

STANDING ORDER FOR DIABETES CARE INREACH

POLICY:

Under this standing order, medical assistants and RNs with proper training may provide diabetes panel management for patients who fit these criteria.

PURPOSE:

As of 2011, diabetes affects 8% of the U.S. population. Diabetes is the 7th leading cause of death in the United States. Uncontrolled diabetes can damage many parts of the body including the heart, blood vessels, eyes, kidneys, and nerves.

Although diabetes does not have a cure, it can be controlled. Keeping sugar, cholesterol and blood pressure levels at or below the recommended goals and getting routine lab tests and procedures at recommended intervals can prevent complications from diabetes.

PROCEDURE:

1. This protocol applies to all patients with a diagnosis of type 1 or type 2 diabetes who come into the clinic for any appointment.
2. At every visit, check and document in the medical record:
 - a. weight and BMI
 - b. blood pressure
 - c. smoking status (if a smoker, give smoking cessation resources)
3. At every visit, review the chart and identify whether patient is due for the following routine lab tests. If due, complete lab requisition and do test today if possible:
 - a. Hemoglobin A1c:
 - If most recent A1c result is above 7, repeat A1c every 3 months.
 - If most recent A1c result is at or below 7, repeat A1c every 6 months
 - b. Serum Creatinine: Repeat every 12 months.
 - c. Fasting Lipid Panel: Repeat every 12 months.
 - d. Urine Microalbumin Test: Repeat every 12 months
4. At every visit, identify whether patient is due for the following routine procedures:
 - a. Retinal eye exam: Repeat every 12 months
 - i. Alert patient they are due for their annual exam
 - ii. Refer patient to optometrist or ophthalmologist, provide form for documentation (Insured/Medi-Cal patients may use an independent VSP optometrist; uninsured/HSF patients must go to the hospital associated with their medical home)
 - iii. If patient says they had an exam in the past 12 months, ask which provider performed exam, document in chart.
 - b. Monofilament foot exam: Repeat every 12 months
 - i. Trained medical assistants may perform monofilament at visit when due
 - ii. Document results of monofilament in chart

- c. Visual Foot inspection: Repeat at every visit to identify cracks and sores. Request patient to remove shoes and socks at every visit.
5. Identify whether patient requires immunizations
 - a. Flu: repeat once a year
 - b. Pneumococcal:
 - i. If no previous immunization, administer one dose of PPSV23
 - ii. If patient is 65 and older AND previous dose of pneumococcal vaccine was administered more than 5 years ago, revaccinate once with PPSV23
 - iii. See pneumococcal protocol
 - c. Td/Tdap:
 - i. If previous Td but no previous Tdap, administer one dose Tdap immediately
 - ii. If previous Td or Tdap is more than 10 years ago, revaccinate with Td
 - iii. See Td/Tdap protocol
 6. Provide basic patient education as needed
 - a. Deliver education based on the patient's baseline knowledge level.
 - b. Include information on disease and medication
 7. Offer self-management support and goal setting at each visit
 - a. Create an action plan with patient
 - b. Document verbal or written action plan in chart or electronic medical record
 - c. Ask patient about action plan progress at next visit or establish follow-up date
 8. Offer referral to the following as needed:
 - a. Smoking cessation
 - b. Nutrition
 - c. Exercise group
 - d. Blood pressure group
 - e. Pharmacist
 - f. Behavioral Health
 9. Refer to community resources
 10. Document the visit and procedures taken in patient chart or electronic medical record.

Medical Director _____
 Printed Name

 Signature

Effective date _____

Date reviewed _____

Date revised _____