAGE 1 HYPERTENSION (High Blood Pressure)	130-139	or	80-89
STAGE 2 HYPERTENSION (High Blood Pressure)	140 OR HIGHER	or	90 OR HIGHER
SEVERE HYPERTENSION (If you don't have symptoms*, call your health care professional.)	HIGHER THAN 180	and/or	HIGHER THAN 120
HYPERTENSIVE EMERGENCY (If you have any of these symptoms*, call 911.)	HIGHER THAN 180	and/or	HIGHER THAN 120

*symptoms: chest pain, shortness of breath, back pain, numbness, weakness, change in vision or difficulty speaking

heart.org/bplevels

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Figure 4: [Click to enlarge image](#)

6 [National Diabetes Statistics Report | Diabetes | CDC](#)

7 [Diabetes, Hypertension, and Cardiovascular Disease: Clinical Insights and Vascular Mechanisms - PMC](#)

Set

Lipid Management

Dyslipidemia occurs in diabetes primarily due to insulin resistance and the metabolic changes associated with high blood sugar levels⁸. Because of this, diabetes and lipid management are closely interlinked as both conditions significantly impact cardiovascular health. The AHA emphasizes the importance of regular lipid screenings and the use of statins or other lipid-lowering therapies as part of a comprehensive diabetes management plan.

Check. Change. Control. Cholesterol.™ is an Outpace CVD™ program designed to highlight the importance of statin utilization for major risk groups.

Learn more about [Check. Change. Control. Cholesterol | American Heart Association™](https://www.heart.org/ReadySetGo).

Standardizing Lipid Management

AHA has also developed a Ready, Set, Go Implementation Guide for Standardizing Lipid Management. You can continue your journey in standardizing care processes at www.heart.org/ReadySetGo

Kidney Health

Utilize the Kidney Disease- Improving Global Outcomes (KDIGO) heat map to evaluate your patient’s kidney health and decide when treatment and referrals are needed. Timely diagnosis and treatment of chronic kidney disease can slow disease progression and reduce risks and complications.

To continue the conversation, this [kidney health screening guide](#) provides audio, video, and print resources for both patients and clinicians to understand the importance of kidney health in Type 2 diabetes. For a full toolkit on screening for kidney disease to reduce CVD risk, check out [AHA24 Screening for Kidney Disease to Reduce CVD Risk: uACR and eGFR.](#)

CKD is classified based on:

- GFR (G)
- Albuminuria (A)

GFR categories (mL/min/1.73 m ²) Description and range	Albuminuria categories Description and range		
	A1	A2	A3
	Normal to mildly increased <30 mg/g <3 mg/mmol	Moderately increased 30-299 mg/g 3-29 mg/mmol	Severely increased ≥300 mg/g ≥30 mg/mmol
G1 Normal or high ≥90	Screen 1	Treat 1	Treat and refer 2
G2 Mildly decreased 60-89	Screen 1	Treat 1	Treat and refer 2
G3a Mildly to moderately decreased 45-59	Treat 1	Treat 2	Treat and refer 3
G3b Moderately to severely decreased 30-44	Treat 2	Treat and refer 3	Treat and refer 3
G4 Severely decreased 15-29	Treat and refer 3	Treat and refer 3	Treat and refer 4+
G5 Kidney failure <15	Treat and refer 4+	Treat and refer 4+	Treat and refer 4+

■ Low risk (if no other markers of kidney disease, no CKD)
■ Moderately increased risk
■ High risk
■ Very high risk

Figure 5: [Click to enlarge image](#)

Set

Team-Based Care

Team-based care has proven to be highly effective in managing Type 2 diabetes. Studies show that this approach, which involves a coordinated effort among healthcare professionals such as primary care providers, diabetes education specialists, and pharmacists, leads to significant improvements in patient outcomes⁹. For instance, team-based care is associated with a reduction in HbA1c levels by an average of 0.5%, and patients receiving team-based care are more likely to achieve target blood pressure and lipid levels¹⁰. This collaborative model not only enhances clinical outcomes but also improves the overall quality of life for patients by addressing various aspects of diabetes management, including education, self-care, and psychosocial support.



