

## Care Guide for *Diabetes*

SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS, MEASUREMENTS AND VALUES	INTERVENTIONS	FOLLOW-UP
Screening for Diabetes (DM) <sup>1,2, 15</sup>	<ul style="list-style-type: none"> <li>• Fasting plasma glucose (FPG) is the preferred test</li> <li>• All adults 45 years or older</li> <li>• Consider screening at a younger age in individuals with BMI &gt;25 kg/m<sup>2</sup> with additional risk factors including:               <ul style="list-style-type: none"> <li>➢ Habitual physical inactivity</li> <li>➢ History of gestational diabetes or delivering a baby weighing &gt;9 lbs.</li> <li>➢ Polycystic Ovarian Syndrome (PCOS)</li> <li>➢ Family history of diabetes in a first degree relative</li> <li>➢ Member of a high risk racial/ethnic group (Black, Latino, Native American, Asian, Pacific Islander)</li> <li>➢ Hypertension</li> <li>➢ High triglycerides and/or low HDL-C</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Diabetes</b> <ul style="list-style-type: none"> <li>➢ Symptoms of DM and a random glucose <math>\geq 200</math> mg/dL</li> <li>➢ FPG <math>\geq 126</math> mg/dL</li> <li>➢ 2-h PG <math>\geq 200</math> mg/dL during a 75 gm OGTT. In the absence of unequivocal hyperglycemia with acute metabolic decompensation these criteria should be confirmed by retesting on a different day</li> <li>➢ Hemoglobin A1c (A1C) <math>\geq 6.5\%</math>. The test should be performed in a laboratory using a method that is NGSP certified and standardized to the DCCt assay.</li> </ul> </li> <li>• <b>Pre-diabetes:</b> <ul style="list-style-type: none"> <li>➢ FPG 100 – 125 mg/dL = Impaired Fasting Glucose (IFG)</li> <li>➢ 2-h PG 140 – 199 mg/dL = Impaired Glucose Tolerance (IGT)</li> </ul> </li> <li>• Re-Test on a separate occasion to confirm diagnosis</li> </ul>	<ul style="list-style-type: none"> <li>• If abnormal, follow diabetes guideline</li> </ul>	<ul style="list-style-type: none"> <li>• If normal, repeat at least every three years</li> <li>• For high-risk patients, repeat more frequently, but at least annually</li> </ul>
Monitoring for Glucose Control <sup>1</sup>	<b>A1C:</b> <ul style="list-style-type: none"> <li>• If at goal: every six months</li> <li>• If not at goal, or change in therapy:</li> </ul>	<b>Goal:</b> <ul style="list-style-type: none"> <li>• A1C &lt; 7.0 %</li> <li>• A1C should be normal (<math>\leq 6\%</math>) or as close to normal as possible without leading to excessive</li> </ul>	<ul style="list-style-type: none"> <li>• If above goal of &lt; 7.0 %, follow guidelines for pharmacologic and non-pharmacologic treatment – Medical Nutrition Therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Repeat every three months until goal is reached</li> <li>• Repeat every six months if meeting treatment goal</li> </ul>

