Connections℠ supports the doctor/patient relationship by:

- Providing patients with reliable, evidence-based information so that they can understand their diagnoses and treatment options.
- Promoting meaningful dialog and active patient participation in care decisions.
- Supporting self-care education and adherence to the physician care plan.
- Providing physicians with information on opportunities to improve the effectiveness of testing and treatment for their patients.

Consider using Connections℠ for eligible AmeriHealth patients who:

- Have been diagnosed with one or more chronic conditions (asthma, CAD, CHF, COPD, diabetes) and need education and support.
- Are at high risk for ER visits, hospital admissions, or readmissions.
- Are non-adherent with your treatment plan, medications, or testing.
- Need support when making decisions to address problems such as back pain, osteoarthritis, benign prostatic hyperplasia (BPH), or abnormal uterine bleeding or fibroids.
- May benefit from support on a case-by-case basis (e.g., end-of-life decisions).

HOW TO REFER YOUR AMERIHEALTH PATIENTS

- Complete a **Connections℠ Fax Referral Form** and fax to (800) 276-3075, or
- Give your patient a **Connections℠ Referral Slip**, encouraging them to call a Health Coach directly, or
- Complete the referral section on the individual patient report in your **Connections℠ SMART™ Registry** and fax to (800) 276-3075, or
- Call **Connections℠ Provider Support Line** at (866) 866-4694 with patient name, phone #, and reason for referral.

Connections℠ HEALTH MANAGEMENT PROGRAM

AmeriHealth

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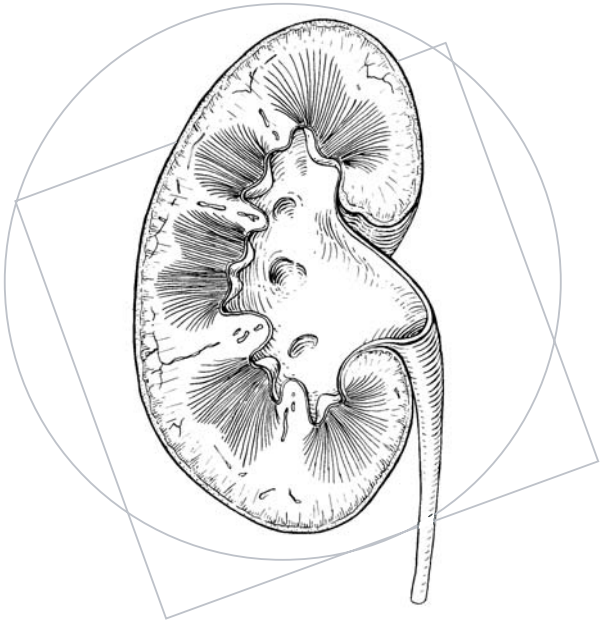
Diabetes and Kidney Disease

The Importance of **Microalbumin Testing**



Connections℠ HEALTH MANAGEMENT PROGRAM

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Important information:

- 20-40% of U.S. diabetics develop diabetic nephropathy, the single leading cause of end-stage renal disease (ESRD).[1]
- Early detection/management may delay progression to ESRD.[2]
- Microalbuminuria (30 mg/day or 20 µg/min) is first sign of diabetic nephropathy.[3]
- At least two of three urine tests measured within a 6-month period must show elevated albumin levels to diagnose microalbuminuria.[4]
- American Diabetes Association (ADA) recommendations for microalbuminuria screening: 1) Type 2 diabetics at diagnosis and annually thereafter; 2) Type 1 diabetics 5 years after diagnosis and annually thereafter.[3]
- Most authorities recommend screening the spot urine albumin-to-creatinine ratio because it is inexpensive and accurate.[4]
- Recommended treatment: either ACEIs or ARBs except during pregnancy.[1]
- ADA recommends annual monitoring of microalbuminuria in patients on ACEI or ARB; however, the impact on outcomes remains under study.[3]
- To reduce the risk and/or slow the progression of nephropathy, optimize glucose and blood pressure control.[1]
- Recommended criteria for specialist referral: glomerular filtration rate (GFR) <60ml/min/1.73m^2 or resistant hypertension or hyperkalemia.[1]

[1]http://care.diabetesjournals.org/cgi/content/full/28/suppl_1/s4
[2]http://www.kidney.org/kidneyDisease/
[3]Diabetic Nephropathy. Diabetes Care 2002; 25(Supp.1):S85-S89
[4]Standards of medical care in diabetes-2006. Diabetes Care 2006; 29(Supp1):S4-42S

Consider this...

During each office visit for your patients with diabetes, please consider reviewing the following:

- **WRITTEN ACTION PLAN**
  Assist patients in writing a plan for responding to hypoglycemia, other changes in blood glucose, or other symptoms.
- **MEDICATIONS**
  Including oral hypoglycemic agents, insulin, ACE Inhibitors (or angiotension-2 receptor blockers, if ACEI not tolerated), beta blockers, aspirin (low dose).
- **BLOOD PRESSURE MANAGEMENT**
  Goal for patients with diabetes mellitus is 130/80 or lower.[4]
- **LIPID MANAGEMENT**
  Using diet and medications, as needed, to achieve an LDL goal of 100 or lower, depending on patient risk status.[4]
- **GLYCEMIC CONTROL**
  Goal of achieving near-normal glycemia (A1C levels below 7%). A1C levels should be measured twice yearly in patients who are achieving glycemic goals and quarterly in patients who are not achieving goals or in whom therapy has been changed.[4]
- **EYE CARE**
  Dilated retinal exams are recommended annually or more frequently if retinopathy is progressing.
- **WEIGHT MANAGEMENT**
  Goal to achieve a BMI <25.

  Weight loss improves glucose tolerance, reduces blood pressure, improves lipid levels and reduces cardiovascular risks.[4]
- **FOOT CARE**
  Experts suggest visual inspection of feet at each office visit and a comprehensive foot exam annually.

  Encourage patients to examine their own feet daily.[4]