Diabetes Clinical Pathway

CareFirst
PCMH

HEDIS Core 10 Goal

This measure is divided into five sub-measures. Members must meet all sub-measures they are included in to be compliant:

- HbA1c <8.0%
- Blood pressure <140/<90 mm Hg
- Chronic kidney disease screening
- Retinal eye exam
- Statin therapy adherence

Optimal Care for Diabetic Population

Measure	Population	Sub-measures	Expectation	Data Used to Measure Compliance (refer to Playbook and Value Sets for complete information)
1: Optimal Diabetes Care ***NOTE:*** All relevant sub-measures must be met in order to achieve compliance for the measure.	Members 18-75 years of age with diabetes (type 1 or type 2)	HbA1c <8%	Each year, ensure most recent HbA1c level is <8.0% for members with diabetes as identified by automated laboratory data or attestation	CPT-II Coding Lab Values
		Blood Pressure <140/<90 mm Hg	Most recent blood pressure (BP) during the year is <140/<90 mm Hg to be in control	CPT-II Code
		Chronic Kidney Disease (CKD) Screening	Screen annually for chronic kidney disease (CKD) using both albumin-to-creatinine ratio (ACR) and estimated glomerular filtration rate (estimated GFR, eGFR) tests	CPT Code Lab Values
		Retinal Eye Exam	Members receive timely retinal or dilated eye exam by an eye care professional	CPT Code from the eye care professional or Attestation
	Members 40-75 years of age with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD)	Statin Therapy Adherence	Ensure member remains on statin medication of any intensity for at least 80% of treatment period during the year	Indicated by prescription claim for appropriate Statin medication

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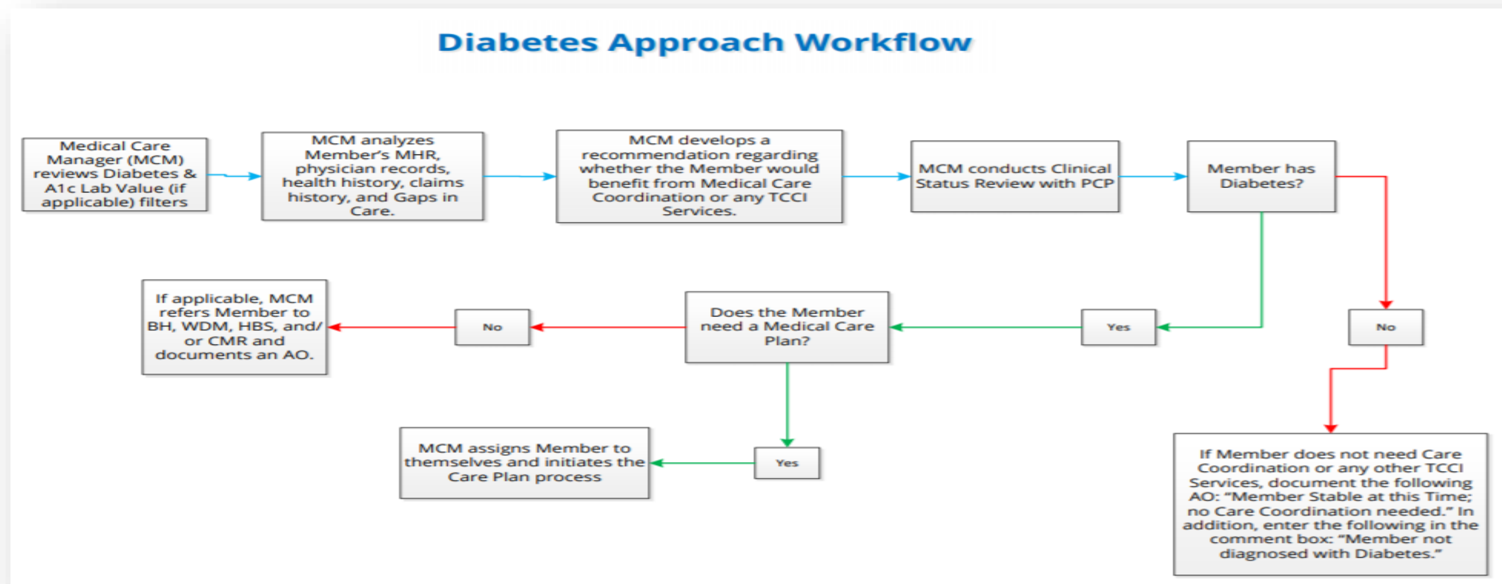
Assessment of Diabetic Population

