

PREDIABETES

Assessment, Management, and Education Guidelines

Prediabetes programming is aimed at preventing/delaying the onset of diabetes and modifying cardiovascular risk. Programming focuses on self-care and the promotion of direct linkage to available community supports and services.

Refer to Diabetes Centre (DC)

Required blood work to accompany DC referral:

- Diagnostic test results: fasting plasma glucose and/or 2-hr PG in a 75g OGTT.
- Lipid profile: LDL-C, HDL-C, ratio Total Cholesterol (TC):HDL-C, and triglycerides.

DC Assessment

- Self-assessment: Mailed to and completed by patient and/or family/support person.
DC staff person reviews for other risks that may indicate the need for individual assessment/treatment plan: hypertension, dyslipidemia, renal impairment, significant weight loss or gain, depression/anxiety, etc.
- Questionnaires: Knowledge and quality of life
- Physical measures:
 - Blood pressure (standard measure and reporting)
 - Weight and height (BMI)
 - Waist circumference or waist-to-hip ratio

Targets

- BMI: < 25 kg/m² (normal weight)
- Waist circumference: men ≤ 102 cm; women < 88 cm
- Blood Pressure: < 140/90 mmHg
- Lipids: determine based on Framingham Risk Assessment

Management Goals

- Weight reduction: Reduce 5 to 7% of total body weight.
- Healthy Eating: Fat reduced and high fibre (calorie/energy reduced for weight loss). Other modifications, i.e., low sodium, dependent on presence of hypertension.
- Physical Activity: Add 30 minutes of moderate activity most days of the week. This can be accomplished in 10- minute cumulative blocks of time.
- Modify other risk factors including smoking, stress, and metabolic abnormalities (hypertension and dyslipidemia).

Self-Management Education

Inclusive of realistic goal setting and problem-solving, based on readiness, to assist with behavior change.

1. Module 1--Prediabetes: what is it, diagnostic criteria, study findings in support of prevention through lifestyle and pharmacotherapy, DM signs/symptoms, routine surveillance (frequency of screening), linkage to community programming and resources
2. *Module 2--Healthy Eating and Physical activity (short and long-term goal setting)
3. *Modules 3a and 3b--as required depending on metabolic abnormalities:
 - a. Hypertension module
 - b. Dyslipidemia module
4. *Other Optional Modules:
 - a. Stress reduction/management
 - b. Smoking cessation
 - c. Self-care (to be delivered as part of Chronic Disease Management Strategy)

Predabetes cont

No need for:

- A1C testing
- Self-blood glucose monitoring
- Routine eye or foot examinations, unless indicated for other reasons
- Kidney and renal function (unless considering medication initiation)

Report to Referring/Family Physician

- At completion of the first intervention period
- After the follow-up appointment at 6 and/or 12 months.

Follow-up at six to 12 months

- Provide requisition for routine blood work (as per referral blood work) prior to scheduled follow-up appointment
- Group follow-up: assess patient goals and provide encouragement/reinforcement; assess linkage to/use of community programming and resources for lifestyle supports
- Questionnaires: Knowledge and quality of life
- Physical measures: blood pressure, weight, waist circumference and/or waist to hip ratio

Discharge at 12 months

- Review DM signs and symptoms—annual screening and results
- Community resources (reinforcement of lifestyle modification)

** Delivered at community level, not necessarily by DC staff. In the future, module 1 may be delivered outside the DC as well.*