Adult Diabetes Care

EXAMINATION/TEST	FREQUENCY	GOAL RECOMMENDATION
HISTORY AND PHYSICAL		
Blood Pressure (BP) [1]	Every visit	<140/90 with individual adjustment to lower systolic BP target as appropriate.
Weight & BMI	Every visit	Healthy Weight = BMI ≥18.5 and <25 Advise weight management to optimize BMI.
Comprehensive Foot Exam[2]	At least Annually	Sensory, visual and vascular inspection, without shoes and socks. Teach protective foot care if sensation is 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.
Hypoglycemia Assessment	Every visit	Ask about symptomatic and asymptomatic hypoglycemia.
Dilated Retinal Exam	Annually[3]	Detect retinopathy/refer to eye care professional. May be every 2 yrs if no retinopathy detected.
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]	Annual CVD risk assesment[5]	At the discretion of the physician based on CVD risk.[5]
Urine albumin-to-creatinine ratio (UACR) & estimated glomerular filtration rate (eGFR)	At least annually	Assess urinary albumin (e.g., spot urine albumin-to-creatinine ratio [UACR] [6] & estimated glomerular filtration rate) in patients with type1 diabetes duration of ≥5 yrs & in all patients with type 2 diabetes and in all patients with comorbid hypertension. (S88, 89)
IMMUNIZATIONS [8]		
Flu Vaccine	Annually	
Pneumococcal Vaccine	Initial/ Follow-up	Administer pneumococcal polysaccharide vaccine 23 (PPSV23) to all patients with diabetes ≥2 yrs of age. Adults who are immunocompetent and aged 65 years of age or order should receive 13-valent pneumococcal conjugate vaccine (PCV13) followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) at least 1 year after PCV 13.
Hepatitis B Vaccine	Initial	For unvaccinated adults with diabetes <60 years ASAP after diabetes diagnosis & should also be given to adults diagnosed with diabetes in the past. For unvaccinated adults with diabetes >60 years, vaccinate at discretion of health care provider. *Source: CDC*
COUNSELING AND RISK REDUCTION		
Alcohol and Tobacco Use [1]	Annually/ Periodically	Assess alcohol use and smoking status, advise pts. to quit. See Resources on pg 5.
Psychosocial Adjustment	Annually/ Periodically	Suggest support groups/counsel Assess for depression or other mood disorder. See Resources on pg 5.
Sexual Functioning	Annually/ Periodically	Discuss function and therapy options with both male and female pts.
Preconception	Initial/ Periodically	Preconception counseling should address the importance of glycemic control as close to normal as is safely possible, ideally A1C <6.5% (48 mmol/mol) to reduce the risk of congenital anomalies. (S114). Evaluate medications. Statins, ACE, ARBs and most noninsulin therapies contraindicated prior to and during pregnancy. (S78)
Diabetes During Pregnancy	Initial/ Periodically	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. (S78) Comprehensive eye exam during 1st trimester. (S61) Refer to high risk program.
Aspirin Therapy	Periodically	Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in pts. with DM with a history of CVD. (S54, 55)
Statin Therapy	Initial/ Periodically	In addition to lifestyle therapy: 1) all ages with diabetes and /ASCVD should use high intensity statin therapy, 2) 40 – 75 yrs of age with diabetes, should use moderate intensity statin therapy, 3) >75 yrs of age with diabetes, statin therapy should be individualized based on risk profile. (S79, 80)
ACE Inhibitor/ARB	Periodically	An ACE inhibitor or angiotensin receptor blocker, at the maximum tolerated dose indicated for blood pressure treatment, is the recommended first-line treatment for hypertension in patients with diabetes and urinary albumin-to-creatinine ratio ≥300 mg/g creatinine or 30-299 mg/g creatinine. If one class is not tolerated, the other should be substituted. (S76) Other agents may also be appropriate.

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REVIEW SELF-MANAGEMENT SKILLS		
Patient and Clinician Jointly Set Goals	Initial/every visit	Ongoing setting and monitoring of A1C, BP, and lipid goals. Support pts.' 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. (S33-34)
Physical Activity	Initial/ Periodically	Assess and prescribe based on pts.' health status.[10] (S37-38)
Nutrition	Initial/ Periodically	If BMI ≥ 25, advise weight management. Asian-American adults of any age have a lower BMI threshold for risk than other ethnic groups with a BMI ≥ 23. Assess for alcohol use. Recommend Medical Nutrition Therapy (MNT) as needed.[9] See Resources on page 5.
Medication Review/Adherence	Initial/ Periodically	Review current medications and adherence. Adjust medications as indicated to achieve target goals for glucose, BP, and lipids. Assess and address barriers to patient adherence.
Self Monitoring Blood Glucose (SMBG)	Initial/ Periodically	Pt. to monitor glucose as necessary to minimize risk of hyper- and hypoglycemic episodes.[11] Ongoing assessment of cognitive function is suggested with increased vigilance for hypoglycemia by the clinician, patient, and caregivers if low cognition or declining cognition is found. (S53-54)

See footnotes on page 7. Visit http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160 for full recommendations or specific citations (i.e.S33).