

2009-2010 VIRGINIA PREMIER HEALTH PLAN DIABETES MELLITUS PRACTICE GUIDELINES¹

These standards of diabetes mellitus care seek to provide physicians and other healthcare providers with a means to set treatment goals, assess the quality of care provided, identify areas where more attention or self-management training are needed, and define timely and necessary referral patterns to appropriate specialists.

COMPONENTS OF THE INITIAL VISIT

- I. Medical History
 - A. Symptoms
 - B. Nutritional assessment, weight history
 - C. Previous and present treatment plans, including medications, nutrition therapy, self-management training, self-monitoring of blood glucose results
 - D. Exercise history
 - E. Acute complications
 - F. History of infections
 - G. Chronic diabetes complications
 - H. Family history
 - I. CHD risk factors
 - J. Psychosocial/economic factors
 - K. Type 1 or 2
 - L. Smoking history

- II. Physician Exam
 - A. Height and weight (BMI) body mass index (BMI) included in each chart
 - B. Blood pressure < 130/80 - goal
 - C. Ophthalmoscopic examination (meets standard if referral or consult documented)
 - D. Thyroid palpation
 - E. Cardiac examination
 - F. Evaluation of pulses
 - G. Foot examination (meets standard if referral or consult documented)
 - H. Skin examination
 - I. Neurological examination – microfilament device
 - J. Oral examination
 - K. Sexual maturation (if peripubertal)

Source, "Standards of Medical Care in Diabetes" Diabetes Care 2009, 28:S4-36.

III. Laboratory Evaluation

- A. Fasting plasma glucose (a random plasma glucose may be obtained in an undiagnosed symptomatic patient for diagnostic purposes) Both need to be repeated for confirmation.
- B. Glycated hemoglobin every 3-6 months
- C. Fasting lipid profile (cholesterol, triglycerides, HDL/LDL)
- D. Serum creatinine
- E. Annual urine microalbumin or 24 hour urine protein estimation in all type 2 diabetics and type 1 diabetics of >5 years duration
- F. Urine culture (if indicated)
- G. Thyroid function tests (if indicated) - TSH
- H. Electrocardiogram (adults) and/or stress test
- I. Fructosamine in certain situations i.e. pregnancy

IV. Management Plan

- A. Short and long term goals (HgbA1C < 7%)
- B. Medications
- C. Nutrition assessment/counseling
- D. Lifestyle changes
- E. Self-management education
- F. Glucose monitoring instructions
- G. Annual referral to eye specialist
- H. Specialty consultations (as indicated)
- I. Understanding continuing support/follow-up

COMPONENTS OF THE CONTINUING CARE VISITS

I. Contact Frequency

- A. Frequent contact for initiation of insulin or change in insulin regimen
- B. Frequent contact for initiation of oral glucose lowering agents or change in regimen
- C. Routine diabetes care
 - 1. Quarterly for all patients

II. Medical History

- A. Assess treatment regimen
 - 1. Frequency/severity of hypo/hyperglycemia
 - 2. Self-monitoring of blood glucose results
 - 3. Patient regimen adjustments
 - 4. Adherence problems
 - 5. Lifestyle changes
 - 6. Symptoms of complications
 - 7. Other medical illnesses

8. Medications
9. Psychosocial issues

III. Physical Examination

- A. Full Physical examination annually
- B. Dilated eye examination annually
- C. Every diabetes visit
 1. Weight
 2. Blood pressure
 3. Previous abnormalities on the physical exam
 4. Foot examination

IV. Laboratory Evaluation

- A. Glycated Hemoglobin
 1. Quarterly if treatment changes or not meeting goals
 2. Twice per year if stable
- B. Fasting plasma glucose (optional)
- C. Annual fasting lipid profile or sooner if making treatment changes
- D. "Annual urine microalbumin or 24-hour urine protein in all Type 2 diabetics and Type 1 diabetics of > 5 years duration. If on ACE-I/ARB or after diagnosis of microalbuminuria, estimation of urine protein is discretionary

V. Review of Management Plan

- A. Evaluate at each visit
 1. Short and long term goals
 2. Glycemia
 3. Frequency/severity of hypoglycemia
 4. Self-monitoring of blood glucose results
 5. Complications
 6. Control of dyslipidemia
 7. Blood pressure
 8. Weight
 9. Nutrition assessment/counseling
 10. Exercise regimen
 11. Adherence with self-management training
 12. Follow up of referrals
 13. Psychosocial adjustment
- B. Evaluate annually
 1. Knowledge of diabetes
 2. Self-management skills