



تعميم رقم (188 / 2025) Circular No

Date: 2025/09/26

التاريخ: 2025/09/26

To: All Healthcare Facilities Providing the Comprehensive Screening Program (IFHAS) Healthcare Professionals

السادة/ جميع المنشآت الصحية التي تقدم برنامج
الفحص الدوري الشامل (افحص)
المهنيين الصحيين

Subject: Introducing the Diabetes Disease Management Program

الموضوع: تقديم برنامج إدارة مرض السكري

Greetings,

تحية طيبة وبعد ،،،

We extend our greetings and best wishes for your continued success.

بدايةً، يسرُّنا أن نتقدم لكم بخالص التحية والتقدير متمنين
لكم دوام التوفيق والسداد.

Kindly be advised that the Department of Health (DoH) and Abu Dhabi Public Health Center (ADPHC) have announced the launch of a new pilot phase for the Diabetes Disease Management Program. This initiative is a part of the ongoing efforts to enhance the health of the Abu Dhabi population.

نود إعلامكم بأن دائرة الصحة ومركز أبوظبي للصحة العامة
قد أعلننا عن إطلاق مرحلة تجريبية جديدة لبرنامج إدارة
مرض السكري. وتأتي هذه المبادرة كجزء من الجهود المستمرة
لتعزيز صحة السكان في أبوظبي.

The program focuses on enhancing health outcomes and improving overall management to prevent the progression and complications of Type 2 diabetes.

يركز البرنامج على تعزيز النتائج الصحية وتحسين الإدارة
الشاملة لمنع تفاقم مرض السكري من النوع الثاني وتجنب
مضاعفاته.

Due to the importance of the program in protecting community health, and reducing the burden of diabetes, you are required to:

وانطلاقاً من أهمية البرنامج في حماية صحة المجتمع وتقليل
عبء مرض السكري، فإنه يجب عليكم الآتي:

- **Enrolment in Diabetes Disease Management Program:** Ensure the enrolment of eligible members into the program based on the inclusion and exclusion criteria specified in the attached appendix.

- **التسجيل في برنامج إدارة مرض السكري:**
التأكد من تسجيل المؤهلين للالتحاق في البرنامج بناءً
على معايير الإدراج والاستبعاد المحددة في الملحق
المرفق.





• **Regular Reporting:**

1. Submit clinical outcome indicators on a monthly or quarterly basis.
2. Provide weekly updates on enrolment progress.

Contact Details:

For any inquiries in this regard, please contact Chronic Conditions Team at ADPHC via the following email address: ccs@adphc.gov.ae

Appendices:

- Inclusion and Exclusion Criteria
- Clinical Pathway
- Patient Journey

We hope that all will adhere to the above, for the best interest of work.

Thank you for your cooperation,

"This circular is designed for regulatory procedures and should not be used as content for media publication."

• **التقارير الدورية:**

1. الالتزام التام بتقديم مؤشرات النتائج السريرية بشكل شهري أو ربع سنوي.
2. تقديم تقرير أسبوعي حول مدى تقدم التسجيل.

بيانات التواصل:

في حال وجود أي استفسارات بهذا الشأن، يرجى التواصل مع فريق الأمراض المزمنة في مركز أبوظبي للصحة العامة عن طريق البريد الإلكتروني: cs@adphc.gov.ae

الملحقات:

- معايير الإدراج والاستبعاد من البرنامج
- المسار السريري
- رحلة المريض

آملين من الجميع الالتزام بما ورد أعلاه، لما فيه مصلحة العمل.

شاكرين لكم حسن تعاونكم معنا،،،

"هذا التعميم للإجراءات التنظيمية وغير مخصص كمحتوى للنشر الإعلامي"

د. نورة خميس الغيثي
وكيل دائرة الصحة





Diabetes Disease Management Program



Diabetes Disease Management Program



Background

- Uncontrolled diabetes and its complications lead to high healthcare costs due to frequent hospitalizations and emergency department visits.
- Increased healthcare utilization places a strain on medical resources, resulting in worse patient outcomes and higher treatment expenses.
- The Diabetes Management Program (DMP) provides coordinated care that: Improves glycemic control, Manages risk factors, Promotes healthier lifestyles and Prevents the progression and complications of Type 2 diabetes

Purpose

- This comprehensive program includes key collaborators—regulator, payer, and provider—aiming to address the needs of diabetic populations.
- By providing evidence-based, coordinated care, the program strives to enhance patient health outcomes and improve overall management of

Type 2 diabetes.

- The program's duration is 12 months, offering sufficient time for patients to benefit from continuous care and support. Throughout the year, participants will undergo regular evaluations, receive tailored interventions, and have access to ongoing educational opportunities.

Why is it important?

