

Chronic Care Management Diabetes Assessment, Referrals and Resources

Introduction

This diabetes assessment, referral and resource guide was updated June 2012. The intent of this diabetes treatment guide is to provide evidence based practice guidelines, nursing assessment tools, client and caregiver education materials and journal articles with supporting evidence, for use with CCM clients.

Based on the review of the data from predictive modeling and claims data, diabetes, and the management of diabetes is one of the primary diagnosis of our clients enrolled in the CCM program. Considering the scope of diabetes and the ability to impact the outcome of this chronic illness, this manual will provide useful information and resources for the nursing staff. As additional resources are used or new practices are recommended this guide can be updated.

Diabetes Action Plan Clients enrolled in CCM with diabetes or pre-diabetes will be assessed for and offered a Health Action Plan. This plan may include:

1. The client identifying his or her diabetes care team
2. The client identifying his or her diabetes goals.
3. Testing and management of A1c (7 or less)
4. Testing and control of blood pressure. (130/80 or less)
5. Testing and management of cholesterol. (LDL 100 or less)
6. Following a diabetic food plan.
7. Getting physical activity.
8. Stop smoking.
9. Taking medications as prescribed.
10. Checking feet every day for skin changes.
11. Dental care twice a year.
12. Home blood glucose monitoring as recommended.

The most difficult step for most clients to control diabetes is the first step; setting a goal, and then making a plan to meet that goal. CCM can assist clients with setting goals and adopting healthy life style behaviors and or diabetes control by using a patient centered approach. Patient centered care includes using strategies that incorporates patient preferences, assesses literacy and numeracy, and addresses cultural barriers to care. The CCM program will also need to identify and addresses barriers to care, integrate

evidenced based guidelines for diabetes and incorporate care management teams in order to effectively assist clients with goal setting and providing interventions that support the patients treatment plan and overall health goals.

One of the resource tools included in this resource manual is “My Action Plan”. Each diabetic client should work with their nurse to create an action plan, and share that with caregivers, family, friends and health care providers.

Importance for patient care	Recommendation	Treatment Goals
<p>A1c management</p> <p>The A1C test helps health care providers adjust medication to reduce the risk of long-term diabetes complications. Studies have demonstrated substantial reductions in long-term complications with the lowering of A1C levels.</p> <p>Lowering A1C to below or around 7% has been shown to reduce microvascular complications of diabetes, and if implemented soon after the diagnosis of diabetes is associated with long-term reduction in macrovascular disease.</p>	<p>Performed at initial assessment and every three months for poorly controlled diabetes, and twice yearly for well controlled diabetes.</p>	<p>A1c < 7</p> <p>People will have different A1C targets depending on their diabetes history and their general health. People should discuss their A1C target with their health care provider. Studies have shown that people with diabetes can reduce the risk of diabetes complications by keeping A1C levels below 7 percent. However, an A1C level that is safe for one person may not be safe for another. For example, keeping an A1C level below 7 percent may not be safe if it leads to problems with hypoglycemia, also called low blood glucose. Less strict blood glucose control, or an A1C between 7 and 8 percent—or even higher in some circumstances—may be appropriate in people who have the following:</p> <ol style="list-style-type: none"> 1. Limited life-expectancy 2. Long-standing diabetes and difficulty attaining a lower goal 3. Severe hypoglycemia 4. Advanced diabetes complications such as chronic kidney disease, nerve problems, or cardiovascular disease
<p>Lipid management</p>	<p>Fasting lipid profile is obtained at initial</p>	<p>LDL < 100</p> <ul style="list-style-type: none"> • In individuals <u>without</u> overt CVD, the primary goal is an LDL

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<p>Persons with diabetes are at higher risk of coronary heart disease. Lowering serum cholesterol levels can reduce the risk for CHD events.</p>	<p>assessment. Levels should be repeated every year, and two years if levels fall in lower risk levels.</p>	<p>cholesterol, 100 mg/dL .</p> <ul style="list-style-type: none"> In individuals <u>with</u> overt CVD, a lower LDL cholesterol goal of 70 mg/dL. <p>HDL Men > 40 Women > 50 Triglycerides < 150</p> <p>Lifestyle modification focusing on the reduction of saturated fat, trans fat, and cholesterol intake; increase of n-3 fatty acids, viscous fiber and plant stanols/sterols; weight loss (if indicated); and increased physical activity should be recommended to improve the lipid profile in patients with diabetes.</p> <p>Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:</p> <ul style="list-style-type: none"> <u>With</u> overt CVD; and <u>Without</u> CVD who are over the age of 40 years and who have one or more other CVD risk factors.
<p>Urine Protein Screening</p> <p>Diabetes is the leading cause of end stage renal disease, diabetic nephropathy accounting for one-third of all cases of ESRD.</p> <p>The earliest evidence of renal disease is the appearance of low, but abnormal levels of albumin in the urine.</p> <p>Screening for</p>	<p>A test for the presence of microalbuminuria should be performed at diagnosis in patients with type 2 diabetes, and annually thereafter.</p>	<p>Albumin Levels</p> <ul style="list-style-type: none"> Normal < 30 Microalbuminuria < 30-299 Macroalbuminuria ≥ 300 <p>In the treatment of the nonpregnant patient with micro or macroalbuminuria, either ACE inhibitors or ARBs should be used. If one class is not tolerated, the other should be substituted.</p>