Refer to ***Job Aid: Printing Your Diabetes Population List from iCentric*** *and* ***Working Your Diabetes Population List***



The Source: Diabetes Program Information

Diabetes Approach

https://provider.carefirst.com/providers//pcmh-the-source/field-support-materials/population-health/diabetes-approach/diabetes-program-homepage.page?

Diabetes Treatment Recommendations

https://provider.carefirst.com/carefirst-resources/provider/pcmh-kc/population-health-programs/diabetes-approach-treatment-recommendations.pdf

Diabetes Approach eLearning's

https://provider.carefirst.com/providers/pcmh-the-source/field-support-materials/learning-videos.page

Diabetes Approach Talking Points

https://provider.carefirst.com/carefirst-resources/provider/pcmh-kc/population-health-programs/diabetes-approach-talking-points.pdf

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Roadmap to Graduation Strategy Grid: Key Focus Areas for Diabetes Management

Six Focus Areas for Condition Management
Understand Condition ○ *Assess Member's understanding and adherence to the treatment plan/medication regimen including current level of health literacy and barriers to understanding/adherence* ○ *Assess Member's ability to self-monitor key symptoms including those of hyper and hypoglycemia* ○ *Develop diabetes action plan in partnership with the Member* ○ *Assess Member's use of tobacco and alcohol* ▪ *Assess need/readiness to quit/reduce intake*
Understand Medications ○ *Oral antihyperglycemics* ○ *Proper administration for short acting and long acting insulin at the proper times* ○ *Recommend a 3-month fill or auto refill to prevent running out of medication* ▪ *Assist if necessary and verify Member's system for refilling medications* ○ *Pill organizer and/or alarm for medications* ○ *Statin therapy adherence: ACE or ARB, as warranted*
Clinical Monitoring (Results/Implications/Actions) ○ *Glucose monitoring plan adherence* ▪ *Working glucometer with a back-up glucometer and test strips on hand* ▪ *System for logging results* ○ *Assess for completion of required monitoring including:* ▪ *Hgb A1C every 3-6 months depending on severity of disease* ▪ *Fasting Blood Glucose* ○ *Monitoring and management of cardiovascular; renal function; peripheral neuropathy* ▪ *Serum creatinine annually* ▪ *Albuminuria annually* ▪ *Maintain BP at <130/80* ▪ *Cholesterol management with lipid panel at minimum annually and assess for CAD* ○ *Presence of long acting and immediate acting treatment plan* ▪ *Presence of action plan for both hyper and hypoglycemia if needed* ○ *Schedule and maintain follow up PCP/Specialist/Ancillary provider appointments as appropriate for Member* ▪ *Coordinate when possible to have A1C resulted at the time of the visit to allow timely treatment decisions*
Preventive Care ○ *All Gaps in Care addressed* ○ *Dilated Eye Exam* ○ *Foot Exam* ○ *Comprehensive Dental Assessment*

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○ *Risk for Depression* ○ *Vaccinations* ▪ *Influenza vaccine yearly* ▪ *Pneumococcal vaccine 1 dose ≥65 years of age (recommended sooner if additional risk factors exist)*
Connection with Resources ○ *Understanding benefits* ○ *Clinical Support Programs* ○ *CareFirst Staywell Health Library (Topic Index: Diabetes)* ○ *Community Resources Directory (Diabetes, Diabetic Educator, Smoking Cessation, Co-Pay/Prescriptions, etc.)*
Provider Relations ○ *Endocrinology or Nephrology* ○ *Eye professional for dilated eye exams* ○ *Podiatry for foot exam* ○ *Diabetic Educator* ○ *Nutritionist/Registered Dietician*

