

# BASIC GUIDELINES for DIABETES CARE

## PHYSICAL AND EMOTIONAL ASSESSMENT

\* **Blood Pressure, Weight/BMI - Every visit. For Adults:** Blood pressure target goal <130/80 mm Hg. **For children:** Blood pressure target goal <90<sup>th</sup> percentile adjusted for age, height, and gender; BMI (body mass index)-for-age <85<sup>th</sup> percentile.

**Foot Exam (for adults)** - Thorough visual inspection **every diabetes care visit**; pedal pulses, neurological exam yearly.

**Dilated Eye Exam (by trained expert) - Type 1: Five years post diagnosis, then every year. Type 2: Shortly after diagnosis, then every year. Note:** Internal quality assurance data may be used to support less frequent testing.

\* **Depression** - Probe for emotional/physical factors linked to depression **yearly**; treat aggressively with counseling, medication, and/or referral.

\* **Dental** - Oral exam - comprehensive periodontal evaluation at least **twice yearly**; periodontal maintenance **two to four times a year**.

## LAB EXAM

\* **A1C (HbA1c) - Quarterly**, if treatment changes or if not meeting goals; **One-two times/year** if stable. Target goal <7.0% or <1% above lab norms. **For children: Modify as necessary** to prevent significant hypoglycemia.

\* **Microalbuminuria (Albumin/Creatinine Ratio) - Type 1: Begin with puberty** once the duration of diabetes is **more than five years** unless proteinuria has been documented. **Type 2: Begin at diagnosis**, then **every year** unless proteinuria has been documented.

\* **Glomerular Filtration Rate (GFR):** Estimate whenever chemistries are checked.

\* **Blood Lipids (for adults)** - On **initial visit**, then **yearly** for adults. Target goals (mg/dL): cholesterol, triglycerides <150; LDL<100; HDL>40 for men; HDL>50 for women.

## SELF-MANAGEMENT TRAINING

**Management Principles and Prevention of Complications - Initially and ongoing:** Focus on helping the patient achieve the AADE 7 self-care behaviors: healthy eating, being active, monitoring, taking medications, problem solving, healthy coping, and reducing risks. Screen for problems with and barriers to self-care; assist patient to identify achievable self-care goals.

**For children: As appropriate** for developmental stage.

**Self-Glucose Monitoring - Type 1:** Typically test **four times a day**. **Type 2 and others: As needed** to meet treatment goals.

**Medical Nutrition Therapy (by trained expert) - Initially:** Assess needs/condition, assist patient in setting nutrition goals. **Ongoing:** Assess progress toward goals, identify problem areas.

**Physical Activity - Initially and ongoing:** Assess and prescribe physical activity based on patient's needs/condition.

**Weight Management - Initially and ongoing:** Must be individualized for patient.

## INTERVENTIONS

\* **Preconception, Pregnancy, and Postpartum Counseling and Management - Consult** with high-risk, multidisciplinary perinatal/neonatal programs, and providers where available (e.g., California Diabetes and Pregnancy Program "Sweet Success"). **For adolescents: Age appropriate counseling advisable, beginning with puberty.**

**Aspirin Therapy (for adults) - 75-162 mg/day** as primary and secondary prevention of cardiovascular disease unless contraindicated.

**Smoking Cessation** - Ask, advise, assess readiness to quit, and assist at **every visit**, adjusting the frequency as appropriate to the patient's response. Refer to California Smokers' Helpline 1-800-NO-BUTTS (662-8887).

**Immunizations** - Influenza and pneumococcal, **per CDC recommendations.**

\*See Explanatory notes

## EXPLANATORY NOTES

### BASIC GUIDELINES for DIABETES CARE

1. These Guidelines are intended for use by primary care professionals, optimally in a team care setting.
2. These Guidelines are meant to be basic guidelines, not accountability standards.
3. Internal quality assurance data may be used to support less frequent testing.
4. One or more of the following criteria were used for inclusion of an item in these Guidelines:
  - Published evidence demonstrated either the efficacy or the effectiveness of the item.
  - Published studies on cost-identification, cost-effectiveness, or cost-benefit analysis of the item demonstrated favorable economic results.
  - A preponderance of expert opinion held that the item is considered to be essential to the care of persons with diabetes.
5. It is assumed that the following are routinely occurring in the medical setting:
  - A history and physical appropriate for a person with diabetes are performed. Visits are sufficiently frequent to meet the patient's needs and treatment goals.
  - Abnormal physical or laboratory findings result in appropriate and individualized interventions.
  - Expert multi-disciplinary health professionals provide self-management training. For children/adolescents and their families, training from a diabetes team or team member with experience in child and adolescent diabetes is strongly recommended to begin at diagnosis.
  - Physicians should consult current references for normal values and for appropriate treatment goal values, both for children and adults.
  - Specialists should be consulted when patients are unable to achieve treatment goals in a reasonable time frame, when complications arise, or whenever the primary care physician deems it appropriate. Under similar circumstances, children/adolescents should be referred to specialists who have expertise in managing children and adolescents with diabetes.
6. Additional comments on specific items included in these Guidelines:
  - **Blood Pressure/BMI** – For children, to determine blood pressure percentile adjusted for age, height, and gender use <http://www.cdc.gov/nccdphp/dnpa/growthcharts/training/modules/module3/text/bloodpressure.htm>. To calculate and determine BMI percentile use [http://www.cdc.gov/nccdphp/dnpa/bmi/childrens\\_BMI/about\\_childrens\\_BMI.htm](http://www.cdc.gov/nccdphp/dnpa/bmi/childrens_BMI/about_childrens_BMI.htm).
  - **Psychosocial Assessment** – Assess barriers to self-care: common environmental obstacles, cultural issues, beliefs and feelings about diabetes, disorders of eating and mood, life stresses, and substance use. Consider using PHQ9 as a depression monitoring tool (<http://www.pfizer.com/pfizer/download/do/phq-9.pdf>).
  - **A1C (HbA1c) / Self-Glucose Monitoring** – Certification by the National Glycohemoglobin Standardization Program as traceable to the DCCT reference ensures portability of A1C results. Verify that the laboratory is certified in this method. A1C target goals should be achieved gradually over time. Target goals should be less stringent for children, the elderly, and other fragile patients. Clinicians have found that making the patient aware of his/her A1C values and their significance helps motivate the patient toward improved glycemic control. This principle also applies to self-glucose monitoring. Target goals should be individualized for each patient.
  - **Microalbuminuria** – Screening is not needed if proteinuria has been documented. See Screening and Initial Management of Diabetic Microalbuminuria and Nephropathy algorithm.
  - **Glomerular Filtration Rate (GFR)** – See Screening and Initial Management of Diabetic Microalbuminuria and Nephropathy algorithm and explanatory notes for purpose and calculation of GFR.
  - **Blood Lipids** – Abnormal blood lipids are often under-treated. An active, progressive treatment and monitoring plan should be instituted.
  - **Dental** – Primary care providers are urged to include oral examination as a part of basic diabetes care and referral for oral routine care.
  - **Children / Adolescents** – For specific diabetes care recommendations, see references.
7. A list of general and specific references is included in the Basic Guidelines for Diabetes Care Packet.