

Quick Reference Guide

Clinical Practice Guidelines for Standards of Medical Care in Diabetes – 2015

88

Diabetic Classifications	<p>The classification of diabetes includes four clinical classes:</p> <ul style="list-style-type: none"> • type 1 diabetes: results from β-cell destruction, usually leading to absolute insulin deficiency • type 2 diabetes: results from a progressive insulin secretory defect on the background of insulin resistance • other specific types of diabetes due to other causes, e.g., genetic defects in β-cell function, genetic defects in insulin action, diseases of the exocrine pancreas, and drug- or chemical-induced (such as in the treatment of AIDS or after organ transplant) • gestational diabetes mellitus (GDM): diabetes diagnosed during pregnancy
Glycemic Control	<p>Self-monitoring of Blood Glucose (SMBG)</p> <ul style="list-style-type: none"> • SMBG should be carried out three or more times daily for patients using multiple insulin injections or insulin pump therapy. • For patients using less frequent insulin injections, noninsulin therapies, or medical nutrition therapy (MNT) alone, SMBG may be useful as a guide to the success of therapy. • To achieve postprandial glucose targets, postprandial SMBG may be appropriate. • When prescribing SMBG, ensure that patients receive ongoing instruction and regular evaluation of SMBG technique, SMBG results, and their ability to use SMBG data to adjust therapy. • Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimens can be a useful tool to lower A1C in selected adults (aged ≥ 25 years) with type 1 diabetes. • Although evidence for A1C lowering is less strong in children, teens, and younger adults, CGM may be helpful in these groups. Success correlates with adherence to ongoing use of the device. • CGM may be a supplemental tool to SMBG in those with hypoglycemia unawareness and/or frequent hypoglycemic episodes. <p>Glycated Hemoglobin Test (A1C) - (HEDIS Measure)</p> <ul style="list-style-type: none"> • Perform the A1C test at least two times a year in patients meeting treatment goals (and have stable glycemic control). • Perform the A1C test quarterly in patients whose therapy has changed or who are not meeting glycemic goals. • Use of point-of-care testing for A1C allows for timely decisions on therapy changes, when needed.
Glycemic Goals	<ul style="list-style-type: none"> • Lowering A1C to below or around 7% has been shown to reduce microvascular complications, and if implemented soon after diagnosis, is associated with long-term reduction in macrovascular disease. Therefore, a reasonable A1C for many non-pregnant adults is $<7\%$. • Providers might suggest more stringent A1C goals (such as $<6.5\%$) for selected individual patients, if achievable without significant hypoglycemia or other adverse effects. Appropriate patients may include those with short duration of diabetes, long life expectancy, and no significant CVD. • Less stringent A1C goals (such as $<8\%$) may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions, and for those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose-lowering agents including insulin.

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Screening Tests	<ul style="list-style-type: none"> • Blood pressure should be measured at every routine diabetes visit. (HEDIS measure) • B/P targets - systolic blood pressure <140 mmHg and diastolic blood pressure <90 mmHg. (HEDIS measure) • Measure fasting lipid profile at least annually. (HEDIS measure) • LDL cholesterol <100 mg/dl (HEDIS measure), HDL cholesterol >50 mg/dl, and triglycerides <150 mg/dl. • Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of ≥ 5 years and in all type 2 diabetic patients starting at diagnosis. (HEDIS measure) • Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye exam by an ophthalmologist or optometrist within 5 years after onset. Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis. • Subsequent eye exams for type 1 and type 2 diabetes should be repeated annually by an ophthalmologist or optometrist. Less-frequent exams (every 2 years) may be considered if no retinopathy is present. Exams will be required more frequently if retinopathy is progressing. (HEDIS measure) • Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. • All patients should be screened for distal symmetric polyneuropathy starting at diagnosis of type 2 diabetes, 5 years after the diagnosis of type 1 diabetes, and at least annually thereafter, using simple clinical tests. • Screening for signs and symptoms of cardiovascular autonomic neuropathy should begin at diagnosis of type 2 diabetes and 5 years after diagnosis of type 1 diabetes. • Perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. • Advise all patients not to smoke. Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care.
Immunizations	<ul style="list-style-type: none"> • Annually provide an influenza vaccine to all diabetic patients ≥ 6 months of age. • Administer pneumococcal polysaccharide vaccine to all diabetic patients ≥ 2 years of age. A one-time revaccination is recommended for individuals >65 years of age previously immunized when they were <65 years of age if the vaccine was administered >5 years ago. Other indications for repeat vaccination include nephrotic syndrome, chronic renal disease, and other immunocompromised states, such as after transplantation. • Administer hepatitis B vaccination to adults with diabetes as per CDC recommendations.
Medical Nutrition Therapy (MNT)	<ul style="list-style-type: none"> • People with pre-diabetes or diabetes should receive individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietician familiar with the components of diabetes MNT. • Weight loss is recommended for all overweight or obese patients who have or are at risk for diabetes. • For weight loss, either low-carbohydrate or low-fat calorie-restricted diets may be effective in the short-term (up to 2 years). • For patients on low-carbohydrate diets, monitor lipid profiles, renal function and protein intake (in those with nephropathy) and adjust hypoglycemic therapy as needed.

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	<ul style="list-style-type: none"> Physical activity and behavior modification are important components of weight loss programs and are most helpful in maintenance of weight loss. The mix of carbohydrate, protein, and fat may be adjusted to meet metabolic goals and individual preferences of the person. Monitoring carbohydrate intake, whether by carbohydrate counting, choices, or experience-based estimation, remains a key strategy in achieving glycemic control. The amount of dietary saturated fat, cholesterol, and trans fat recommended for people with diabetes is the same as that recommended for the general population.
Physical Activity	<ul style="list-style-type: none"> People with diabetes should be advised to perform at least 150 min/week of moderate-intensity aerobic physical activity (50–70% of maximum heart rate). In the absence of contraindications, people with type 2 diabetes should be encouraged to perform resistance training three times per week.
Psychosocial Assessment and Care	<ul style="list-style-type: none"> Assessment of psychological and social situation should be included as an ongoing part of the medical management of diabetes. Psychosocial screening and follow-up should include, but is not limited to, attitudes about the illness, expectations for medical management and outcomes, affect/mood, general and diabetes-related quality of life, resources (financial, social, and emotional), and psychiatric history. Screen for psychosocial problems such as depression, anxiety, eating disorders, and cognitive impairment when adherence to the medical regimen is poor.

References

American Diabetes Association, Position Statement: Standards of medical care in diabetes - 2015. Jan. 2015. DOI: 10.2337/dc14.5014 Vol 38.
 Accessed 03/31/2015 at:
http://professional.diabetes.org/admin/UserFiles/0%20-%20Sean/Documents/January%20Supplement%20Combined_Final.pdf