Other Diabetes Resources

Diabetes Online Health Information	
Types of Diabetes ○ **Prediabetes** https://www.diabetes.org/diabetes-risk/prediabetes ○ **Diabetes Overview (Type 1 & 2)** https://www.diabetes.org/diabetes ○ **Gestational Diabetes** https://www.diabetes.org/diabetes/gestational-diabetes	**Understanding Signs & Symptoms of Diabetes** ○ **Hypoglycemia** https://www.diabetes.org/diabetes/medication-management/blood-glucose-testing-and-control/hypoglycemia ○ **Hyperglycemia** https://www.diabetes.org/diabetes/medication-management/blood-glucose-testing-and-control/hyperglycemia?referrer=https%3A//www.google.com/ ○ Diabetic Ketoacidosis (DKA) https://www.diabetes.org/diabetes/complications/dka-ketoacidosis-ketones
Diabetes Lab Tests/Diagnostics ○ **Understanding A1C** https://www.diabetes.org/a1c	**Diabetes Self-Monitoring** ○ **Blood Glucose Monitoring** https://www.diabetes.org/diabetes/medication-management/blood-glucose-testing-and-control/checking-your-blood-glucose
Preventive Care for Diabetics ○ **Foot Complications** http://www.diabetes.org/living-with-diabetes/complications/foot-complications/	**Diabetes Medications** ○ **Medications** https://www.diabetes.org/diabetes/medication-management

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○ **Eye Complications** http://www.diabetes.org/living-with-diabetes/complications/eye-complications/ ○ **Diabetes Skin, Foot, and Dental Care** https://my.clevelandclinic.org/health/articles/11649-diabetes-skin-foot-and-dental-care?_ga=2.66668139.452300932.1585316654-773166623.1576859351	○ **Supplements** https://nccih.nih.gov/health/diabetes/supplements
Diet ○ **Prescribed Diet: ADA** https://www.diabetes.org/nutrition ○ **Managing Eating Out** https://www.cdc.gov/diabetes/managing/eat-well/eating-out.html ○ **Carbohydrate Counting** https://www.diabetes.org/nutrition/understanding-carbs/carb-counting	**Lifestyle Modifications for Diabetes** ○ **Managing Weight** https://www.diabetes.org/diabetes-risk/prevention/overweight ○ **Fitness** https://www.diabetes.org/fitness ○ **Smoking Cessation** https://www.diabetes.org/diabetes-risk/prevention/smoking ○ **Managing Blood Pressure** https://www.diabetes.org/diabetes-risk/prevention/high-blood-pressure

Diabetes Self-Management Strategies

DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
Understand Condition ○ *What is it?* ○ *Causes, symptoms, and treatment* ○ *Signs and symptoms to report to Provider* ○ *Action plan* ○ *Preparing for unexpected events* ○ *Resetting routines*	Member can make connection between health problems/symptoms and their diabetes.	Member describes how diabetes affects other systems in the body. Member describes diabetes in simple terms.		Member exhibits full understanding of diabetes diagnosis.
	Member describes risk factors for diabetes: age, race, family history, being overweight, not being physically active, history of gestational diabetes	Member can define key diabetes words/terms: high blood glucose, hypoglycemia, carbohydrate, blood pressure, heart disease, etc.		Member reaches full adherence to the diabetes management and treatment plan.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
	Member is aware of own risk factors that exist for diabetes.	Member identifies lifestyle changes necessary to address identified modifiable risk factors. - medication adherence - dietary adherence - engagement in regular physical activity - stress management - smoking cessation - alcohol avoidance	Member is implementing lifestyle changes necessary to address identified modifiable risk factors. - medication adherence - dietary adherence - engagement in regular physical activity - stress management - smoking cessation - alcohol avoidance	Member demonstrates full awareness of own risk factors and has made lifestyle modifications to lower risk of complications associated with diabetes.
	Member describes reasons for wanting to manage diabetes and prevent complications.	Member explains possible complications of uncontrolled diabetes such as cardiovascular disease, neuropathy, nephropathy, retinopathy, foot damage, etc. Member explains the dangers of acquiring the flu/pneumonia. Member explains the importance of receiving vaccines as recommended (influenza, pneumococcal).		Member describes how to manage sick days with diabetes.
	Member identifies common symptoms of diabetes - increased urination, increased thirst, increased hunger, fatigue, unexplained weight loss.	Member recognizes the signs of hypo/hyperglycemia.	Member describes concerning symptoms such as those associated with diabetic ketoacidosis.	Member independently recognizes signs and symptoms of hypoglycemia, hyperglycemia, and diabetic ketoacidosis and teaches back action plan for these concerning symptoms.
	Member identifies concerning s/s and indicates when to seek medical attention.	Member identifies when and where to seek medical attention (PCP, UC, ER).	Member indicates when and where to seek medical attention (PCP, UC, ER).	Member describes when and where to go when experiencing concerning symptoms or when medical emergencies arise, and understands how to