- **High Prevalence in the Population:** With the increasing prevalence of diabetes and its related complications, there is an urgent need to optimize care and reduce long-term healthcare costs. By focusing on early intervention and personalized treatment plans, the program aims to improve both patient quality of life and the overall efficiency of healthcare delivery.
- **Proven Effectiveness:** Such programs have demonstrated effectiveness in improving clinical outcomes, offering a strong rationale for implementation.



Inclusion & Exclusion Criteria

Diabetes Disease Management Program



Effective identification of individuals with diabetes is essential for initiating timely interventions and managing disease progression effectively. To ensure appropriate participation and program efficacy, clear eligibility criteria have been established. These criteria help identify suitable members.

➤ Inclusion and Exclusion Criteria:

1. Inclusion:

- a. Thiqa Portfolio
- b. 18 years and above
- c. Diagnosis criteria:
 - At least two outpatient visits for Diabetes in 1 year
 - HBA1C level of 6.5% or higher

2. Exclusion:

- a. Diagnosis of Cancer
- b. Maternity
- c. Major Organ Transplant



Program Objective



The program offers patients continuous care over a 12-month period, categorizing individuals with diabetes into risk groups using evidence-based models.

The specific objectives include:



- **Education and Awareness:** Raise awareness about prediabetes and diabetes, including risk factors and potential complications.



- **Lifestyle Modification:** Promote and support lifestyle changes such as healthy eating, increased physical activity, and weight management to improve the Type 2 diabetes outcomes.



- **Monitoring and Follow-up:** Regularly monitor individuals with prediabetes and diabetes to assess their progress and adjust interventions, as necessary.



- **Support and Resources:** Provide access to essential resources like nutrition counseling, fitness programs, and support groups to help individuals adopt and maintain healthy lifestyle changes.



- **Achieve Cost-Effectiveness:** Enhance healthcare delivery by improving cost-effectiveness through targeted interventions and preventive care.



Risk Stratification

Framingham Risk Score



The **Framingham Risk Score (FRS)** is a tool used to estimate the likelihood of an individual developing cardiovascular disease (CVD).

Diabetes is a major risk factor for developing cardiovascular disease (CVD). People with diabetes are at a significantly higher risk of developing heart disease, stroke, and other related complications. The FRS can help identify individuals with diabetes who are at higher risk of these cardiovascular events, guiding targeted interventions and more personalized care within a diabetes disease management program

Framingham Risk Score calculation steps:



Step 1: Gather Patient Information

- **Age:** Patient's age in years.
- **Gender:** Male or female.
- **Total Cholesterol:** Measured in mg/dL.
- **HDL Cholesterol:** Measured in mg/dL.
- **Blood Pressure:** Systolic blood pressure (measured in mmHg).
- **Diabetes Status:** Presence of diabetes (yes or no).
- **Smoking Status:** Current smoker (yes or no).



Framingham Risk Score



Step 2: Assign Points

Use the following scoring system based on the collected data:

Risk Factor	Risk Points	
	Men	Women
Age		
30-34:	0	0
35-39:	2	2
40-44:	5	4
45-49:	6	5
50-54:	8	7
55-59:	10	8
60-64:	11	9
65-69:	12	10
70-74:	14	11
75+:	15	12

Risk Factor	Risk Points			
	Men		Women	
Blood Pressure (Systolic):	Not Treated	Treated	Not Treated	Treated
<120 mmHg	-2	0	-3	-1
120-129 mmHg	0	2	0	2
130-139 mmHg	1	3	1	3
140-149 mmHg	2	4	2	5
150-159 mmHg	2	4	4	6
≥160 mmHg	3	5	5	7

Risk Factor	Risk Points	
	Men	Women
HDL Cholesterol:		
>60 mg/dL	-2	-2
50-59 mg/dL	-1	-1
45-49 mg/dL	0	0
35-44 mg/dL	1	1
<35 mg/dL	2	2

Risk Factor	Risk Points	
	Men	Women
Total Cholesterol:		
<160 mg/dL	0	0
160-199 mg/dL	1	1
200-239 mg/dL	2	3
240-279 mg/dL	3	4
≥280 mg/dL	4	5

Risk Factor	Risk Points	
	Men	Women
Diabetes Status:		
Yes	3	3
No	0	0

Risk Factor	Risk Points	
	Men	Women
Smoking Status:		
Yes	4	4
No	0	0



Framingham Risk Score



Step 3: Calculate Total Points

Sum the points from each category based on the patient's data to obtain the total score.



Step 4: Determine Risk Category

Using the total points from Step 3, refer to the Framingham Risk Score chart to determine the 10-year cardiovascular disease (CVD) risk percentage.



Step 5: Estimate 10-Year Cardiovascular Risk

Based on the calculated risk percentage from Step 4, classify the risk as follows:

- FRS Score less than 10%: **Low Risk**.
- FRS Score between 10% - 20%: **Moderate Risk**.
- FRS Score more than or equal 20%: **High Risk**.