[Click to watch \(56 mins\)](#)

Team-Based Care Strategies to Improve Patient Outcomes



[Click to watch \(2 mins\)](#)

Using Team-Based Care to Improve Diabetes - and Cardiovascular - Related Outcomes

⁹ [Improving Quality Outcomes: The Value of Diabetes Care and Education Specialists | Clinical Diabetes | American Diabetes Association](#)

¹⁰ [Team-Based Care to Improve Diabetes Management: A Community Guide Meta-analysis](#)

Set

Diabetes Self-Management Education and Support (DSMES)

DSMES is an effective way for patients to learn about diabetes and how they can be involved in the management of the disease.

The four recommended times to provide DSMES are:

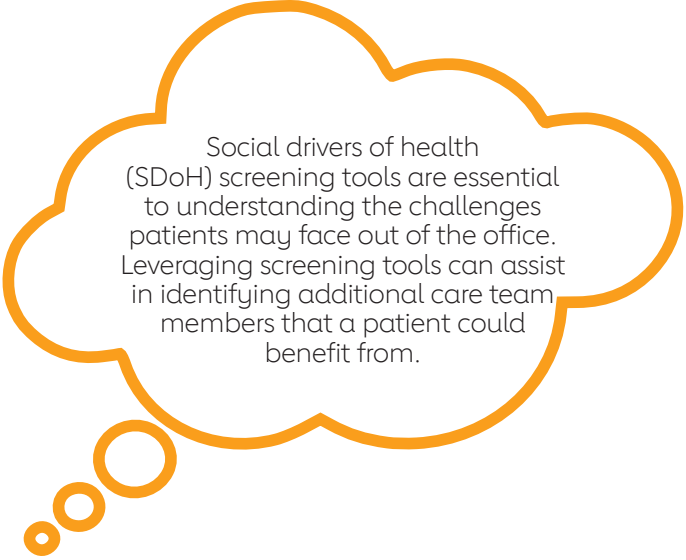
- At the time of diagnosis
- At annual visits
- When new complicating factors arise
- At transitions of care

DSMES services include education on the following topics:

1. Pathophysiology of diabetes and treatment options
2. Healthy coping
3. Healthy eating
4. Being Active
5. Taking medication
6. Monitoring recommendations
7. Reducing risk (treating acute and chronic complications)
8. Problem solving and behavior change strategies

[Find a DSMES provider close to you](#)

Use this [referral form](#) for a standardized way to refer your patients for DSMES. Social drivers of health (SDoH) screening tools are essential to understanding the challenges patients may face out of the office. Leveraging screening tools can assist in identifying additional care team members that a patient could benefit from.



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Go! > INTEGRATE

In addition to getting your site **Ready** through self-evaluation and getting your diabetes management strategies **Set**, you can now prepare to successfully **Go** by implementing your workflows and process improvements.

Implementing a standardized diabetes management workflow within a health system or clinic is an important first step toward helping more patients achieve diabetes control. A successful system involves:

- Identifying high-risk patients
- Utilizing evidence-based treatment guidelines
- Prioritizing comorbid risk reduction

Disseminating this protocol to all care team members is key, so everyone is on the same page and patients receive consistent care.

Leveraging Technology

Harnessing health information technology can significantly enhance diabetes management and improve clinical outcomes. Here are some ways to leverage existing systems of care:



Electronic health records (EHRs) and patient registries:

Identifies patients who would benefit from a comprehensive diabetes management plan.



Clinical decision support tools: Prompts clinicians during visits to order the appropriate tests and adjust treatments as needed when integrated within EHR systems.



Nurses and care coordinators: Conducts targeted outreach to high-risk patients, offers medication and lifestyle counseling, and schedules follow-up appointments.



Pharmacists: Identifies potential drug interactions and ensures patients adhere to their medication regimens.

By stratifying your diabetes control rates by demographics, you can further understand how to best focus your efforts in your community.

By activating the entire care team and embedding these protocols within healthcare systems, more patients can achieve their diabetes management goals and reduce the risk of complications.

Go!

Continuous Glucose Monitoring (CGM)

Continuous glucose monitor use has been shown to lead to reductions in HbA1c and may help reduce episodes of hypoglycemia for some patients¹¹. This technology can provide patients with additional data that they can use to alter their habits, such as changing their food choices.

Utilize resources from the [American Diabetes Association's Time in Range professional development series](#) to assist in implementing a CGM program in your organization. Additionally, the [Making Diabetes Technology Work](#) CE program covers the implementation and management of cutting-edge diabetes technology.

S **eek** your patient's participation

H **elp** your patient explore & compare treatment options.