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
				appropriately utilize various levels of healthcare (PCP/Specialist/UC/ER/ED)
	Member explains how to use their Hypoglycemia Action Plan to identify warning signs as well as manage DM symptoms.	Member verbalizes the importance of utilizing a Hypoglycemia Action Plan for symptom management.	Member utilizes their individualized Hypoglycemia Action Plan to manage symptoms.	Member independently utilizes their individualized Hypoglycemia Action Plan to manage symptoms.
	Member acknowledges that condition self-management may be impacted by mental health and/or substance use disorder(s).	Member describes ways in which condition self-management may be impacted by mental health and/or substance use disorder(s) and identifies a process for seeking assistance when needed.	Member describes ways in which condition self-management may be impacted by mental health and/or substance use disorder(s) and explains the process for seeking assistance when needed.	Member independently seeks assistance with addressing mental health and/or substance use disorder(s) when condition self-care is impacted.
Understand Medications ○ *Name, purpose, dose, schedule, side effects* ○ *Establish routine to take meds* ○ *Schedule refills to avoid running out (automatic refills)*	Member indicates the name, dosage, schedule, and reason for taking each prescribed medication.	Member indicates the name, dosage, schedule, reason for taking, and possible side effects of each prescribed medication.	Member indicates the name, dosage, schedule, reason for taking, and possible side effects of each prescribed medication.	Member indicates the name, dosage, schedule, reason for taking, and possible side effects of each prescribed medication.
		Member describes potential side effects of their prescribed diabetes medications (hypoglycemia, upset stomach, weight gain, gas/bloating, diarrhea, rash or itching, tiredness)	Member understands risks of stopping prescribed medications.	Member understands the importance of taking maintenance medications.
		Member identifies strategies for managing undesirable side effects of prescribed medications (to include statin therapy).	Member identifies and implements actions to manage undesirable side effects of prescribed medications.	Member describes how to adequately manage undesirable side effects.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
		Member understands the importance of adhering to recommended statin therapy.		Member understands the risks of slacking off statin therapy when there are no symptoms present.
	Member identifies ways to improve medication adherence.	Member improves medication adherence. - Member develops a routine that works - Member identifies and implements strategies to overcome barriers (set alarm, use of pillbox, calendar. coupon for discount)	Member exhibits full medication compliance. Member proactively refills medications before running out	Member reaches full medication adherence. Member proactively refills medications before running out. Member develops strategies to handle change in routine.
	Member explains the basics of medication safety - properly storing, disposal of expired meds, following dosing, sliding scale, needle disposal, etc.	Member explains the basics of medication safety - properly storing, disposal of expired meds, following dosing, sliding scale, needle disposal, etc.		
	Member creates a medication chart and keeps a copy to share with PCP/Specialists.	Member creates a medication chart and keeps a copy to share with PCP/Specialists.		
Clinical Monitoring (Results/Implications/ Actions) ○ *Symptoms* ○ *Physiologic measures* ○ *Labs/diagnostic tests* ○ *Follow up appointments with PCP and specialists*	Member explains the importance of routine blood glucose monitoring.	Member describes the frequency of routine blood glucose monitoring as recommended by the PCP (fasting, before meals, at bedtime). Member obtains personal glucometer. Member explains how to properly use a glucometer.	Member monitors blood glucose levels using personal device at frequency as recommended by the PCP. Member verbalizes goal blood glucose range as ______.	Member reaches full adherence with regular blood glucose monitoring.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
		Member monitors blood glucose levels using personal device at frequency as recommended by the PCP.	Member keeps a glucose and symptom diary to log and track blood glucose readings and symptoms.	Member develops strategies to stabilize glucose levels when numbers are off.
		Member describes the impact of elevated blood glucose levels on renal function and the importance of routine screening for CKD.		Member develops a plan for glucose monitoring when routine changes occur.
	Member acknowledges the specific screening lab tests and procedures associated with diabetes management. - HgbA1c - CMP (serum glucose, renal function) - eGFR, UACR (CKD staging and treatment plan establishment) - Lipid Panel (LDL)	Member describes the various screening labs associated with diabetes management including HgbA1c, CMP, eGFR, UACR, and lipid panel.	Member verbalizes goal A1c as ______. Member verbalized goal LDL as ______.	Member independently schedules and completes screening lab tests and procedures as recommended to include CKD screening.
		Member describes why managing A1c, blood pressure, and cholesterol are important for individuals with diabetes.	Member verbalized goal blood pressure is ______.	
		Member describes how eGFR and UACR are completed for CKD staging and treatment plan establishment.	Member completes CKD screening for evaluation and treatment.	
	Member explains the importance of completing screening lab tests and procedures as recommended.	Member completes screening labs and tests for management of diabetes.	Member completes all specific screening lab and tests for management of diabetes.	Member monitors blood pressure at least yearly/at intervals recommended by the PCP.
Preventive Care ○ *Preventive tests/screenings/immunizations* ○ *All Gaps in Care addressed*	Member acknowledges and addresses Gaps in Care including: (select appropriate gaps) - Diabetes Care - Hypertension Care - Colorectal Cancer Screening - Breast Cancer Screening - Cervical Cancer Screening	Member acknowledges and addresses Gaps in Care including: (select appropriate gaps) - Diabetes Care - Hypertension Care - Colorectal Cancer Screening - Breast Cancer Screening - Cervical Cancer Screening	Member acknowledges and addresses Gaps in Care including: (select appropriate gaps) - Diabetes Care - Hypertension Care - Colorectal Cancer Screening - Breast Cancer Screening	Member acknowledges and addresses Gaps in Care including: (select appropriate gaps) - Diabetes Care - Hypertension Care - Colorectal Cancer Screening - Breast Cancer Screening - Cervical Cancer Screening

