New York Diabetes Coalition

Guidelines for Adult Diabetes (DM) Care

Developed by the **New York Diabetes Coalition**® in collaboration with the New York State Dept. of Health, Diabetes Prevention & Control Program.
Based on the American Diabetes Association Clinical Practice Recommendations and reviewed yearly.
Visit http://professional.diabetes.org/CPR_search.aspx for full recommendations or specific citations (i.e. S33)
The guidelines are minimum recommendations and are not intended to replace the clinical judgment of health care providers.

CLINICAL PRIORITIES **A B C 'S** ■ **A1C** ■ **Blood Pressure** ■ **Cholesterol** ■ **Smoking Status**

	EXAM/TEST	FREQUENCY	GOAL RECOMMENDATION
HISTORY & PHYSICAL	**Blood Pressure(BP)**[1]	Every visit	<130/80 with individual adjustment as appropriate. (S27)
	Weight & BMI	Every visit	Healthy weight=BMI≥18.5 and < 25. Advise weight management to optimize BMI.
	Comprehensive Foot Exam[2]	Annually	Sensory, visual and vascular inspection, without shoes and socks. Teach protective foot care if sensation diminished. Refer to podiatrist.
	Visual Inspection of Feet	Every visit	Inspect skin for signs of pressure and breakdown to prevent ulceration and infection. Teach protective foot care.
	Dilated Retinal Exam	Annually[3]	Detect retinopathy/refer to eye care professional.[3]
	Dental	Every 6 months	Evaluate teeth and gums. Encourage daily brushing and flossing. Refer to dentist.
LABORATORY*	**A1C**	2-4 times yearly	General Goal: <7.0 with individualized goal adjustment to be more or less stringent for individual pts. as appropriate.[4]
	Fasting Lipid Profile[1]	Annually[5]	For pts. without overt CVD, goal is LDL cholesterol of <100 mg/dl.[6]
	Urine Microalbumin/ Creatinine Ratio[1]	At diagnosis and annually[7]	Perform test on spot urine for albumin and creatinine, calculate ratio: ≥30 µg alb/mg creatinine is abnormal. (S34,38)
	eGFR(Calculated from Serum Creatinine)	Annually	Obtain estimated glomerular filtration rate (eGFR)[8] to stage the level of chronic kidney disease (CKD). Refer to CKD staging and guidelines on management of CKD in DM (S34,35). See Resource A.
IMMUNIZATIONS	**Flu Vaccine**	Annually	
	Pneumovax	Once*	*Administer to all pts. with DM. A one-time revaccination is recommended for individuals >64 years of age previously immunized when they were <65 years of age if the vaccine was administered >5 years ago.[9]
COUNSELING AND RISK REDUCTION	**Tobacco Use**[1]	Annual/ongoing	Assess smoking status, advise pts. to quit. Refer to NYS Quitline. See Resource B.
	Psychosocial Adjustment	Annual/ongoing	Suggest support groups/counsel/refer. Assess for depression or other mood disorder. See Resource C.
	Sexual Functioning	Annual/ongoing	Discuss function and therapy options with both male and female pts.
	Preconception	Initial/ongoing	Target A1C as close to normal as possible (<7%) before conception is attempted. Evaluate medications. Statins, ACE, ARBs and most noninsulin therapies contraindicated prior to and during pregnancy. (S41-42)
	Diabetes During Pregnancy	Initial/ongoing	For pregnant women with type 1 or type 2 DM, an A1C of <6% is recommended if it can be achieved without excessive hypoglycemia. Evaluate medications. Statins, ACE, ARBs and most noninsulin therapies contraindicated prior to and during pregnancy. (S42) Comprehensive eye exam during 1st trimester. (S35) Refer to high risk program
	Aspirin Therapy	Ongoing	Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in pts. with DM with a history of CVD. (S31)
	ACE Inhibitor/ARB	Ongoing	Pharmacological therapy regimen for non-pregnant (S42) pts. with DM and hypertension should include either ACE inhibitor or ARB. (S27) In the treatment of micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. If one class is not tolerated, the other should be substituted. (S33)
REVIEW SELF-MANAGEMENT SKILLS	**Patient and Clinician Jointly Set Goals**	Initial/every visit	Ongoing setting and monitoring of A1C, BP, and lipid goals. Support pt.'s behavior change efforts including physical activity; healthy eating; tobacco avoidance; weight management; effective coping; medication management. Refer to DM self-management education (DSME) at diagnosis and as needed. (S22)[10]
	Physical Activity	Initial/ongoing	Assess and prescribe based on pt.'s health status. (S24)[11]
	Nutrition	Initial/ongoing	If BMI ≥25, advise weight management.[10] Assess for alcohol use. Recommend Medical Nutrition Therapy (MNT) as needed. See Resource D.
	Medication Review/ Adherence	Initial/ongoing	Review current medications and adherence. Adjust medications as indicated to achieve target goals for glucose, BP, and lipids. Assess and address barriers to pt. adherence.
	Self Monitoring Blood Glucose (SMBG)	Initial/ongoing	Pt. to monitor glucose as necessary to minimize risk of hyper- and hypoglycemic episodes.[12] Review and check pt. log book for accuracy.