	every three months	<p>hypoglycemia</p> <ul style="list-style-type: none"> <li>Less stringent treatment goals may be appropriate for patients with a history of severe hypoglycemia, patients with limited life expectancies, very young children or older adults, and individuals with comorbid conditions.</li> </ul>	<p>(MNT) and exercise</p> <ul style="list-style-type: none"> <li>Self-management education as indicated</li> </ul>													
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Self-Monitoring of Blood Glucose (SMBG) <sup>1,3, 18</sup>	<ul style="list-style-type: none"> <li>SMBG three or more times a day if using multiple insulin injections or insulin pump</li> <li>SMBG pre- and post-prandially, as needed, for non-insulin treated patients</li> <li>Routinely assess technique</li> <li>Identify and manage episodes of hypoglycemia</li> </ul>	<p><b>Goal:</b></p> <table border="0"> <tr> <td><u>Test</u></td> <td><u>Plasma Glucose</u></td> </tr> <tr> <td>Preprandial</td> <td>90-130 mg/dL</td> </tr> <tr> <td>Postprandial</td> <td>&lt; 180 mg/dL</td> </tr> </table> <p><b>Parameters for Additional Action:</b></p> <table border="0"> <tr> <td><u>Test</u></td> <td><u>Plasma Glucose</u></td> </tr> <tr> <td>Preprandial</td> <td>&lt;90 or &gt;150 mg/dL</td> </tr> <tr> <td>Postprandial</td> <td>&lt;110 or &gt;180 mg/dL</td> </tr> </table> <ul style="list-style-type: none"> <li>May use 15-20 g of oral glucose (in any form) in conscious patients. After 15 minutes, if continued hypoglycemia, repeat.</li> <li>➤ Once SMBG returns to normal, encourage a snack or meal with protein</li> </ul>	<u>Test</u>	<u>Plasma Glucose</u>	Preprandial	90-130 mg/dL	Postprandial	< 180 mg/dL	<u>Test</u>	<u>Plasma Glucose</u>	Preprandial	<90 or >150 mg/dL	Postprandial	<110 or >180 mg/dL	<ul style="list-style-type: none"> <li>Adjust therapies based on results of SMBG</li> <li>Prescribe and appropriate rapid carbohydrate source for all who are at risk for hypoglycemia</li> <li>Instruct patient and/or caregivers in identifying and managing episodes of hypoglycemia</li> <li>Glucagon should be prescribed for those at high risk for severe hypoglycemia</li> </ul>	<ul style="list-style-type: none"> <li>Self-management at home, based on results</li> </ul>
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Foot Care and Neuropathy Screening <sup>1,3</sup>	<ul style="list-style-type: none"> <li>Screen for distal polyneuropathy annually</li> <li>Screening test should include the use of a 10-g monofilament, assessment of pin prick, vibration using a 128-Hz tuning fork, and temperature perception, at the distal plantar aspect of both great</li> </ul>	<ul style="list-style-type: none"> <li>Document full foot exam each year – foot structure, vascular status, and skin integrity</li> <li>Consider obtaining an Ankle Brachial Index (ABI)</li> <li>Identify those at high risk for foot complications which include those with: <ul style="list-style-type: none"> <li>Vision impairment</li> <li>Diabetic nephropathy (especially those on dialysis)</li> <li>Poor glycemic control</li> <li>Cigarette smoking</li> <li>Evidence of PAD/PVD</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Provide foot self-care education annually</li> <li>Refer to foot care specialist if high-risk (peripheral neuropathy with loss of sensation, altered biomechanics, peripheral vascular disease and /or bone deformities)</li> <li>Evaluate for appropriate footwear prescription or referral if abnormal</li> <li>Repeat basic foot-care education</li> </ul>	<ul style="list-style-type: none"> <li>Screen annually</li> </ul>												

	<p>toes, and assessment of ankle reflexes</p> <ul style="list-style-type: none"> <li>• The foot exam should include a visual inspection and palpation</li> <li>• Initial screening should include a claudication history and assessment of pedal pulses</li> <li>• Screen at time of diagnosis for Type 2 and 5 years after the diagnosis of Type 1 for autonomic neuropathy</li> </ul>			
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Retinopathy Screening and Treatment <sup>1,3</sup>	<ul style="list-style-type: none"> <li>• Yearly dilated retinal examination by an optometrist or ophthalmologist</li> <li>• Initial Exam: <ul style="list-style-type: none"> <li>➤ Type 1: Beginning at age 10 and within five years after diagnosis of diabetes</li> <li>➤ Type 2: At time of diagnosis</li> <li>➤ Within the first trimester of pregnancy</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Presence/absence of retinopathy</li> </ul>	<ul style="list-style-type: none"> <li>• If abnormal exam by optometrist, refer for further evaluation and treatment by ophthalmology</li> </ul>	<ul style="list-style-type: none"> <li>• Yearly routine examination and more frequently if retinopathy is progressing</li> <li>• Less frequent exams (every two to three years) may be considered in the setting of a normal eye with the advice of an eye care professional</li> <li>• Close follow-up during pregnancy and for 1 year postpartum</li> </ul>
Nephropathy Screening and Treatment <sup>1,3</sup>	<ul style="list-style-type: none"> <li>• Measure serum creatinine annually to estimate glomerular filtration rate</li> </ul>	<p>Creatinine only</p> <p><b>Spot urine albumin-to creatinine ratio:</b></p> <ul style="list-style-type: none"> <li>• Normal: &lt;30 ug/mg creatinine</li> <li>• Microalbuminuria: 30-299</li> </ul>	<ul style="list-style-type: none"> <li>• Confirm with repeat test and rule out other causes (infection)</li> <li>• Therapy with ACE-I and/or ARBs to treat proteinuria,</li> </ul>	<ul style="list-style-type: none"> <li>• Repeat at least annually</li> <li>• At least two of three tests measured within a 6 month period should show elevated levels before a patient is</li> </ul>

