Bi-directional feedback loop **process**

Clinical care team

National Diabetes Prevention Program (National DPP) lifestyle change program provider

Patient

PROCESS BEGINS

Refer patient to lifestyle change program.*

Receive referral and conduct outreach to the patient.

Enroll in lifestyle change program.

No

Yes

Notify clinical care team of the patient's enrollment status.**

Update medical record with patient's enrollment status.

Participate in weekly and monthly lifestyle change program sessions.

Provide regular feedback to clinical care team on patient's progress and outcomes.***

Update medical record with feedback on patient's progress and outcomes.

No

Notify clinical care team of change in patient's participation status.**

Update medical record with change in patient's participation status.

Complete lifestyle change program.

Yes

Notify clinical care team of patient's program completion and provide final outcomes.**

Update medical record to reflect patient's program completion and final outcomes.

* Referral placement or receipt can be through a variety of methods, including Health Information Exchange (HIE) systems, electronic health record (EHR) functions, program locators, care coordination platforms, fax or email notifications. A resource to optimize your electronic health record to prevent type 2 diabetes and a template lifestyle change program referral and authorization release form can be found on amapreventdiabetes.org.

** Notifications to clinical care teams can be sent through a variety of mechanisms, including electronic health record functions (EHRs), secure email, fax or letters.

*** For more information about feedback, refer to the other side of this resource.

Bi-directional feedback loop **FAQ**

Q: What is a bi-directional feedback loop for diabetes prevention?

A: A bi-directional feedback loop refers to the process by which information flows from the clinical care team to the National Diabetes Prevention Program (National DPP) lifestyle change program provider (referral) and from the National DPP lifestyle change program provider to the clinical team (feedback on the patient's progress). In this diagram, the patient is also included to help illustrate best practices for communication. Bi-directional feedback begins after a patient has been diagnosed with prediabetes and a clinical decision has been made to refer the patient to a National DPP lifestyle change program. Bi-directional feedback ends when the clinical team is notified by the National DPP lifestyle change program that the patient left the program early or completed the program in its entirety.

Q: What does this bi-directional feedback loop diagram not include?

A: The diagram in this resource does not address the expected follow-up actions of clinical care teams and program providers, but rather focuses on providing guidance on the information exchange process. For example, after receiving a notification that a patient has declined enrollment in a program, the clinical care team may conduct outreach to the patient. Another example of this is when program staff reaches out to the patient to re-engage them or verify that they have chosen to leave the program. This diagram does not include these actions, but it does highlight events that should prompt information exchange between clinical care teams and program providers.

Q: Why is a bi-directional feedback loop important to establish?

A: The bi-directional feedback loop complements a patient-centered approach and supports clinical-community linkages. It creates an opportunity for clinical care teams to support patients in enrolling and participating in the National DPP lifestyle change program. It also outlines the expected communication between the program provider and the clinical care team to ensure appropriate patient follow-up and monitoring.

Q: Does the bi-directional feedback loop process change if patients are referred using different methods?

A: Yes. The bi-directional feedback loop process changes based on if you are leveraging the point of care or care management approach. However, the information being shared and the times to transmit information do not change.

Q: What needs to be considered if a clinical care team is referring patients to an external organization for the lifestyle change program compared to referring patients to a program within their organization?

A: If a clinical care team is referring patients to an external National DPP lifestyle change program (i.e., outside of their health care organization), it is important to establish a secure, HIPAA-compliant mechanism to exchange patient information, including referral, enrollment, participation and completion notifications, and to ensure that the appropriate legal and contractual agreements are in place. If a clinical care team is referring patients to a National DPP lifestyle change program offered within their health care organization, there is likely an existing process for sharing patient health information (e.g., using approved and secure internal messaging software or electronic health record functionality). The AMA recommends consulting with clinical operations, information technology and/or legal business units when establishing a referral process to determine necessary steps for secure, appropriate and complete bi-directional exchange of patient health information.

Q: What data elements should be shared between the National DPP lifestyle change program provider and the clinical care team as part of ongoing feedback and how often?

A: The AMA suggests National DPP lifestyle change program providers send feedback to the clinical team that includes participant attendance, weight loss and physical activity minutes at regular, agreed upon intervals, such as after the third, ninth and 16th sessions of the program. The clinical care team and National DPP lifestyle change program provider should collaborate to determine how often feedback is expected, what content should be included and if feedback should be provided on an individual patient level, an organizational site level or at an aggregate organization level. The AMA's progress report templates on the tools & resources page can be leveraged to assist with this process.

Q: What data elements should be shared between the clinical care team to the National DPP lifestyle change program provider at the time of referral?

A: The AMA suggests clinical care teams include participant contact information, including preferred contact methods and times, along with the relevant patient eligibility criteria to National DPP lifestyle change program providers at the time of referral. The AMA has developed a sample referral form that health care organizations can leverage as a template.

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