***Additional monitoring:** EKG (initial/as indicated: pt. ≥40 y.o. or DM ≥10 yrs), Thyroid Assessment (initial/as indicated, palpation & function), Blood Glucose & Urinalysis (as indicated)

RESOURCES:

A. GFR Calculator & PC Download: www.nkdep.nih.gov
Stages of Chronic Kidney Disease: www.kidney.org/professionals/kdoqi/guidelines.cfm

B. Smoking Cessation Counseling:
NYS Smokers' Quitline: 1-866-NYQUITS (697-8487), www.nysmokefree.com
www.nyhpa.org/pdf/Smoking_Cessation_Guideline.pdf
www.nyhpa.org/pdf/Guide_Your_Patients.pdf
www.mssny.org/mssnyip.cfm?c=i&nm=Smoking_Cessation
www.surgeongeneral.gov/tobacco/tobaqrg.htm

C. MacArthur Depression Screening and Management Toolkit:
www.depression-primarycare.org/clinicians/toolkits/full

D. Nutrition:
ADA Nutrition Principles http://care.diabetesjournals.org/content/31/Supplement_1/S61.full
American Diabetes Association: MNT services are defined in statute as "nutritional diagnostic, therapy, and counseling services for the purpose of disease management which are furnished by a registered dietitian or nutrition professional...pursuant to a referral by a physician."
www.diabetesarchive.net/for-health-professionals-and-scientists/recognition/mnt-faqs.jsp#Q1

FOOTNOTES:

[1]Annual review of CVD risk factors.

[2]Foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (LOPS) (10-g monofilament plus vibration testing, e.g.tuning fork). (S37)

[3]Type 1: Within 5 yrs after onset, then annually. Type 2: Refer at time of diagnosis, then annually. ADA recommends ophthalmologist or optometrist. Fundus photography may serve as a screening tool for retinopathy, but is not a substitute for a comprehensive eye exam. (S35)

[4]At least 2x a year in pts. who are meeting treatment goals. Quarterly in pts. whose therapy has changed or who are not meeting glycemic goals. (S18) See Summary of Glycemic Recommendations Table 10. (S21)

[5]In adults with low-risk lipid values (LDL cholesterol <100 mg/dl, HDL cholesterol >50 mg/dl, and triglycerides <150 mg/dl), repeat every 2 years. (S29)

[6]Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels for DM pts. with overt CVD, and for those without CVD who are >40 years and have one or more other CVD risk factors. (S29)

[7]Type 1: Annual with DM duration ≥ 5 years; Type 2: Annual, starting at diagnosis. (S33)

[8]When the eGFR is less than <60 ml/min per 1.73 m2, screening for anemia, malnutrition, and metabolic bone disease is indicated. Consider referral to a physician experienced in the care of kidney disease when there is uncertainty about the etiology of kidney disease. (S35)

[9]Also revaccinate for nephrotic syndrome, chronic renal disease and immunocompromised states, such as after transplantation. (S27)

[10]To locate Certified Diabetes Educator (1-800-832-6874, www.diabeteseducator.org) or Registered Dietitian (www.eatright.org)

[11]Advise physical activity at least 150 min/week of moderate-intensity aerobic activity including resistance training 3x's week. (S24)

[12]Recommend postprandial testing (goal <180 mg/dl) when A1C levels are not optimal but pre-meal targets are being met. (S21)

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