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
			- Cervical Cancer Screening	
	Member receives annual physicals.	Member receives annual physicals.	Member receives annual physicals.	Member receives annual physicals.
	Member receives all recommended vaccinations including Influenza and Pneumococcal.	Member receives all recommended vaccinations including Influenza and Pneumococcal.	Member receives all recommended vaccinations including Influenza and Pneumococcal.	Member receives all recommended vaccinations including Influenza and Pneumococcal.
	Member receives twice yearly dental health assessments.	Member receives twice yearly dental health assessments.	Member receives twice yearly dental health assessments.	Member receives twice yearly dental health assessments.
	Member receives yearly eye exams (dilated retinal eye exam). Member understands the possible effects of diabetes on the eyes and the importance of routine eye exams.	Member receives yearly eye exams (dilated retinal eye exam).	Member receives yearly eye exams (dilated retinal eye exam).	Member receives yearly eye exams (dilated retinal eye exam).
	Member receives yearly podiatry assessments. Member understands the possible effects of diabetes on the feet (neurologic, vascular, skin integrity) and the importance of meticulous skin care.	Member receives yearly podiatry assessments.	Member receives yearly podiatry assessments.	Member receives yearly podiatry assessments. Member performs self-foot exams daily.
Provider Relations ○ *Bring a support person during appointment* ○ *Ensure understanding of next steps (treatment plan)* ○ *Preparing a list of questions* ○ *Making sure your list of questions has been answered*	Member describes the important role that they play as an active part of their healthcare team.			Member independently schedules, prepares for, and attends Provider appointments.
	Member shares specialty appointment experiences they may have had.	Member understands the importance of specialty care and routine follow up.	Member schedules specialty appointments, as recommended by the PCP.	Member recognizes when additional specialty appointments may be needed.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
○ *Connection with ancillary services*		Member acknowledges the roles of the various specialists involved for management of individuals with diabetes - Endocrinologist - Diabetes educator - Registered Dietician - Podiatrist - Nephrologist - Ophthalmologist/Optometrist/Retinal Specialist - Neurologist - Cardiologist - Dentist		
		Member prepares for Providers during specialty appointments. - Keeps a journal of symptoms - Prepares a list of questions/concerns to address with the provider - Ensures required lab work and tests are completed prior to the appointment and brings results if available - Brings all current medications or a list of allergies and current medications (prescribed and OTC) to all Provider appointments - Brings a family member or friend to the appointment if desired - Brings a pen and notebook and/or folder for taking notes and storing new paperwork or educational materials from the visit	Member prepares for and engages with Providers during specialty appointments. - Keeps a journal of symptoms - Prepares a list of questions/concerns to address with the provider - Ensures required lab work and tests are completed prior to the appointment and brings results if available - Brings all current medications or a list of allergies and current medications (prescribed and OTC) to all Provider appointments - Brings a family member or friend to the appointment if desired	