A **ssess** your patient's values and preferences

R **each** a decision with your patient.

E **valuate** your patient's decision

Shared Decision Making

Goals and treatments for diabetes should be established with patient input. Recognizing the patient's individual factors to create a plan tailored to meet their preferences and needs can increase the patient's willingness to adhere to the treatment plan and result in better outcomes. Communication with patients with diabetes should be collaborative and utilize active listening techniques for the best results.

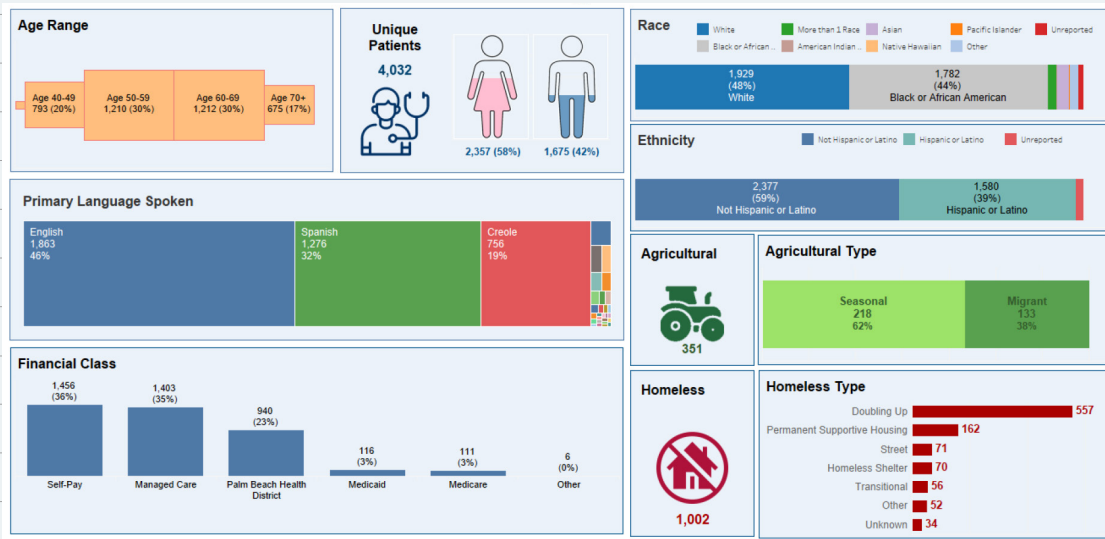
Utilize [patient education materials](#) to support your patients' understanding of diabetes and the shared decision-making process. Additionally, Life's Essential 8™ covers many priority topics related to diabetes to support patient understanding of health promoting behaviors.

¹¹ American Diabetes Association Professional Practice Committee; 7. Diabetes Technology: Standards of Care in Diabetes—2025. *Diabetes Care* 1 January 2025; 48 (Supplement_1): S146–S166. <https://doi.org/10.2337/dc25-S007>

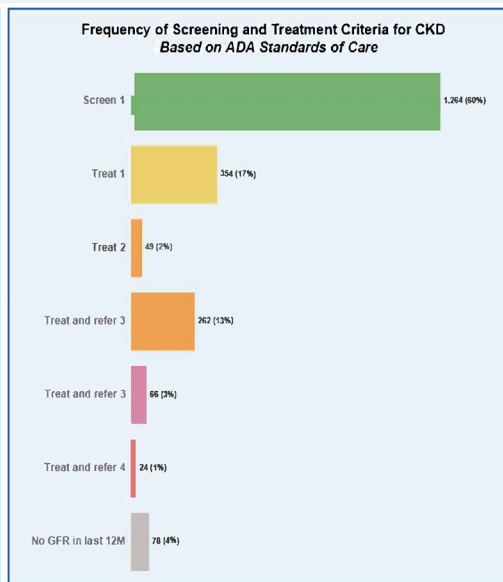
Go!

Dashboards Model Share

Visualizing your data using dashboards can inform priority areas for improvement. In the example below, an organization participating in an AHA-led learning collaborative structured their patient population's kidney health data against KDIGO guidelines. Visualizing the data in this way helps care team members understand where gaps in care exist.



