MANAGEMENT OF DIABETES MELLITUS IN ADULTS

Community First has adopted the Minimum Standards for Diabetic Care that were developed by the Texas Diabetes Council, as the standard physician protocol for the preventive care of members who have been diagnosed with diabetes mellitus. The Texas Diabetes Council was created in 1983 by the 68th legislature as the recommendation of the Special Committee on Diabetes Services in Texas. The Council’s mission is to assist in the planning and coordination of diabetes control activities and to develop and carry out a state plan for diabetes control. Diabetes can cause blindness, kidney failure, amputations, heart disease, birth defects, strokes, and premature death and disability. Early interventions can prevent many of the complications associated with diabetes.

Diabetes is prevalent in the San Antonio, Texas area. The 2006 Bexar County Community Health Assessment Report Summary, presented by the Bexar County Community Health Collaborative, reported the following key findings:

- The Healthy People 2010 goal challenges communities to reduce the overall rate of diabetes (new and existing cases) to 25 cases per 1,000 population (2.5 percent). In 2002, 11 percent of Bexar County residents reported they had been told by a health professional that they had diabetes. More recent survey results from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that 11 percent of Bexar County residents reported that they have been told they have diabetes in the period 2004-2005.
- The Healthy People 2010 goal is that no more than 15 percent of the population will be obese. The rate of obesity in Bexar County appears to be growing faster than the statewide rate, increasing from 24 percent in 2002 to 35 percent in the period 2004-2005.
- The Bexar County diabetes mortality rate (41 per 100,000) is 40 percent higher than the Texas rate (30 per 100,000). The diabetes mortality rate for Hispanics living in Bexar was 60 per 100,000; this is twice the rate for the non-Hispanic population 30 per 100,000.

The purpose of the guidelines is to ensure that all adults with diabetes who are enrolled with Community First receive accepted standards of care. These guidelines will promote consistency in clinical practice and improve the quality and outcome of care for our members.

Diabetes Minimum Practice Recommendations
(Established by the Texas Diabetes Council)

Examination/Test	Schedule
1. Complete history & physical	Initial visit and at clinician’s discretion (including risk factors, exercise and diet)
2. Diabetes Education*	Initial visit and at clinician’s discretion
3. Medical Nutrition Therapy	Initial visit and at clinician’s discretion
4. Exercise Counseling	Initial visit and at clinician’s discretion
5. Psychosocial Counseling	Initial visit and at clinician’s discretion
6. Lifestyle / Behavior Changes Counseling	Initial visit and at clinician’s discretion Smoking cessation Alcohol reduction
7. Weight / Height / BMI **Adult Overweight = BMI 25-29.9** **Adult Obesity = BMI ≥30**	Every visit
8. Blood Pressure Target: <130/80 mm Hg Target: < 125/75 mm Hg if ≥ 1 g proteinuria	Every visit
9. Foot Inspection Visual inspection for skin and nail lesions, calluses, infections	Every visit
10. Oral / Dental Inspection Refer for dental care annually or as needed	Every visit

11. Growth and Development (including height) in Children	Every visit
12. Aspirin / Antiplatelet Prophylaxis (if no contra-indications) Type 1 or 2 $\geq$ age 30	Every visit
13. A1c Target: A1c$\leq$6.5%	Every 3 - 6 months
14. Kidney Evaluation Estimate GFR (eGFR) & microalbumin determination ($\geq$30mg = abnormal). Consider nephro/endocrine evaluation at Stage 3 CKD (eGFR <60); also consider PTH & Hgb if CKD Stage 3 If significant proteinuria; monitor serum creatinine every 3-6 months	Type 1: Annually beginning 5 years from diagnosis Type 2: Initial visit and then annually
15. Dilated Funduscopic Eye Exam *By an ophthalmologist or therapeutic optometrist*	Type 1: Annually beginning 5 years from diagnosis Type 2: Initial, then annually.
16. Oral / Dental Exam Refer to appropriate provider	Annually or as needed
17. Foot Exam Complete foot exam and neurologic assessment	Annually or as needed
18. Lipid Profile Targets: LDL-C <100 mg/dL (CHD<70mg/dL) Triglycerides <150 mg/dL	Annually if at goal; otherwise every 3 – 6 months ($\geq$ age 18)
19. Immunizations Influenza (flu) Shot Td Vaccine Pneumococcal Vaccine Childhood Immunizations	Annually Every 10 Years Initial; repeat per ACIP Per CDC Schedule
See web site (http://www.texasdiabetescouncil.org) **for latest version and disclaimer.**	

***Diabetes Education should address:**

a. Self-management skills (including monitoring, sick day management)
b. Medications
c. Frequency of Hypoglycemia
d. High risk behaviors (e.g. smoking, alcohol)
e. Adherence with self-care (self-management plan from the last visit, i.e. diet, medication use, exercise plan)
f. Assessment of complications
g. Diabetes knowledge
h. Follow-up of referrals