	<p>(eGFR)</p> <ul style="list-style-type: none"> <li>In the absence of previously documented proteinuria, screen annually for microalbuminuria**</li> </ul>	<p>un/mg</p> <ul style="list-style-type: none"> <li>Macroalbuminuria: <math>\geq 300</math> ug/mg</li> </ul> <p><b>Stages of Chronic Kidney Disease:</b></p> <ul style="list-style-type: none"> <li>Stage 1: Kidney damage with normal eGFR (eGFR <math>&gt;90</math>)</li> <li>Stage 2: Kidney damage with mildly decreased eGFR (eGFR 60-89)</li> <li>Stage 3: Moderately decreased eGFR (eGFR 30-59)</li> <li>Stage 4: Severely decreased eGFR (eGFR 15-29)</li> <li>Stage 5: Kidney failure (eGFR <math>&lt;15</math>)</li> </ul>	<p>including microalbuminuria if not contraindicated ***/+</p> <ul style="list-style-type: none"> <li>Non-dihydropyridine calcium channel blocker (CCB) may be beneficial if ACE-I and ARB are contraindicated</li> <li>Protein restriction <math>\leq 0.8 - 1.0</math> g/kg/body wt/day for patients with early stage nephropathy, and <math>0.8</math> g/kg/body wt/day for patients with more advanced stage of nephropathy</li> <li>Refer to nephrologist for eGFR <math>&lt; 30</math> ml/min</li> <li>Refer to nephrologist for macroalbuminuria</li> </ul>	<p>designated as having microalbuminuria</p> <ul style="list-style-type: none"> <li>Monitor <math>K^+</math> and Cr if on ACE-I or ARB</li> <li>Kidney transplantation, hemodialysis (in-center or home) or peritoneal dialysis should be considered.</li> <li>Continued surveillance to monitor response to therapy and progression of disease after diagnosis of microalbuminuria</li> </ul>
Blood Pressure Management <sup>1,3-6</sup>	<ul style="list-style-type: none"> <li>Measure blood pressure at every encounter</li> <li>Use Therapeutic Lifestyle Change</li> <li>Use diet, exercise and medications to achieve target BP, tobacco cessation and weight loss</li> <li>Adjust treatment as necessary, at each visit until target values achieved</li> </ul>	<p><b>Goal:</b></p> <ul style="list-style-type: none"> <li><math>&lt; 130/80</math> mm Hg for patients with diabetes or chronic kidney disease and during pregnancy</li> <li><math>&lt; 120/80</math> mm Hg is optimal</li> </ul>	<ul style="list-style-type: none"> <li>If BP is above 120/80 mm Hg</li> <li>➤ Recommend diet and exercise therapy to all patients</li> <li>If BP is above goal:</li> <li>➤ Lifestyle modification: diet and exercise; educate about DASH diet</li> <li>➤ Inform patient of BP goals</li> <li>➤ Encourage home BP monitoring</li> </ul> <p><b>Pharmacotherapy:</b></p> <ul style="list-style-type: none"> <li>All diabetes patients with HTN should be treated with a regimen that includes an ACE-I or ARB unless contraindications present ***/+</li> <li>Stage I (140-159/90-99):</li> <li>➤ ACE-I and/or beta-blocker for pts with CAD/HF(2)</li> <li>Stage II (<math>&gt; 16/100</math>):</li> <li>➤ Two-drug combination preferred</li> <li>Thiazide or loop diuretic if not meeting target BP values or are not within GFR limits</li> </ul>	<ul style="list-style-type: none"> <li>Measure and evaluate at each visit</li> <li>Review home blood pressure record</li> <li>Monitor <math>K^+</math> and Cr in patients on pharmacotherapy</li> <li>Assess for medication side effects</li> </ul>

