Diabetic Care Protocol for [redacted] Care Coordinators (MAs)

Patient: All patients with Diabetes Type 2 and Type 1
When: At every visit
What:

1. **Hemoglobin A1C**
    a. If patient has had the test **done in the last 3 months**, no action required.
    b. Test **done 3 months to 6 months ago**
        a. If previous A1C <7, no action is required unless patient desires A1C, in which case the Care Coordinator should order Point of Care A1C in EPIC, perform the test in-office and record results in EPIC before the clinician visit. Share results with the patient and remind him/her that results are posted in My Health.
        b. If the previous A1C > 7, the Care Coordinator should order Point of Care A1C in EPIC, perform the test in-office and record in EPIC before the clinician visit. Share results with the patient and remind him/her that results are posted in My Health.
    c. Test **done 6 months ago or more**
        a. Care Coordinator should order Point of Care A1C in EPIC, perform the test in-office and record in EPIC before the clinician visit. Share results with the patient and remind him/her that results are posted in My Health.
2. **Urine microalbumin/Creatinine ratio**
    a. If the patient already has a diagnosis of diabetic nephropathy, no test is needed.
    b. If the patient does not have a diagnosis of diabetic nephropathy:
        i. If test **done in the last year**, no action required other than informing patient if a urine test will be due at the next visit
        ii. If **not done in the last year**, Care Coordinator should:
            1. Give patient specimen container an instructions to collect urine sample.

2. Order urine microalbumin/creatinine ratio in EPIC
3. Prepare the specimen for laboratory pickup
4. Remind the patient that the test screens for problems with kidney function related to diabetes and results will be posted in My Health.

3. Lipid profile with direct LDL, hepatic function test, creatinine, potassium

a. If patient has had the test **done in the last year** no action required except:

i. If test will be due within 3 months: Queue order for performance when due with tickler to remind patient when lab is due

ii. If it has been **3 months or more after a statin or niacin was started or dosage adjusted**

1. If the patient has also not had a potassium and creatinine in the last year order a lipid panel with direct LDL and comprehensive metabolic panel.

2. If the patient has potassium and creatinine in the last year, order a lipid panel with direct LDL and hepatic function panel.

3. Draw blood sample and send to lab

4. Remind him/her that results are posted in My Health and that LDL goal is <100

b. If patient has **not had the test done in the last year**

i. If the patient has also not had a **potassium and creatinine** in the last year order a lipid panel with direct LDLand comprehensive metabolic panel.

1. Fasting:is not require for Direct LDL test, so draw sample now and send to lab

2. Remind him/her that results are posted in My Health and that LDL goal is <100

ii. If the patient has a diagnosis of hyperlipidemia and is **on lipid lowering drugs** (e.g. statin, niacin)

1. If the patient has also not had a potassium and creatinine in the last year order a lipid panel with direct LDL and comprehensive metabolic panel.

2. If the patient has potassium and creatinine in the last year, order a lipid panel with direct LDL and hepatic function panel.

3. Draw blood sample and send to lab
4. Remind him/her that results are posted in My Health and that LDL goal is <100

4. **Opthalmology dilated exam**
    a. **Type 1 diabetics:** start annual ophthalmology exams 5 years after diagnosis of diabetes. Thereafter:
        i. If done in the last year, no action required unless the exam is likely to be due before the next visit.
        ii. If not done in the last year, or if it is likely to be due before the patient's next visit
        iii. Queue referral order in EPIC for clinician completion
        iv. Inform patient that an eye exam is due
    b. **Type 2 diabetics:**
        i. If done in the last year, no action required unless the exam is likely to be due before the next visit.
        ii. If not done in the last year, or if it is likely to be due before the patient's next visit
        iii. Queue referral order in EPIC for clinician completion
        iv. Inform patient that an eye exam is due
5. **Better Choices Better Health / Chronic Disease Self Management Program**
    a. If patient has completed the health coaching program at some point, no action is required.
    b. If patient has not completed health coaching program:
        i. Ask if the patient knows about the program and explain it if needed.
        ii. If patient agrees, complete a referral and set time for phone or e-mail follow up.
        iii. Document in EPIC if patient declines and reassesss interest at next visit.
6. Refer to other protocols that may also apply to people with diabetes:
    a. **Influenza vaccination**
    b. **Pneumococcal vaccine**
    c. **Mammogram**
    d. **Colon cancer screening**
    e. **TdaP**

Approved by [redacted] VP of Ambulatory Care 4/9/2012