		A1 - Normal to mildly increased			A2 - Moderately increased			A3 - Severely increased		
		0 - 29	30 - 299	300 - Above	0 - 29	30 - 299	300 - Above	0 - 29	30 - 299	300 - Above
G1	Normal or high	>=90	890 (64%) Screen 1	197 (53%) Treat 1	173 (52%) Treat and refer 3					
G2	Mildly decreased	60-89	375 (27%) Screen 1	105 (28%) Treat 1	89 (27%) Treat and refer 3					
G3a	Mildly to moderately decreased	45-59	52 (4%) Treat 1	30 (8%) Treat 2	21 (6%) Treat and refer 3					
G3b	Moderately to severely decreased	30-44	19 (1%) Treat 2	14 (4%) Treat and refer 3	17 (5%) Treat and refer 3					
G4	Severely decreased	15-29	4 (0%) Treat and refer 3	10 (3%) Treat and refer 3	11 (3%) Treat and refer 4					
G5	Kidney Failure	<15		3 (1%) Treat and refer 4	10 (3%) Treat and refer 4					
	No GFR in last 12M	NULL	50 (4%)	16 (4%)	12 (4%)					



Go!

The PREVENT™ Calculator:

The Predicting Risk of Cardiovascular Disease EVENTS (PREVENT™) calculator was developed to overcome limitations in previous risk prediction equations. The PREVENT™ equation removes race and instead includes a measure of place-based social disadvantage, which supports an improved approach to CVD prevention.

[Learn more about this novel prediction equation](#)

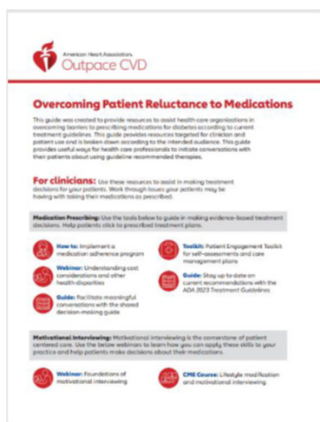
[Learn more about the development and validation of the equation](#)

Overcoming Barriers

We know the barriers you face as health care professionals are not theoretical; they can affect the care of your valued patients. Through our Target: Type 2 DiabetesSM program, we have heard directly from healthcare organizations that some of the top barriers are:

- Patient reluctance to take prescribed medications
- Navigating prior authorizations and formulary challenges
- Cost and affordability concerns

Outpace CVD™ has created resources to help you navigate these barriers with confidence and to support your efforts so that your patients receive the best care.



Overcoming Patient Reluctance to Medications

Use this guide to **help your patients overcome reluctance to taking prescribed medications**. Helping patients overcome common fears of taking prescribed medications may help to increase adherence to guideline recommended pharmacologic agents.

DID YOU KNOW?

Did you know there is a new AHA risk calculator to help you approach shared decision making with your patients?

[To access the calculator click here](#)



[Click to watch \(53 min.\)](#)

Unlocking Medication Access Navigating Drug Formulary and Prior Authorization Challenges

Many clinicians report experiencing systems-based barriers to guideline-directed medical therapy, including formulary challenges and prior authorization issues. Watch this webinar to get information that can help you navigate these challenges.

Go!

Medication Authorization Model Share

The issue of navigating prior authorizations was tackled by a health system in an AHA-led learning collaborative.

Step	Responsible Party	Task
1	Doctor	Associate diagnosis code(s) to the medication order.
2	Doctor	Create a dot phrase to include in the pharmacy note for prior authorization (PA). Insert the needed information in the bolded fields in the dot phrase. Example language: "Medication used/failed in the past: (Include medication name); Dispense amount for 30 days. This is a new start/continuation of medication."
3	Medical Assistant	Receives the PA request from the pharmacy, RxBenefits, CoverMyMeds, BlueE, or via fax.
4	Medical Assistant	<ol style="list-style-type: none"> 1. Create a telephone encounter in the patients medical record. 2. Document the reason for the call as prior authorization. 3. If the PA information is not included in the pharmacy note section, send the telephone encounter to the prescribing doctor and ask to complete step 2.
5	Medical Assistant	If the prescribing doctor doesn't respond in 2 business days, send the encounter again and flag it as high priority.
6	Medical Assistant	<p>When all needed medication information is received, document the following in the note section filling in any needed information:</p> <div style="border: 1px solid black; padding: 5px; background-color: #e0f2f7;"> <p>Received request for prior authorization for: Medication Name: *** Dose Prescribed: *** From Pharmacy: *** PA Key: ***</p> </div> <p>Document any status updates such as: medication pending, medication approved, medication denied.</p>
7	Medical Assistant	Initiate PA through CoverMeds, BlueE, phone call, or paper form for RxBenefits. Route the encounter back to the prescribing provider for monitoring of PA status.