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Lipid Management <sup>1-3, 6,7</sup>	<p><b>Preventive / Surveillance:</b></p> <ul style="list-style-type: none"> <li>• Test adults with diabetes at least annually, more frequently when not at target. For low risk lipid levels (LDL&lt;100), every two years is acceptable</li> <li>• Use diet, exercise and medications to achieve target lipid levels</li> <li>• Adjust treatment as necessary, at each visit until target lipid levels achieved</li> </ul>	<p><b>Goal:</b></p> <ul style="list-style-type: none"> <li>• LDL Cholesterol: Primary goal is &lt; 100 mg/dL <ul style="list-style-type: none"> <li>➢ LDL Cholesterol &lt; 70 mg/dL for patients with established CAD</li> <li>➢ For patients over 40 and/or with established CAD, reduce LDL 30-40%, regardless of initial LDL level</li> </ul> </li> <li>• HDL Cholesterol <ul style="list-style-type: none"> <li>➢ Male and female: &gt; 40 mg/dL</li> </ul> </li> <li>• Triglycerides: &lt; 150 mg/dL <ul style="list-style-type: none"> <li>➢ If TGs &gt; 200, non-HDL cholesterol should be &lt; 130 mg/dL</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Initiate Therapeutic Lifestyle Changes (TLC) for all patients <ul style="list-style-type: none"> <li>➢ Reduce saturated fats and cholesterol</li> <li>➢ Reduce/eliminate trans fats</li> <li>➢ Increase fiber intake</li> <li>➢ Increase omega-3 fatty acids</li> <li>➢ Daily physical activity</li> <li>➢ Weight management</li> </ul> </li> <li>• Drug therapy if LDL-C ≥ 100 mg/dL <ul style="list-style-type: none"> <li>➢ If triglycerides &gt; 500 mg/dL, treat with fibrate or niacin first</li> <li>➢ Treat all diabetic patients over 40 with a statin</li> <li>➢ Treat all diabetic patients of any age with CVD with a statin</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• After drug therapy, measure LDL-C at 6 weeks. If goal not achieved, therapy can be intensified. Re-measure LDL-C at 12 weeks and every 4 to 6 months to assess response to therapy</li> <li>• Monitor liver function tests before treatment with statins and periodically thereafter to assess for drug toxicity</li> <li>• Monitor CPK in patients with muscle discomfort</li> </ul>
Women's Health <sup>1,2, 14, 19</sup>	<ul style="list-style-type: none"> <li>• Pre-pregnancy counseling</li> </ul>	<ul style="list-style-type: none"> <li>• Documentation of counseling in all potentially fertile women</li> </ul>	<ul style="list-style-type: none"> <li>• Discuss and prescribe appropriate birth control. If pregnancy desired, achieve A1C as close to normal as possible without leading to excessive hypoglycemia</li> <li>• Counsel fertile women on medications contraindicated during pregnancy</li> <li>• Oral antidiabetic agents, ACE-I, statins and ARBs should be discontinued before pregnancy. Note: ACE-I and ARBs are contraindicated in pregnancy</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate plans for pregnancy as appropriate</li> </ul>
Tobacco Use <sup>1,3,8-11</sup>	<ul style="list-style-type: none"> <li>• Smoking cessation</li> </ul>	<ul style="list-style-type: none"> <li>• Tobacco use patterns</li> </ul>	<p><b>5 A's</b></p> <ul style="list-style-type: none"> <li>• <b>Ask</b> about smoking</li> </ul>	<ul style="list-style-type: none"> <li>• Call on quit date or within 72 hrs. to boost self-efficacy</li> </ul>

