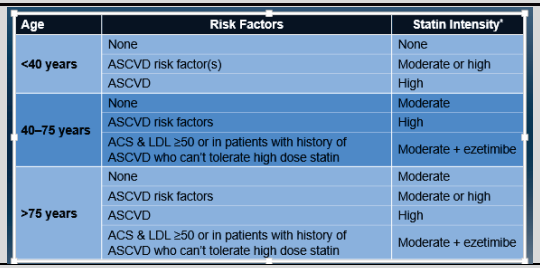
2017 Wisconsin Diabetes Clinical Care Recommendations At-A-Glance

This document is an encapsulated overview of the 2017 American Diabetes Association Clinical Practice Recommendations. If you would like additional information about diabetes in Wisconsin, please refer to the Chronic Disease Prevention Unit webpage: https://www.dhs.wisconsin.gov/diabetes/index.htm or call: 608-261-8868.

<table>
<tr><th>Concern</th><th>Care/Test</th><th>Frequency</th></tr>
<tr><td rowspan="2">Pre Diabetes and Prevention of Type 2 Diabetes</td><td>Check A1C test, fasting plasma glucose test, or oral glucose tolerance test</td><td>Test all adults with BMI ≥ 25 kg/m2 (≥ 23 in Asian Americans) or ≥ age 45 years. If normal, retest in 3 years or less.</td></tr>
<tr><td>Testing for in Children and Adolescents
*Age of initiation 10 years or at onset of puberty</td><td>Overweight with 2 of the following:
• Family history of type 2 diabetes in 1st or 2nd degree relative
• Race/ethnicity
• Signs of insulin resistance or conditions associated with insulin resistance
• Maternal history of diabetes or gestational diabetes</td></tr>
<tr><td rowspan="5">General Recommendations for Care</td><td>Perform diabetes-focused visit</td><td>Type 1: Every 3 months❖ Type 2: Every 3–6 months❖</td></tr>
<tr><td>Review management plan; assess barriers and goals</td><td>Each focused visit; revise as needed</td></tr>
<tr><td>Assess physical activity level</td><td>Each focused visit</td></tr>
<tr><td>Assess lifestyle management and diabetes risk status</td><td>At each visit; refer to evidence-based prevention resources as indicated</td></tr>
<tr><td>Assess nutrition/weight/growth</td><td>Each focused visit</td></tr>
<tr><td>Self-Management Education</td><td>Refer to a Certified Diabetes Educator (CDE) in an American Diabetes Association (ADA) recognized or American Association of Diabetes Educators (AADE) accredited program</td><td>At diagnosis, then every 6–12 months, or more as needed</td></tr>
<tr><td>Medical Nutrition Therapy</td><td>Refer for medical nutrition therapy (MNT) provided by a Registered Dietitian (RD), preferably a CDE</td><td>At diagnosis or first referral to RD: 3-4 visits, completed in 3-6 months; then, 1-2 hours of routine RD visits annually. RD determines additional visits per needs/goals. Medicare Part B covers 3 hours per year of MNT when referred by a physician.</td></tr>
<tr><td rowspan="3">Glycemic Control</td><td>Check A1C, general goal: < 7.0%</td><td>• At least 2x annually in patients meeting treatment goals and have stable glycemic control
• Quarterly in patients with changed therapy or not meeting glycemic goals</td></tr>
<tr><td>Review goals, change in lifestyle/meals pattern, medications, side effects, and frequency of hypoglycemia</td><td>• Each focused visit
• Continuous glucose monitoring (CGM) may be a supplemental tool to Self Monitored Blood Glucose (SMBG) in people with hypoglycemia unawareness and/or frequent hypoglycemic episodes</td></tr>
<tr><td>Assess self-blood glucose monitoring schedule</td><td>• Each focused visit. Patients on multiple-dose insulin or insulin pump therapy should perform self-monitored blood glucose (SMBG) prior to meals and snacks, at bedtime, prior to exercise, when they suspect low blood glucose, and prior to critical tasks.
• Continuous glucose monitoring (CGM) may be a supplemental tool to Self Monitored Blood Glucose (SMBG) in people with hypoglycemia unawareness and/or frequent hypoglycemic episodes
• Patients not on insulin should be treated on an individual basis, as the evidence is insufficient regarding when and how often to SMBG.</td></tr>
<tr><td rowspan="4">Cardiovascular Care</td><td>Check fasting lipid profile</td><td>Children: After age 2, then use American Academy of Pediatrics (AAP) guidelines
Adults: At diagnosis, then every 5 years or more frequently as indicated</td></tr>
<tr><td>Start statin with ongoing lifestyle changes
 