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
			- Brings a pen and notebook and/or folder for taking notes and storing new paperwork or educational materials from the visit - Collaborates to develop goals	
			Member accurately teaches back Provider instructions.	Member accurately teaches back and follows through with Provider instructions.
				Member independently seeks information from a variety of sources related to diagnosis, new medications, resources to address barriers, etc.
Connection with Resources ○ *Understanding benefits* ○ *Clinical Support Programs* ○ *Credible source for Health Information and Organizations* ○ *Community Resources*	Member participates in 3-way CSA call for review of available benefits and to discuss Clinical Support Programs that could benefit the Member.	Member participates in 3-way CSA call for review of available benefits and to discuss Clinical Support Programs that could benefit the Member.	Member participates in 3-way CSA call for review of available benefits and to discuss Clinical Support Programs that could benefit the Member.	Member participates in 3-way CSA call for review of available benefits and to discuss Clinical Support Programs that could benefit the Member.
	Member actively participates in clinically appropriate Clinical Support Programs as recommended (i.e. Home-based assessment, Smoking cessation, Enhanced monitoring, Expert Consult, Wellness/Disease management).	Member actively participates in clinically appropriate Clinical Support Programs as recommended (i.e. Home-based assessment, Smoking cessation, Enhanced monitoring, Expert Consult, Wellness/Disease management).	Member actively participates in clinically appropriate Clinical Support Programs as recommended (i.e. Home-based assessment, Smoking cessation, Enhanced monitoring, Expert Consult, Wellness/Disease management).	Member actively participates in clinically appropriate Clinical Support Programs as recommended (i.e. Home-based assessment, Smoking cessation, Enhanced monitoring, Expert Consult, Wellness/Disease management).

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
	Member independently reviews and utilizes information from credible sources for health information (such as www.diabetes.org).	Member independently reviews and utilizes information from credible sources for health information (such as www.diabetes.org).	Member independently reviews and utilizes information from credible sources for health information (such as www.diabetes.org).	Member independently reviews and utilizes information from credible sources for health information (such as www.diabetes.org).
	Member utilizes community resources and supportive services as recommended.	Member utilizes community resources and supportive services as recommended.	Member utilizes community resources and supportive services as recommended.	Member utilizes community resources and supportive services as recommended.
MODIFIABLE RISK FACTORS				
Diet	Member indicates awareness that a diabetic diet (ADA) should be followed.		Member adheres to diabetic diet (ADA) and adheres to recommended carbohydrate intake recommendation.	Member reaches full adherence to counting carbohydrates and adhering to the recommended diabetic diet (ADA) at home and while out.
		Member identifies good and bad food choices by reviewing key information on food labels and making comparisons between different food choices (carbohydrates, sugar). Member prepares a shopping list that includes low glycemic index foods. Member explains how carbohydrate intake affects blood glucose.	Member keeps a food journal to correlate dietary intake with glucose reading trends.	Member develops strategies to get back on track if member "cheats" by eating fast food or unhealthy snacks.
		Member improves nutrition through a small step achievable change (portion control, increase fruits/veggies, lower sodium options, cut down on snacks).	Member understands the importance of portion size and can describe the plate method of portion control.	Member masters use of glycemic index to make good food choices.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
		Member describes the importance of consulting with a Nutritionist.	Member schedules and attends consultations with a Nutritionist for diet teaching.	
	Member verbalizes the importance of avoiding alcohol consumption.			
Physical Activity	Member understands the benefits of physical activity on overall health.	Member describes the benefits of physical activity (aerobic exercise) in individuals with diabetes to include helping to control BP, helping to manage weight, strengthening the heart, lowering stress levels, and improves blood glucose levels.	Member identifies new activities to incorporate into the exercise regimen.	
	Member identifies barriers to increasing physical activity.	Member identifies solutions to barriers to increasing physical activity and takes actions to test them.	Member encourages friends and family to join in and actively participate exercise for social support.	Member identifies ways to overcome a slump in activity (e.g. become a mentor or motivator for someone else, identify new activities that can help break up the routine when needed).
		Member explains the importance of maintaining a healthy weight to improve blood glucose.		
		Member develops an exercise plan to add to their weekly routine beginning with low intensity and gradually increasing in rigor as tolerated.	Member continues to engage in physical activity gradually increasing in rigor as tolerated.	Member continues to work on daily exercise program with goal of 30 minutes daily and 150 minutes per week.
				Member pursues "stretch" goals for increase in activity to at least 150 minutes per week of moderate-intensity aerobic activity, 75 minutes of vigorous aerobic activity, or a combination of both (for adults) by continuing to increase intensity and duration over time.

