

Controlled Diabetes

Clinical Guideline



Overview of the Condition/Disease

Definition: HbA1C <9 is needed to be considered controlled diabetes. The majority of members should be managed to an HbA1C ≤8

Pathophysiology: In Diabetes Type I, the immune system mistakenly destroys the cells in the pancreas that make insulin. When enough beta cells are destroyed, the pancreas makes little or no insulin. In Diabetes Type II, the body does not use insulin properly. The pancreas will make extra insulin to adjust but over time the pancreas is not able to make enough insulin to manage glycemic control. The body breaks down food eaten into glucose and sends glucose into the blood. Insulin is needed to move the glucose from the blood into the cells. Glucose is used as fuel for energy once it enters the cells or is stored in the cells for future use.

Prevalence: 5.8 to 12.9 percent of adults have diabetes and Diabetes Type II accounts for over 90 percent of diabetes diagnoses



Best Practice Standards for Prevention and Management

Interventions:

- ◆ A1C testing with an agreed upon target A1C level
- ◆ Pharmacologic therapy
- ◆ Fasting lipid profile as indicated
- ◆ Liver function tests as indicated
- ◆ Urine albumin excretion as indicated
- ◆ Serum creatinine as indicated
- ◆ Annual foot examination and prophylactic foot care protocol in place
- ◆ Routine eye exam every two years if no evidence of retinopathy, annually if retinopathy is present
- ◆ Blood pressure control
- ◆ Endocrinologist established if on insulin therapy
- ◆ IDT to coordinate with provider/endocrinologist managing disease process

Education: Stress the importance of medication adherence, dietary compliance, care plan adherence, and maintaining MD appointments

Lifestyle changes: Dietary modification, exercise, weight reduction, smoking cessation

Device therapy: Insulin pens can be an effective way to administer insulin

Additional conditions that negatively impact the condition/disease:

- ◆ Obesity
- ◆ Hypertension
- ◆ Dyslipidemia
- ◆ Fatty liver disease
- ◆ Depression
- ◆ Anxiety
- ◆ Cardiovascular disease
- ◆ Macrovascular disease
- ◆ Poor nutrition
- ◆ Irregular access to food
- ◆ Homelessness
- ◆ Poverty
- ◆ Literacy
- ◆ Problem alcohol use

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Anticipating, Recognizing, and Responding to Symptoms

 **Seek timely medical attention when current interventions and/or medications are not managing symptoms.**

Potential symptoms: Shakiness and irritability due to hypoglycemia or extreme thirst and urination, fruity smelling breath from ketoacidosis

Manifestation of symptoms: Confusion, tachycardia, hunger, loss of consciousness, seizure, coma, or death due to hypoglycemia; pain due to neuropathy, vision loss, blurred vision, floaters due to retinopathy



Interventions to manage symptoms: Medications and additional treatments

- ◆ Oral anti-diabetic, explore if Type 1 Diabetes is taking an oral anti-diabetic as this can lower insulin use which is associated with weight gain and other complications of a higher BMI
- ◆ Medications associated with no weight gain or weight loss are Metformin, Januvia, and Invokana while Trulicity is associated with weight loss
- ◆ Insulin—fast acting and long acting for Type 1 Diabetes only
- ◆ Angiotensin-converting enzyme inhibitor regardless of blood pressure
- ◆ Aspirin to prevent cardiovascular disease
- ◆ Fast acting carbohydrate foods such as candy, fruit juice, glucose tablets for hypoglycemia
- ◆ Anti-seizure medications for nerve pain include; gabapentin, pregabalin, and carbamazepine
- ◆ Antidepressants may provide relief for mild to moderate pain by interfering with the chemical processes in the brain that feel pain
- ◆ Statins to reduce cholesterol levels
- ◆ Laser eye surgery for treatment for retinopathy

Medication Best Practice: Balance use of diabetic medications that promote weight gain vs those that do not, so that HbA1C is controlled and BMIs do not rise to levels that are high. All members with a diabetes diagnosis should be on Metformin, if tolerated.



Guidelines and Process for Interdisciplinary Team

Resources for negotiating incorporation of condition/disease prevention and management plan into the Member Centered Plan (MCP)

- ◆ MCP Policy
- ◆ Motivational Interviewing techniques
- ◆ Collaboration with Primary Care Provider (PCP) and/or Endocrinologist

Quality Assurance Monitoring



The risk and performance team completes HEDIS data exports quarterly that include: A1C testing, nephrology testing, annual eye exam, blood pressure controlled (<140/90), HbA1C<8, HbA1C>9 poor control, statin therapy, and statin adherence

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References

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