PHYSICIANS HEALTH CHOICE

PHYSICIANS HEALTH CHOICE GUIDELINES		
Title: **Diabetes Mellitus Guidelines**	Purpose: Maximize the Management and Outcomes of Members with Diabetes	PAC Review/Approval Date: QIC Approval Date:
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Date of Last Review: 12/08/03		

ASSESSMENT	RECOMMENDATIONS
Routine Visits	Quarterly, until achievement of treatment goals. More frequent visits are required if not meeting glycemic target, BP is not controlled, or there is evidence of microvascular or macrovascular complications and/or undergoing intensive insulin therapy.
Weight	Every routine visit
Glycosylated Hb (A1C) **HEDIS:** Annual testing	Annually or semi-annually Target Goal of ≤7% Reevaluate treatment regimen for patients with Hb >8% Quarterly

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Blood Pressure **HEDIS**	• Every routine visit with a target goal of < 130/80 • Patients with systolic between 130-139 and diastolic between 80-89 should be given lifestyle/ behavior therapy alone for a maximum of three months, and then if targets not achieved should be treated pharmacologically. • Patients with hypertension (systolic blood pressure >140 or diastolic blood pressure >90) should receive drug therapy in addition to lifestyle/behavior therapy. • Initial drug therapy may include ACE, ARB, BB or diuretics. • In hypertensive patients with Microalbuminuria, or clinical albuminuria/nephropathy, an ACE should be considered. • In patients over age 55 yrs, with HTN, or another cardiovascular risk factor, ACE should be considered to reduce risk of cardiovascular events. • In patients with recent MI, BB, in addition, should be considered to reduce mortality.
Foot Exam **HEDIS**	Visual inspection at every contact with health care professional is required Comprehensive exam should be performed annually to identify high-risk foot conditions. Assessment should include: ▪ Protective sensation, foot structure and biomechanics, neurological, vascular status and skin integrity. ▪ Neurological status includes quantitative somatosensory threshold test using monofilament, vibratory sensation or Vibration Perception Threshold (VPT) Meter.
Dilated Retinal Exam **HEDIS:** one during reporting year, or year prior for low-risk patients	Annual comprehensive dilated exam by ophthalmologist or optometrist: • For all patients >12 years old and who have had DM for 5 years • All patients > age 30 • Any patient with visual symptoms

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Blood Lipids **HEDIS:** tested once during reporting year or year prior; looking for LDL < 100mg/dl	All adults should be tested initially and annually thereafter. Tests should be performed in a fasting state and should include: **Goal** • Cholesterol <200mg/dl • Triglyceride <150mg/dl • HDL >45mg/dl • LDL <100mg/dl If all values are normal, clinician may consider performing less frequently. Abnormal values requiring therapy should follow NCEP recommendations: 1. Advise all DM patients with CAD to follow the Low Fat, Low Sugar diet 2. LDL: Lowering LDL is associated with a reduction in cardiovascular events. If LDL > 100 mg/dl despite diet management, consider adding drug therapy. Use statins as first line pharmacotherapy for LDL lowering. 3. Prescribe to patients with LDL >100 mg/dl despite diet management. The goal of therapy is to reduce the LDL to <100md/dl. 4. If HDL <35 mg/dl, emphasize weight management and increasing physical activity.

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Nephropathy: **HEDIS:** Monitoring evidence	Optimize glucose and blood pressure control to minimize risk and/or slow progression of nephropathy. Screen for nephropathy annually: Type I begin at puberty and > 5 years post diagnosis, then annually. Type II at time of diagnosis, then annually. Testing should include: • Routine urinalysis annually • If protein is positive, a 24-hour quantitative measure is often helpful • If U/A is protein negative, perform Microalbumin test • Microalbuminuria testing can be performed by any of the following: 1. Urine albumin/creatinine ratio in a random spot collection 2. 24-hour collection with creatinine clearance time collection. 3. If Microalbumin positive, repeat twice within three months. 4. If still positive, begin treatment with ACE inhibitors.	
MEDICATIONS		
Angiotensin –Converting Enzymes (ACE) Inhibitor Use	• Unless contraindicated, as primary treatment for all hypertensive patients (BP > 140/90) with or without Microalbuminuria, or overt nephropathy. • Unless contraindicated, initial agents for all Type I patients with Microalbuminuria or clinical albuminuria, even if normotensive • All patients over 55 with or without hypertension, but with another cardiovascular risk factor should be considered.	
Angiotensin Receptor Blockers (ARBs)	Initial agents of choice in hypertensive type 2 patients with Microalbuminuria or clinical albuminuria, or those who have not tolerated or failed ACE	
Aspirin Therapy	• Use 75mg to 325 mg in all adult patients with diabetes and macrovascular disease. • Consider beginning therapy for primary prevention in patients >40 yrs with diabetes and one more cardiovascular risk factor	
Diabetic Agents	Insulin and oral agent therapy based on recommendations from P&T committee	
IMMUNIZATIONS	**RECOMMENDATION**	**COMMENTS**
Influenza Vaccination	Annually	See Preventive Health Guideline

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Pneumococcal Vaccination	All adults 65 and older with competent immune systems	See Preventive Health Guideline
COUNSELING	**RECOMMENDATION**	**COMMENTS**
Self-Management Training and Education Focus to include, but not limited to the following: • Referral to WellMed Diabetic Educator • Nutrition Counseling • Exercise and Physical Activity • Weight Management • Importance of Foot Care	Every routine visit, conduct an assessment to evaluate patient's: • Status • Compliance • Nutrition and Exercise Regimen Annually to include: • Diabetes knowledge • Self-Management Skills • Review of treatment plan, progress, and revise with patient as needed.	• Nutrition therapy may be more effective with individualized medical nutrition therapy provided by a CDE or a registered dietitian familiar with the components of diabetes medical nutrition therapy • A regular activity program, adapted to the presence of complications is recommended for all patients with diabetes who are capable of participating.
Smoking Cessation for smokers **HEDIS**	Each visit Advise all patients on smoking cessation	

REFERENCES:

ADA, NIH, NHLBI, NCEP, AHCPR 2002