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
		Member will monitor blood glucose levels prior to and following exercise sessions.	Member will monitor blood glucose levels prior to and following exercise sessions.	Member will monitor blood glucose levels prior to and following exercise sessions.
		Member will monitor for s/s hypoglycemia every 30 minutes during exercise and will implement Hypoglycemia Action Plan if necessary.	Member will monitor for s/s hypoglycemia every 30 minutes during exercise and will implement Hypoglycemia Action Plan if necessary.	Member will monitor for s/s hypoglycemia every 30 minutes during exercise and will implement Hypoglycemia Action Plan if necessary.
		Member explains the risk associated with exercise in the presence of blood glucose >250mg/dL and/or high levels of ketones noted in the urine.	Member avoids exercise when blood glucose is >250mg/dL and/or if high levels of ketones are noted in the urine as they are at risk for ketoacidosis. - Take measures to correct the high blood sugar levels and wait to exercise until ketone test indicates an absence of ketones in the urine.	Member avoids exercise when blood glucose is >250mg/dL and/or if high levels of ketones are noted in the urine as they are at risk for ketoacidosis. - Take measures to correct the high blood sugar levels and wait to exercise until ketone test indicates an absence of ketones in the urine.
Smoking Cessation	Member understands the benefits of smoking cessation. Member discusses how smoking has impacted his/her life.	Member describes the impact of smoking on individuals with diabetes.		
	Member describes reasons for wanting to quit smoking.	Member establishes a smoking cessation plan. - Member picks a "quit date" - Member identifies preferred smoking cessation method(s)	Member executes smoking cessation plan. Member utilizes resources provided for smoking cessation.	Member creates a plan for dealing with triggers/temptations - Make a list of reasons for not smoking - Take a bath - Chew sugarless gum

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DIABETES SELF-MANAGEMENT STRATEGIES	PAM LEVEL 1	PAM LEVEL 2	PAM LEVEL 3	PAM LEVEL 4
		- Member builds supportive team (family friends) for motivation and accountability.	Member participates in a formal smoking cessation program.	- Sip some water - Find something to do with your hands - Take a walk
		Member identifies smoking cessation methods to include: "cold turkey", behavioral therapy (counseling), nicotine replacement therapy (gum, patches, lozenges, sprays), medications (Chantix, Bupropion), and combo treatments.	Member throws away cigarettes, lighters, and ashtrays at work and at home to make it hard to give in to the urge to smoke.	
	Member develops a self-awareness by studying their own smoking habits. - How much and how often does the Member smoke? - What is the Member's smoking triggers?	Member sets small achievable goal to decrease amount of smoking.	Member identifies nicotine withdrawal symptoms and how best to manage them.	Member develops a strategy for getting back on track following relapse.
		Member creates a Reward Plan for sticking to the goal.	Member identifies strategies for managing cravings.	

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