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
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.

- Make 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.
Assess and provide strategies for reducing risk for and managing complications

- Heart healthy lifestyle
- Stroke prevention
- Blood pressure control target level: \( \leq 139/89 \)
- Daily blood glucose **target FBS level: 80-140** (target can vary with Member circumstances – please check with physician)
- HbA1C **target level: \( \leq 7\% \)** (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 physician

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