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<p>microalbuminuria can be performed by measurement of the albumin-to-creatinine ratio in a random spot collection.</p>		
<p>Eye Examination</p> <p>Retinopathy is a serious threat to vision. The prevalence of retinopathy is strongly related to the duration of diabetes.</p>	<p>Dilated eye exam be completed initially and annually. The level of exam and frequency should be determined by the ophthalmologist.</p>	<p>To reduce the risk or slow the progression of retinopathy, optimize glycemic control.</p> <p>To reduce the risk or slow the progression of retinopathy, optimize blood pressure control.</p>
<p>Foot Examination</p> <p>Persons with diabetes are at higher risk of foot ulcers and amputations.</p>	<p>Foot exam to occur annually to identify high risk foot conditions; assessment of protective sensation, foot structure, vascular status, and skin integrity.</p> <p>Perform a visual inspection of client’s feet at each routine visit.</p> <p>Provide general foot self-care education to all patients with diabetes</p>	<p>People with neuropathy should have visual inspection of their feet at every contact with a health care professional.</p> <p>A multidisciplinary approach is recommended for individuals with foot ulcers and high-risk feet, especially those with a history of prior ulcer or amputation.</p> <p>Refer patients who smoke, have loss of protective sensation and structural abnormalities, or have history of prior lower-extremity complications to foot care specialists for ongoing preventive care and long term foot surveillance.</p>
<p>Immunizations</p> <p>Persons with diabetes are considered to be at higher risk of complications, hospitalization and death from influenza and pneumonia.</p>	<p>Influenza: Annually provide an influenza vaccine to all diabetic patients ≥6 months of age.</p> <p>Pneumonia: Administer pneumococcal polysaccharide vaccine to all diabetic adult patients. A one-time revaccination is</p>	

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	<p>recommended for individuals > 64 years of age previously immunized when they were <65 years of age if the vaccine was administered 5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease, and other immunocompromised states, such as after transplantation.</p> <p>Hepatitis B: Administer hepatitis B vaccination to adults with diabetes as per Centers for Disease Control and Prevention (CDC) recommendations.</p>	
<p>Blood Pressure Management</p> <p>Intensive control of blood pressure in patients with diabetes reduces diabetes complications, deaths, strokes, heart failure, and microvascular complications.</p>	<p>Blood pressure should be measured at every routine diabetes visit. Clients with systolic > 130 or diastolic > 80 should have blood pressure confirmed on a separate day.</p> <p>Orthostatic measurement of blood pressure should be performed to assess for the presence of autonomic neuropathy.</p>	<p>Systolic < 130 Diastolic < 80</p> <p>Treatment options for patients with blood pressure 130-139mmHg or a diastolic pressure 80-89mmHG include:</p> <ol style="list-style-type: none"> 1. Life style changes 2. Patient may be given life style therapy alone for maximum of 3 month. 3. Lifestyle therapy for hypertension consists of weight loss, if overweight; Dietary Approaches to Stop Hypertension (DASH)-style dietary pattern, including reducing sodium and increasing potassium intake; moderation of alcohol intake; and increased physical activity.

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		<p>4. Patients with more severe hypertension (systolic bp \geq 140mmHg or diastolic blood pressure $>$90mmHG at diagnosis <u>or follow up should receive pharmacologic therapy in addition to life style therapy.</u></p> <p>5. Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an ACE inhibitor or an ARB. If one class is not tolerated the other should be substituted.</p>
<p>Aspirin Use</p> <p>Daily low dose aspirin therapy is important for both primary and secondary prevention of cerebral and cardiac events.</p>	<p>Aspirin therapy has been recommended as a primary and secondary prevention strategy for diabetics depending on CVD risk factors. Please refer to Diabetes guidelines for appropriate use and dosage. http://care.diabetesjournals.org/content/35/Supplement_1/S11.full.pdf+html</p>	<p>Please refer to guidelines for aspirin therapy precautions, and recommended dosages. http://care.diabetesjournals.org/content/35/Supplement_1/S11.full.pdf+html</p>
<p>Smoking cessation</p> <p>Studies of individuals with diabetes consistently demonstrate that smokers have a heightened risk of CVD and premature death and increased rate of microvascular complications of diabetes.</p>	<p>Assessment of tobacco use.</p> <p>Advise all patients not to smoke.</p> <p>Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care.</p>	
<p>Physical Activity</p> <p>Exercise is an important part of the diabetes management plan. Regular exercise has</p>	<p>People with diabetes should be advised to perform at least 150 minutes of physical exercise/activity per week.</p>	<p>Before recommending a program of physical activity, providers should assess patients for conditions that might contraindicate certain types of exercise or predispose to injury, such as uncontrolled hypertension, severe</p>

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<p>been shown to improve blood glucose control, reduce cardiovascular risk factors, contribute to weight loss, and improve well-being. Furthermore, regular exercise may prevent type 2 diabetes in high-risk individuals.</p>	<p>In the absence of contraindications, people with type 2 diabetes should be encouraged to perform resistance training at least twice per week.</p>	<p>autonomic neuropathy, severe peripheral neuropathy or history of foot lesions, and unstable proliferative retinopathy. The patient's age and previous physical activity level should be considered.</p> <p>Four Kinds of physical activity are suggested:</p> <ol style="list-style-type: none"> 1. Extra active during the day 2. Aerobic exercise 3. Strength training 4. Stretch