Step 4:

Total Points		
	Men	Women
<= -3	<1	<1
-2	1.1	<1
-1	1.4	1
0	1.6	1.2
1	1.9	1.5
2	2.3	1.7
3	2.8	2
4	3.3	2.4
5	3.9	2.8
6	4.7	3.3
7	5.6	3.9
8	6.7	4.5
9	7.9	5.3
10	9.4	6.3
11	11.2	7.3
12	13.2	8.6
13	15.6	10
14	18.4	11.7
15	21.6	13.7
16	25.3	15.9
17	29.4	18.5
18	>30	21.5
19	>30	24.8
20	>30	28.5
21	>30	>30



Clinical Pathway

Diabetes Disease Management Program

The management of diabetes is critical in reducing the risk of cardiovascular complications. A well-structured clinical pathway helps guide care for diabetic patients at elevated cardiovascular risk, ensuring timely and effective interventions. The following outlines the key components of the pathway development, review, and alignment with healthcare standards.



Healthcare Providers: Responsible for developing the clinical pathway tailored to diabetic members. This pathway will be designed to address the unique needs of diabetic individuals at risk of cardiovascular diseases.



Review by Daman: Developed clinical pathway will be reviewed Daman team to ensure it reflects current best practices and meets established standards for quality patient care



Alignment with Healthcare Standards: The clinical pathway must be aligned with the guidelines published by regulators



Cost Calculation Methodology

Diabetes Disease Management Program

1. Members Identification

- Patients diagnosed with Diabetes were identified.
- Stratification was performed using the Framingham Risk Score into three categories:
 - Low Risk
 - Moderate Risk
 - High Risk

2. Patient Attribution

- Patients were attributed to the most frequently visited provider for diabetes treatment.
- Attribution was determined based on the provider who accounted for at least 60% of the patient's diabetes treatment