<table>
<tr><th>Age</th><th>Risk Factors</th><th>Statin Intensity*</th></tr>
<tr><td rowspan="3"><40 years</td><td>None</td><td>None</td></tr>
<tr><td>ASCVD risk factor(s)</td><td>Moderate or high</td></tr>
<tr><td>ASCVD</td><td>High</td></tr>
<tr><td rowspan="3">40–75 years</td><td>None</td><td>Moderate</td></tr>
<tr><td>ASCVD risk factors</td><td>High</td></tr>
<tr><td>ACS & LDL ≥50 or in patients with history of ASCVD who can't tolerate high dose statin</td><td>Moderate + ezetimibe</td></tr>
<tr><td rowspan="4">>75 years</td><td>None</td><td>Moderate</td></tr>
<tr><td>ASCVD risk factors</td><td>Moderate or high</td></tr>
<tr><td>ASCVD</td><td>High</td></tr>
<tr><td>ACS & LDL ≥50 or in patients with history of ASCVD who can't tolerate high dose statin</td><td>Moderate + ezetimibe</td></tr>
</table></td><td>For patients with diabetes:
• < 40 years with additional cardiovascular disease risk factors, consider using moderate or high intensity statin and lifestyle therapy
• 40-75 years without additional cardiovascular disease risk factors, consider high intensity statin and lifestyle therapy
• > 75 years without additional cardiovascular disease risk factors, consider using moderate intensity statin and lifestyle therapy</td></tr>
<tr><td>Check blood pressure, Adult goal: < 140/90 mmHg ✦</td><td>Children: Each focused visit; follow National High Blood Pressure Education Program recommendations for children and adolescents
Adults: Each office visit; weight loss if overweight, DASH-style diet, Moderation of alcohol intake, increased physical activity</td></tr>
<tr><td>Assess smoking/tobacco use status</td><td>Each office visit; (5As: Ask, Advise, Assess, Assist, Arrange)</td></tr>
</table>

	Start aspirin therapy (unless contraindicated)	• Age > 50 years for most men and women with diabetes and at least one other major risk factor • Men ≤ 50 years, and women ≤ 60 years, individualized based on risk • Consider adding 75-162 mg/day
Kidney Care	Test serum creatinine to estimate GFR and chronic kidney disease (CKD) stage	**Type 1:** 5 years after diagnosis, then at least annually **Type 2**: At diagnosis, then at least annually
	ACR: Check albumin/creatinine ratio for micro albuminuria using a random urine sample: Goal <30 mg/g	**Type 1:** 5 years after diagnosis, then at least annually **Type 2**: At diagnosis, then at least annually *Ace inhibitors or angiotensin II receptor blockers reduce progression of CKD to ESRD and improve survival for hypertension with heavy albuminuria
	Hypertension diagnosis or BP >140/90 mmHg AND albumin-creatinine ratio, urine ratio greater than or equal to 300mg/g creative (A evidence) or 30-299 mg/g creatinine (B evidence) use ACE inhibitor or angiotensin II receptor blocker	Assess at least annually
Eye Care	Dilated and comprehensive eye exam by an ophthalmologist or optometrist	**Type 1**: ≥ 10 years of age: Retinal exam within 5 years of diagnosis and then annually (or once every 2 years if no retinopathy found on **LAST** exam) **Type 2**: At diagnosis, then annually;(or once every 2 years if no retinopathy found on **LAST** exam) **Pregnant with pre-existing Type 1 or Type 2**: within first trimester then second, third, and 1 year post-partum. **Solely gestational diabetes**: low-risk for retinopathy and not recommended for screening
Neuropathies and Foot Care	Assess/screen for neuropathy - autonomic and diabetic peripheral neuropathy (DPN)	**Type 1**: Five years after diagnosis, then annually **Type 2**: At diagnosis, then annually **Type 1 and Type 2:** Either pregabalin or duloxetine are recommended as initial pharmacologic treatments for neuropathic pain in diabetes
	Visual inspection of feet with shoes and socks off	Each focused visit; stress daily self-exam
	Perform comprehensive lower extremity/foot exam	At diagnosis, then annually
	Screen for peripheral artery disease (PAD) – consider ankle-brachial index (ABI)	At diagnosis, then annually
Oral Care	Simple inspections of gums and teeth for signs of periodontal disease	At diagnosis, then each focused visit
	Dental exam by general dentist or periodontal specialist	At diagnosis, then individualize based on an oral assessment and risk, as more frequent exams may be needed
Emotional and Sexual Health Care	Assess emotional health; screen for depression	Each focused visit
	Assess sexual health concerns	Each focused visit
Communicable Diseases Prevention	Provide influenza vaccine	Annually, if age ≥ 6 months
	Provide pneumococcal vaccine	Once; then per Advisory Committee on Immunization Practices
	Provide hepatitis B series	Once at diagnosis for age 19 -59 years of age; individualize for ≥ 60 years of age
	Screen for tuberculosis infection or disease	As needed
Preconception, Pregnancy and Postpartum Care	Ask about reproductive intentions/assess contraception	At diagnosis and then every visit ✧
	Provide preconception counseling/assessment that addresses the importance of glycemic control as close to normal as safely possible, ideally <6.5% A1C to reduce the risk of congenital anomalies	3–4 months prior to conception
	Counsel on the risk of development and/or progression of diabetic retinopathy	Occur before pregnancy and then within first trimester then second, third, and 1 year post-partum as indicated by degree of retinopathy
	Screen for undiagnosed type 2 diabetes in women with known risk	At first prenatal visit ✧
	Screen for gestational diabetes mellitus (GDM) in all women not known to have diabetes	At 24–28 weeks gestation ✧
	Screen for type 2 diabetes in women who had gestational diabetes mellitus (GDM)	At 4–12 weeks postpartum then at least every 3 years lifelong, using OGTT

❖ Consider more often if A1C is above the patient's goal and/or individual risk and/or complications exist, or less often if at goal and individual risk and/or complication do not exist
◈ Consider referring to provider experienced in care of women with diabetes during pregnancy
✦ More or less stringent blood pressure goals must be individualized if < 140/90 is not reasonable to achieve

State of Wisconsin
Department of Health Services
Division of Public Health
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