Go!

Step	Responsible Party	Task
8	Medical Assistant	<p>If two prior authorization denials are received, send the patient a message to follow-up with insurance or the pharmacy to determine what alternatives are available. An example patient message is provided below:</p> <p>Dear [patient name],</p> <p>We have submitted a prior authorization request for your [***] medication and we have received a denial from your insurance on two separate attempts. Unfortunately, your insurance does not allow any further prior authorization submission after two denials. Please follow up with your insurance or pharmacy to determine what alternatives, if any, are available to you for this medications.</p> <p>Thank you, [clinician name]</p>
9	Medical Assistant	<p>If approval is received notify the patient of approval. An example notification is provided below:</p> <p>Hello [patient name],</p> <p>We received a request from your insurance to submit a prior authorization on the [***] medication. The prior authorization was submitted, and has been approved by your insurance. Please call your pharmacy and ask them to re-run the prescription prior to pick up.</p> <p>Please let us know if you have any trouble picking up the prescription.</p>

Ready, Set, Go!

Looking Ahead

We recognize that every organization is on their own quality improvement journey and building a comprehensive and formalized diabetes management plan can take time, synergy and resources to achieve. Be sure to share this guide with all members of your care team to get everyone on the same page.

If you would like some additional support, you can continue to work with us through our Target: Type 2 DiabetesSM program, or reach out via our [Contact Us page](#).

For more information, up-to-date education, and resources, visit www.heart.org/OutpaceCVD

**Good
luck!
Here's
to your
great
success!**

Crossing the Finish Line:

- Evaluate current practices and identify areas for improvement through the provided self-assessment checklist and/or peer review process.
- Understand how patients with diabetes move through your systems. Utilize treatment algorithms to ensure standardization of care for all patients.
- Acknowledge and address social drivers of health to reduce disparities and improve health for underserved populations.
- Familiarize your care teams with the American Diabetes Association's Standards of Care in Diabetes- 2025 for the management of diabetes and keep them up to date through regularly scheduled training.
- Prioritize risk reduction in comorbidities such as obesity, hypertension, high cholesterol, and kidney disease to reduce morbidity and mortality in patients with diabetes.
- Implement a team-based approach involving doctors, nurses, pharmacists, care coordinators, dietitians, diabetes educators and others to better meet patient needs, especially for vulnerable populations.
- Utilize technology via CGM, clinical support tools and dashboards to improve outcomes, enhance ease of following guideline-directed care and visualize care gaps.
- Understand your organization's barriers and utilize supportive resources to minimize their effect on patient care and guideline adherence.



Diabetes Management Readiness Checklist

SELF-ASSESSMENT TOOL

Evaluate your current policies, care practices, and patient pathways for guideline directed diabetes care. The checklist below will allow you to assess gaps in care and opportunities for improvement when building and implementing your standardized diabetes management plan.

These questions are designed to generate conversations with your internal teams to create a model for how your system will approach managing patients with diabetes. Each question is linked to a location in this guide to help support you on your journey.

-
- | | |
|--|--|
| <input type="checkbox"/> Does your diabetes management plan include addressing comorbidities including hypertension, cholesterol and kidney disease? | <input type="checkbox"/> Do you regularly use health alerts, dashboards, or other population health tools to assist in clinical decision making? |
| <input type="checkbox"/> Is your organization routinely assessing kidney health of patients with diabetes, including annual assessment of eGFR and uACR? | <input type="checkbox"/> Do you have a process for identifying patients who would benefit from diabetes self-management education and support (DSMES)? |
| <input type="checkbox"/> Does your organization assess health care professional adherence to current guidelines? | <input type="checkbox"/> Can shared management of patients with diabetes be improved, especially between primary care doctors and specialists? |
| <input type="checkbox"/> Do you regularly monitor your diabetes control rates? | <input type="checkbox"/> Do you currently use tools and/or patient aids for shared decision making? |
| <input type="checkbox"/> Is your staff trained on current diabetes guidelines on a regular cadence? | <input type="checkbox"/> Are barriers to medication adherence and lifestyle changes assessed? |
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