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Aspirus Network, Inc.
Diabetes Mellitus Care Guideline 2013

Adopted from: American Diabetes Association: Standards of Medical Care in Diabetes—2013, *Diabetes Care*, January 2013 36:S11-S66

Always individualize treatment and testing. Not all national guidelines are applicable after age 75.

ADA Criteria for Identification and Diagnosis of Diabetes:	· **Hemoglobin A1C > 6.5%, or** · **Fasting plasma glucose > 126 mg/dl, or** · **2-hour plasma glucose > 200 after 75g oral glucose tolerance test, or** · **A symptomatic patient with > 200 mg/dl random plasma glucose.**

Concern	Care/Test	Frequency / Recommendation
Identification and Diagnosis of Type 2 Diabetes	· Fasting plasma glucose test, · Oral glucose tolerance test, or · Hemoglobin A1C **(NOTE: Medicare will only cover an A1C every 4 months.)**	Test all adults ≥ age 45 yrs (see full Guidelines for testing of Type 2 diabetes in children and adolescents); if normal and person has no risk factors, retest in 3 years or less; consider earlier testing for those at high risk of diabetes.
General Recommendations for Care	· Perform diabetes-focused visit .... · Review management plan; assess barriers and goals......... · Assess physical activity level... · Assess nutrition/weight/BMI/growth	Type 1: Every 3 months. Type 2: Every 3 – 6 months. Each focused visit; revise as needed. Each focused visit. Each focused visit; consider Bariatric surgery for adults with BMI >35 kg/m2 and type 2 diabetes.
Self-Management Education	· Refer to diabetes educator, preferably a CDE in an ADA Recognized Program	At diagnosis, then as needed depending on control needs and goals.
Medical Nutrition Therapy	· Refer for medical nutrition therapy (MNT) provided by a registered dietitian (RD), preferably one who is also a CDE..	At diagnosis or first referral to RD: initial visits completed in 3 to 6 months, then RD determines additional visits based on needs/goals.
Glycemic Control	· Check A1C; goal: below or around 7.0% (higher A1C goals maybe appropriate for some individuals)................................ · Review goals, medications, side effects, and frequency of hypoglycemia...	Type 1: Every 3 months. Type 2: Every 3 – 6 months. Each focused visit. Each focused visit, 2 – 4 times/day, or as recommended.
Cardiovascular Care	· Check fasting lipid profile... Adult goals: Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL HDL > 40 mg/dL (men) HDL > 50 mg/dL (women) LDL < 100 mg/dL LDL < 70 mg/dL (for very high risk or history of vascular disease) · Start statin with ongoing lifestyle changes .... · Check blood pressure.. Adult goal: < 130/80 mmHg; Begin pharmacological treatment when BP > 140/80 mmHg · Assess smoking/tobacco use status .... · Start aspirin prophylaxis (unless contraindicated)..............	Children: If positive family history of early cardiovascular disease (CVD), check lipids after age 2 but before age 10. Repeat annually if abnormal, repeat in 5 years if normal. Adults: Annually. If abnormal, follow NCEP III guidelines. Adults with CVD; Age > 40 yrs with one or more risk factors for CVD, if high risk CVD or LDL >100 despite lifestyle changes. Children: Each focused visit; treat if consistently > 95% percentile for sex/age. Adults: Each focused visit. Each visit; (5As: Ask, Advise, Assess, Assist, Arrange). Men > 50 yrs or women > 60 yrs with one additional CVD risk factor.
Kidney Care	· Check albumin/creatinine ratio using a random urine sample, also called urine microalbumin/creatinine ratio ...... · Check serum creatinine and estimated GFR .... · Perform routine urinalysis... · ACE inhibitor or ARB if micro or macroalbuminuria (unless contraindicated)	Type 1: At puberty or after 5 years duration, then annually. Type 2: At diagnosis, then annually. At diagnosis, then annually. At diagnosis, then as indicated. If ACE/ARB used, monitor serum creatinine and potassium levels for development of acute kidney disease and hyperkalemia.
Eye Care	· Dilated eye exam by eye care professional ……………..….....	Type 1: If age ≥ 10 yrs, within 3 – 5 years of onset, then annually. Type 2: At diagnosis, then annually.
Neuropathy and Foot Care	· Assess/screen for neuropathy (autonomic/DPN) .... · Visual inspection of feet with shoes and socks off .... · Perform comprehensive lower extremity/foot exam (use monofilament and tuning fork) .... · Screen for PVD (consider ABI)	Type 1: Five years after diagnosis, then annually. Type 2: At diagnosis, then annually. Each focused visit; stress daily self-exam. At diagnosis, then annually. At diagnosis, then annually.
Emotional/ Sexual Health Care	· Assess emotional health; screen for depression..........…… · Assess sexual health concerns	Each focused visit. Each focused visit.
Immunizations	· Provide influenza vaccine.. · Provide pneumococcal vaccine.. · Administer hepatitis B vaccination…………………………..	Annually, if age ≥ 6 months. Once; then per Advisory Committee on Immunization Practices. To unvaccinated adults with diabetes who are aged 19-59 years.
Preconception and Pregnancy Care	· Provide preconception counseling/assessment .... · Assess contraception/discuss family planning .... · Assess risk for gestational diabetes mellitus (GDM)........... · Screen for GDM... · Screen for Type 2 diabetes post-GDM...............................	Prior to conception. At diagnosis and each focused visit. At first prenatal visit (if high risk, screen immediately for GDM). At 24 – 28 weeks gestation or earlier if high risk. At 6 – 12 weeks postpartum, then annually; Postpartum Hemoglobin A1C not recommended.