		<ul style="list-style-type: none"> <li>• Prior quit attempts</li> <li>• Readiness assessment</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Advise</b> user to quit</li> <li>• <b>Assess</b> willingness to quit</li> <li>• <b>Assist</b> user to quit (i.e. refer to smoking cessation program and consider pharmacotherapy)</li> <li>• <b>Arrange</b> follow-up</li> </ul> <p><b>Pharmacologic adjuvants:</b></p> <ul style="list-style-type: none"> <li>• Nicotine replacement</li> <li>• Anti-depressants</li> <li>• Varenicline</li> </ul>	<ul style="list-style-type: none"> <li>• Assess each visit: smoking status, weight gain, nicotine withdrawal symptoms</li> </ul>
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Selected Preventive Health Measures <sup>1,3</sup>	<ul style="list-style-type: none"> <li>• Substance abuse</li> <li>• Pneumococcal vaccination</li> <li>• Influenza vaccination</li> <li>• Aspirin therapy</li> <li>• Weight management</li> </ul>	<ul style="list-style-type: none"> <li>• Document patient's use patterns</li> <li>• Document each patient has had a vaccination</li> <li>• Document patient has a vaccination each year and document if adverse event occurs</li> <li>• Document appropriate patients are on aspirin</li> <li>• Encourage significant weight loss with an initial goal of 5-10% of body weight.</li> <li>• Calculate BMI and measure waist:</li> </ul>	<ul style="list-style-type: none"> <li>• Recommend appropriate lifestyle changes and/or referral to appropriate substance abuse program</li> <li>• Administer pneumococcal vaccination beginning at age 2 at time of diagnosis and again at age 65; or to all patients with diabetes <math>\geq 5</math> years</li> <li>• Administer vaccination to all patients with diabetes age <math>\geq 6</math> months beginning each September</li> <li>• Administer aspirin in doses of 75-162 mg a day</li> <li>• Alternative is clopidogrel 75 mg daily for those who cannot tolerate aspirin</li> <li>• Prescribe weight management and physical activity programs</li> <li>• Consider bariatric surgery for adults with BMI <math>\geq 35</math> kg/m<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Re-evaluation each visit and document for each patient</li> <li>• As indicated</li> <li>• Yearly</li> <li>• Evaluate and document with each visit</li> <li>• Monitor progress at each visit</li> </ul>

	<ul style="list-style-type: none"> <li>Physical activity</li> <li>Other laboratory tests</li> </ul>	<ul style="list-style-type: none"> <li>BMI Target: 18.5-24.9 kg/m<sup>2</sup>.</li> <li>Waist Target: ≤ 35 inches for females ≤40 inches for males. (criteria varies for different ethnic groups)</li> <li>Goal is at least 150 minutes per week</li> <li>LFTs</li> <li>TSH</li> <li>Screening for celiac disease</li> </ul>	<p>and Type 2 if BG uncontrolled with lifestyle/drug therapy</p> <ul style="list-style-type: none"> <li>Encourage an appropriate level of exercise based on functional limitations</li> <li>Consider referring to a formal exercise training program where available</li> <li>Evaluation of liver function</li> <li>In type 1 diabetes, dyslipidemia or in women over the age of 50 years</li> <li>Based on signs or symptoms in type 1 disease</li> </ul>	<ul style="list-style-type: none"> <li>Monitor progress at each visit</li> <li>Annually if indicated</li> </ul>
<b>SUGGESTED GUIDELINES</b>	<b>PROCESS</b>	<b>IMPORTANT FINDINGS, MEASUREMENTS AND VALUES</b>	<b>INTERVENTIONS</b>	<b>FOLLOW-UP</b>
Self-Management Education and Counseling <sup>1, 3, 20</sup>	<ul style="list-style-type: none"> <li>Provide ongoing self management education to all diabetic patients in a format that is appropriate with regard to patient preference, education level, language, health beliefs, and culture</li> </ul>	<ul style="list-style-type: none"> <li>Patients receiving education by provider or referred to an education program and managed by a collaborative team, at least one of whom is a registered nurse, dietitian, or pharmacist</li> </ul>	<ul style="list-style-type: none"> <li>TLC, exercise techniques, medical nutrition therapy, risk factor modification, alcohol moderation, smoking cessation, self-management training, sick-day education, avoidance of hyperosmolar states and ketoacidosis, psychosocial evaluation</li> </ul>	<ul style="list-style-type: none"> <li>If control deteriorates or a sentinel event such as hospitalization occurs, repeat education as needed</li> </ul>
Consider Specialty Referral <sup>1, 3</sup>	<ul style="list-style-type: none"> <li>Cardiology</li> <li>Endocrinology</li> </ul>	<ul style="list-style-type: none"> <li>Suspected CAD or HF</li> <li>Patient with advanced needs, complications, or persistent, sub-</li> </ul>	<ul style="list-style-type: none"> <li>Testing and/or therapy as needed.</li> <li>Type 1 diabetes: treatment of</li> </ul>	<ul style="list-style-type: none"> <li>As needed by patient</li> <li>As needed to achieve or</li> </ul>

