Disease Management Guidelines

A working tool intended to assist with the development
of an individualized comprehensive plan of care

Diabetes

Goal: Optimize Glycemic Control and Minimize Risk of Diabetic Complications

Action Steps:

✓ **CM will:**

- ❑ Explore and provide MEMBER/caregivers with information on available expert diabetes management resources (such as diabetes education centers)
- ❑ Contact Member's physician office to discuss diabetes clinical management strategies and obtain physician recommendations for plan of care
- ❑ Facilitate an IDT with RN, PT, Dietitian, Diabetes Educator, Member, PCA, Informal Caregivers, and/or other providers as deemed appropriate and available to assess disease status, safety/supervision needs, program and community appropriateness, and to develop an individualized program of diabetes management
- ❑ Provide referrals as required by plan, to include, but not limited to:
  - ❖ Physical Therapist:
    - _ Assess MEMBER ability for physical activity
    - _ Assess MEMBER need for mobility and safety assistive devices
    - _ Develop an exercise plan adapted to the specific needs and abilities of the MEMBER
    - _ Provide CM with written report documenting assessments, interventions, activity plan, outcomes, and recommendations
  - ❖ Dietitian:
    - _ Assess MEMBER nutritional status
    - _ Assess MEMBER, PCA, and informal caregiver knowledge of diabetic diet requirements
    - _ Provide nutrition education (relevant to MEMBER need) including, but not limited to:
      - ▪ Weight management
      - ▪ Dietary guidelines to manage:
        - – blood sugar
        - – lipids
        - – kidney disease
        - – high blood pressure
        - – congestive heart failure

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- _ Provide CM with written reports documenting assessments, education, diet plan, outcomes, and recommendations

- ❑ Obtain needed equipment and supplies as recommended by the IDT and approved by MEMBER's physician
- ❑ Provide ____ home visits (frequency to be determined by MEMBER need) to:
  - _ Assess medical, psychosocial, and economic needs and explore needed resources
  - _ Monitor and evaluate MEMBER adherence and outcomes to include, but not limited to review of:
    - Medications
    - Lab values
    - FBS logs
    - Exercise logs/PT Plan
    - Daily foot inspections
    - Food diary
    - Vital signs (wt, BP, and pulse) log
    - Eye exam
    - Immunizations
    - Regular medical visits
  - _ Evaluate effectiveness of plan
  - _ Observe and verify MEMBER and caregiver skills and knowledge level
  - _ Provide information on obtaining Medic Alert identifier
- ❑ Obtain and review reports of each visit by all providers, including RN, PT, and Dietitian
- ❑ Collaborate with MEMBER, caregivers, and all providers and amend the plan as needed to meet changing MEMBER needs, including referrals for specialty care

✓ **Skilled Nurse will provide _____ home visits (frequency to be determined by MEMBER need) to:**

- ❑ Obtain comprehensive medical history
- ❑ Monitor and evaluate disease status including blood pressure, weight, blood glucose levels, and skin integrity
- ❑ Monitor and evaluate physician ordered laboratory tests and forward results to CM
- ❑ Assess MEMBER, PCA, and informal caregiver knowledge and skills
- ❑ Provide diabetes management education (relevant to Member need) to include, but not limited to:
  - _ Disease process
  - _ Self–monitoring of blood glucose levels
  - _ Medication purpose, administration, side effects, and adverse reactions
  - _ Signs, symptoms, and management of complications

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- _ Assess and provide strategies for reducing risk for and managing complications
  - Heart healthy lifestyle
  - Stroke prevention
  - Blood pressure control target level: ≤ 139/89
  - Daily blood glucose **target FBS level: 80-140** (target can vary with Member circumstances – please check with physician)
  - HbA1C **target level: ≤7%** (less stringent target may be appropriate for Members with limited life expectancy, in the very young or older adults, and in those with co-morbid conditions)
  - Lipid management: target levels: LDL <100, triglycerides <150, HDL > 45 in men, > 55 in women
  - Nephropathy screening (microalbumin levels to check kidney function)
  - Vision check for retinopathy
  - Immunizations (pneumonia and flu)
  - Diabetic ulcer prevention
  - Foot care
  - Smoking cessation

❑ Monitor and evaluate MEMBER adherence to diabetes management program

❑ Monitor and evaluate MEMBER, caregivers, and PCA for proper use of equipment and supplies

❑ Provide CM with written reports of all visits, documenting assessments, education and clinical interventions, outcomes, and recommendations

✓ **MEMBER, informal caregivers, and/or providers will:**

❑ Keep logs of routine blood glucose levels, weights, and blood pressure

❑ Prepare meals using diet plan as prescribed by dietician, RN, and/or physician

❑ Maintain food diary

❑ Perform daily inspection of feet

❑ Take medications as prescribed by the physician

❑ Participate in an activity program as prescribed by the physical therapist and/or physician

❑ Make and keep all medical appointments including, but not limited to:

- _ Routine check-ups to monitor health status
- _ At least quarterly HbA1C levels
- _ At least annual eye exam, microalbumin test, and lipids level
- _ Annual flu vaccination
- _ One-time pneumococcal vaccination with revaccination as recommended by physican

❑ Report signs and symptoms of illness, blood glucose level above _____ , blood pressure reading above _____ , or skin changes to RN and/or physican

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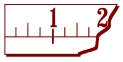
- ❑ Verbalize understanding of when and how to seek emergency care
- ❑ Verbalize understanding of risks and benefits of adherence/non-adherence to plan
- ❑ Report difficulties with plan adherence, changes in health status, or service plan needs to CM



Expected Outcomes:

- PCA, caregivers, and/or MEMBER can verbalize diabetes disease process, diabetes management plan, and target levels for blood glucose, weight, and blood pressure
- PCA, caregivers, and/or MEMBER recognize symptoms of disease progression or complications and can verbalize when to call the RN or physician
- PCA, caregivers, and/or MEMBER can demonstrate proper use of equipment and supplies
- MEMBER and caregivers have adequate information to make informed decisions, including the risks and benefits of adherence/non-adherence to plan

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