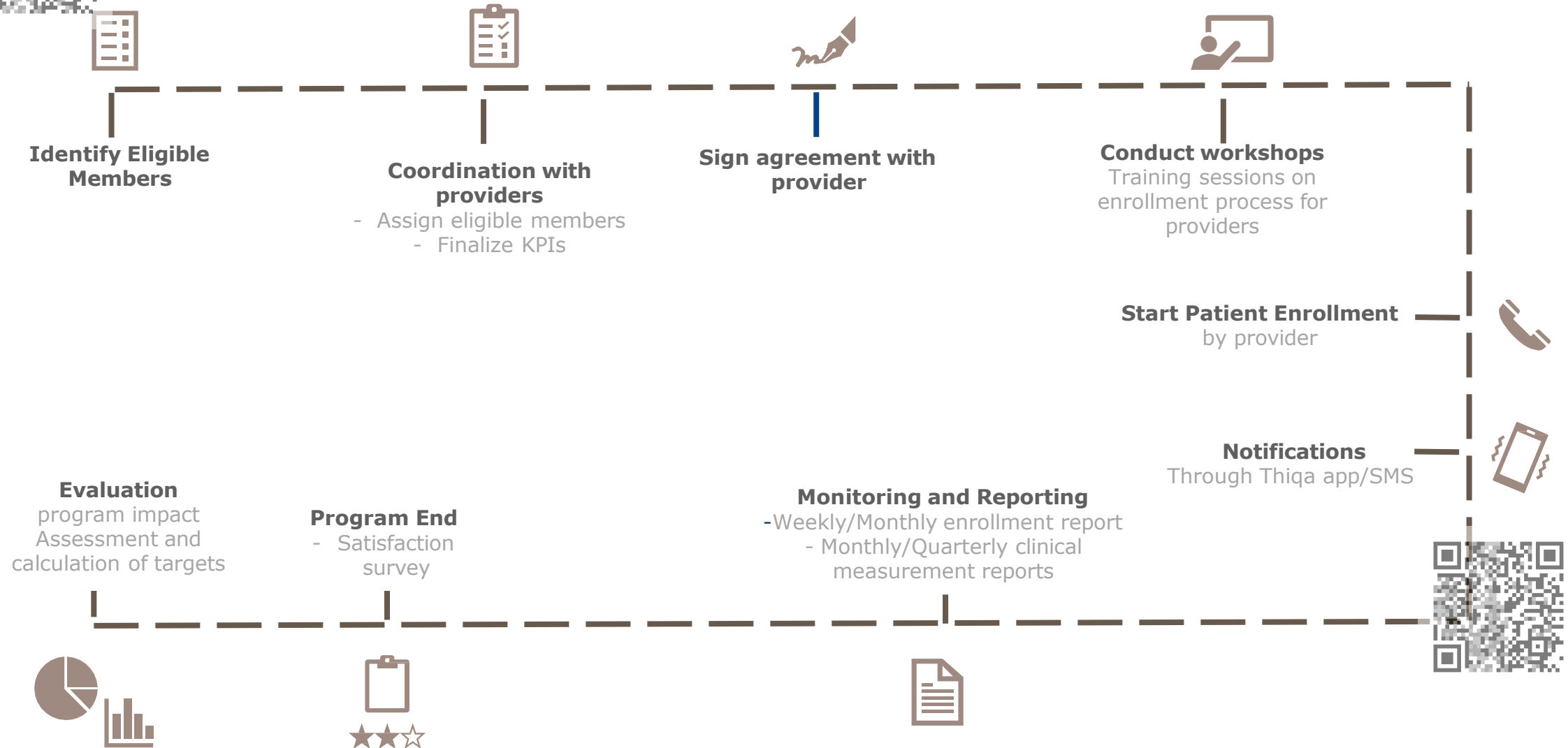
3. Cost Calculation

- Only the cost of diabetes and diabetes-related complications was calculated.
- Costs were determined using ICD-10 codes where diabetes was the primary diagnosis.
- Both direct and indirect costs were considered by ordering clinician.
- Cost is inclusive of all cost blocks.
- Per Member Per Year (PMPY) Approach



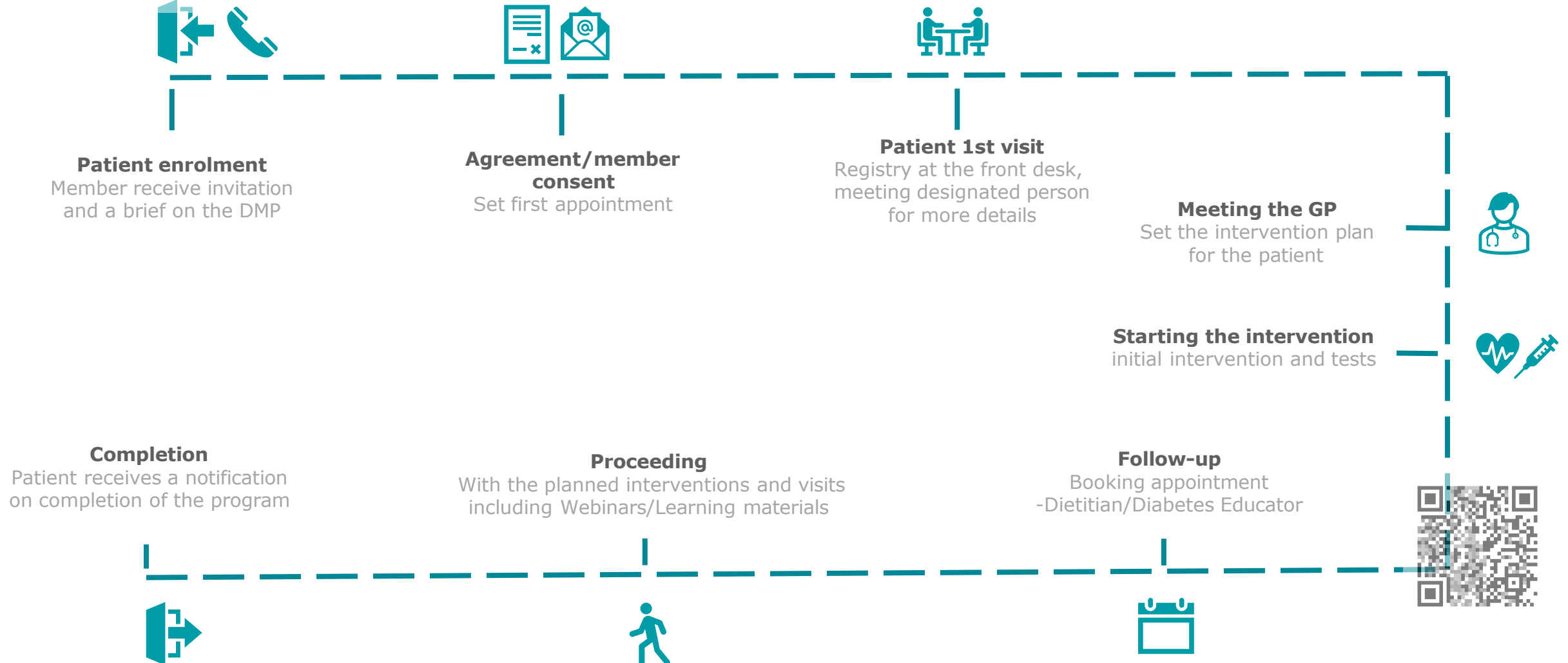
Enrollment Process

Diabetes Disease Management Program



Patient Journey

Diabetes Disease Management Program





Thank you