	<ul style="list-style-type: none"> <li>• Nephrology</li> <li>• Podiatry</li> <li>• Optometry/Ophthalmology</li> <li>• OB/Gyn</li> <li>• Dental</li> </ul>	<p>optimal control</p> <ul style="list-style-type: none"> <li>• eGFR &lt; 30 ml/mn 1.73 m<sup>2</sup> or serum creatinine &gt; 1.5 mg/dL</li> <li>• Abnormal foot exam or peripheral neuropathy</li> <li>• Dilated retinal exam and ophthalmologic treatment</li> <li>• Pregnancy in the diabetic patient</li> </ul>	<p>complications, advanced technologies</p> <ul style="list-style-type: none"> <li>• Evaluation of renal function</li> <li>• Evaluation, treatment for prevention of foot lesions</li> <li>• Dilated retinal eye exam and treatment for macular edema and retinopathy</li> <li>• Gestational diabetes is not included in this care guide and is usually managed by the OB/Gyn or a high risk pregnancy specialist. Refer to the ADA guidelines for recommendations</li> <li>• Refer to dentists for routine check ups, dental cleaning and for any dental issues</li> </ul>	<p>maintain control, or to manage complication (s)</p> <ul style="list-style-type: none"> <li>• As needed by patient</li> <li>• As needed by patient</li> <li>• As needed by patient</li> <li>• As needed by patient</li> <li>• As needed, then annually</li> </ul>
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Depression Screening <sup>1, 12, 13, 16, 17</sup>	<ul style="list-style-type: none"> <li>• Screen for presence of depression</li> </ul>	<ul style="list-style-type: none"> <li>• Consider using a patient depression scale such as the PHQ-2 and if positive the PHQ-9</li> <li>• Mental health history/treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Administer treatment and/or refer patients who meet criteria for depression to a behavioral specialist</li> </ul>	<ul style="list-style-type: none"> <li>• Screening is suggested at subsequent visits</li> <li>• Evaluate response to depression treatment with three follow-up contacts in 12 weeks and adjust meds as indicated and/or confer with appropriate treating mental health specialists</li> </ul>

ACTION	FREQUENCY
SCREENING FOR DIABETES MELLITUS	ANNUALLY FOR HIGH-RISK, EVERY THREE YEARS IF NORMAL
MONITORING GLUCOSE CONTROL (A1C)	EVERY THREE MONTHS UNTIL GOAL IS REACHED, EVERY SIX MONTHS IF GOAL IS MET
NEUROPATHY	SENSORY EXAMINATION ANNUALLY, FOOT INSEPECTION EACH VISIT
RETINOPATY	AT LEAST ANNUALLY UNLESS OTHERWISE ADVISED BY EYE CARE PROFESSIONAL
NEPHROPATHY	AT LEAST ANNUALLY
BLOOD PRESSURE	EACH VISIT
LIPID EVALUATION	AT LEAST ANNUALLY
FLU AND PNEUMONIA VACCINE	ANNUALLY/INITIALLY
SMOKING CESSATION COUNSELING	EACH VISIT
DEPRESSION SCREENING	AT LEAST ANNUALLY
DENTAL REFERRAL	AT LEAST ANNUALLY

Diabetes mellitus is a chronic disorder with potential significant complications, most of which are preventable. Treatment of diabetes requires a team approach, including the patient and the physician. The goals of treatment are: near-normalization of average blood glucose as measured by the A1C, prevention of blindness by a yearly dilated retinal exam, detection and treatment of nephropathy using a yearly urinary microalbumin. Co-morbidities, including hypertension and lipid disorders, will be evaluated and treated to goal levels, and preventive measures taken.

\*\*At least two out of three tests within a six-month period should show elevated levels before a patient is designated as having microalbuminuria.

\*\*\* ACE-I and ARBs are contraindicated in pregnancy.

+ There are some reports of angioedema with ACE-I and ARBs.

## REFERENCE LIST:

<p>1 American Diabetes Association. Standards of Medical Care in Diabetes 2010. Diabetes Care January 2010 33:S11-S61; doi:10.2337/dc10-S011 <a href="http://care.diabetesjournals.org/content/33/Supplement_1/S11.full">http://care.diabetesjournals.org/content/33/Supplement_1/S11.full</a></p>	<p>11 Silagy C, Lancaster T, Stead L, Mant D, Fowler G. Nicotine replacement therapy for smoking cessation. Cochrane Database Syst Rev. 2004;CD000146.</p>
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