The following guideline applies to patients with type 1 and type 2 diabetes mellitus. It recommends specific interventions for periodic medical assessment, laboratory tests and education to guide effective patient self-management.

<table>
<thead>
<tr>
<th>Eligible Population</th>
<th>Key Components</th>
<th>Recommendation and Level of Evidence</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients 18-75 years of age with type 1 or type 2 diabetes mellitus</td>
<td>Periodic assessment</td>
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<td>Height, weight, BMI, blood pressure [A]</td>
<td>Perform periodic assessment at least annually</td>
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<td>Cardiovascular risks (tobacco use, hypertension, dyslipidemia, sedentary lifestyle, obesity, stress, family history, age &gt; 40)</td>
<td>Record BP at every visit</td>
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<td>Barriers to lifestyle and medication adherence</td>
<td>In the absence of retinopathy repeat retinal eye exam in 2 years</td>
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<td>Comprehensive foot exam (inspection, monofilament, and pulses) [B]</td>
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<td>Psychosocial evaluation and screen for depression [D]</td>
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<td>Dilated eye exam by ophthalmologist or optometrist [B], or if no prior retinopathy, may screen with fundal photography [B]</td>
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<td>Laboratory tests</td>
<td>HbA1c every 3-6 months based on individualized therapeutic goal [D]</td>
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<td>Urine microalbumin measurement [B], test annually</td>
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<td>Serum creatinine and calculated GFR [D], test annually</td>
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<td>Lipid profile for estimating initial risk and assessing adherence to therapy [B], preferably fasting</td>
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<td>Consider TSH testing in patients with type 1 diabetes mellitus and LFTs [D]</td>
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<td>Education, counseling and risk factor modification</td>
<td>Comprehensive diabetes self-management education and support (DSME and DSMS) from a collaborative team or diabetic educator if available</td>
<td>At diagnosis and as needed</td>
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<td>Education should be individualized, based on the National Standards for DSME [B] and include:</td>
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<td>Importance of regular physical activity including interrupting sedentary periods at least every 90 minutes with physical activity, and a healthy diet [A], and working towards an appropriate BMI</td>
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<td>Assessment of patient knowledge, attitudes, self-management skills and health status; strategies for making health behavior changes and addressing psychosocial concerns [C]</td>
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<td>Description of diabetes disease process and treatment; safe and effective use of medications; prevention, detection and treatment of acute and chronic complications, including prevention, recognition, and treatment of hypoglycemia</td>
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<td>Role of self-monitoring of blood glucose in glycemic control [A]</td>
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<td>Cardiovascular risk reduction</td>
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<td>Tobacco cessation intervention [B] and secondhand smoke avoidance [C]</td>
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<td>Self-care of feet including nail and skin care and appropriate footwear [B]; preconception counseling [D]; encourage patients to receive dental care [D]</td>
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<td></td>
<td>Medical recommendations</td>
<td>Care should focus on tobacco cessation, hypertension, lipids and glycemic control:</td>
<td>At each visit until therapeutic goals are achieved</td>
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<td>Medications for tobacco dependence unless contraindicated</td>
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<td>Treatment of hypertension using up to 3-4 anti-hypertensive medications to achieve adult target of &lt; 140/90 mmHg [A] (see MQIC hypertension guideline)</td>
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<td>Mortality increases if diastolic therapy is limited to levels &lt; 70 [C]</td>
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<td>Prescription of ACE inhibitor or angiotensin receptor blocker in patients with chronic kidney disease or albuminuria [A]</td>
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<td>Moderate intensity statin** therapy for persons ≥ 40 years without overt CVD or adults ≥ 50 with CVD risk factor(s), for primary prevention against macrovascular complications (e.g. simvastatin 20-40 mg, atorvastatin 10-20 mg)</td>
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<td>High intensity statin (e.g. atorvastatin 40-80 mg) for patients with overt CVD</td>
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<td>Anti-platelet therapy [A]: low dose aspirin, unless contraindicated, for adults with cardiovascular disease.</td>
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<td>Individualize the A1c goal**: Goal for most patients is 7-8%. Mortality increases when A1c is &gt; 9% [B],</td>
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<td>Assurance of appropriate immunization status [Tdap or Td, influenza, pneumococcal vaccine (PPSV23), Hep B] [C]</td>
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</tbody>
</table>

1National Standards for Diabetes Self-Management Education and Support

2There is no evidence that e-cigarettes are a healthier alternative to smoking or that e-cigarettes can facilitate smoking cessation

3Consider referral of patients with serum creatinine value > 2.0 mg/dL (adult value) or persistent albuminuria to nephrologist for evaluation

4Diabetes Care, January 2016: Cardiovascular Disease and Risk Management

52013 ACC/AHA Blood Cholesterol Guideline Table 5. High-, Moderate-, and Low-Intensity Statin Therapy

6Diabetes Care, Volume 39, Supplement 1, January 2016, S43, Table 5.2. (Tight control is risky in certain patients)

Levels of evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline lists core management steps. It is based on the American Diabetes Association Standards of Medical Care in Diabetes - 2016; Volume 39, Supplement 1, Pages S1-S112. Individual patient considerations and advances in medical science may supersede or modify these recommendations.


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