Summary of Standards of Medical Care in Diabetes – 2013

Key concepts in setting glycemic controls: Goals should be individualized; certain populations (children, pregnant women, and elderly) require special considerations; less intensive glycemic goals may be indicated in patients with severe or frequent hypoglycemia; more intensive glycemic goals may further reduce microvascular complications at the cost of increasing hypoglycemia; postprandial glucose may be targeted if A1C goals are not met despite reaching preprandial glucose goals.

A1C screening: To test for diabetes or to assess risk of future diabetes, either A1C, FPG, or 2-h 75-g OGTT are appropriate. An A1C level of 5.7% to 6.4% indicates increased risk for diabetes. An A1C level of 6.5% or higher indicates the presence of diabetes. A1C is not recommended for diagnosis in pediatric patients, type 1 diabetes, hemoglobinopathies, pregnancy and hemolytic anemias.*

Minimal standards

Exam/test	Type 1	Type 2
Complete exam	To classify the patient, detect complications, develop a management plan, and provide a basis for continuing care	
Office visits	Quarterly, but dictated by severity of condition and response to treatment	
A1C Goal: A1C < 7.0%	Quarterly, then 2x/year when stable; more stringent goals (< 6.0%) may further reduce complications at the cost of increased risk of hypoglycemia and may be considered in individual patients. Less stringent goals may be appropriate in specific populations such as the frail elderly, those with advanced atherosclerosis, and those at risk for severe hypoglycemia. A1C goals should be individualized based upon age, life expectancy, co-morbid conditions, known CVD or microvascular complications and hypoglycemia unawareness.	
Weight	Each visit	
Foot examination	Visual inspection at each visit – comprehensive exam annually	
Blood pressure: systolic < 130mm Hg, diastolic < 80 mm Hg	Each visit; ACE-I or ARB recommended for treatment of hypertension	
Diabetic retinal exam by an opthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management	Annually†	Annually†
Lipid profile goals: < 100 mg/dl LDL if high risk, < 70 mg/dl LDL if very high risk, > 40 mg/dl HDL in men, > 50 mg/dl HDL in women may be appropriate, < 150 mg/dl triglycerides	Annually – more often if needed to achieve goals. Every 2 years if low risk (LDL < 100, HDL > 50, triglycerides < 150). Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients: • With overt CVD • Without CVD who are over the age of 40 and have one or more other CVD risk factors	
Urine microalbumin/creatinine (random testing is preferred method) 24-h collection: < 30 mg/24h Timed collection: < 20 mcg/min Spot collection: < 30 mg/g Cr	For children, should begin after five years' duration, then annually. For adults, annually. ACE-I or ARB recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period.	At diagnosis and annually; ACE-I or ARB recommended for treatment of microalbuminuria when 2 of 3 tests are elevated within a 6-month period.
Influenza immunization	Annual influenza vaccination for all persons ages 6 months and older	
Pneumonia immunization	Pneumococcal (pneumonia) vaccination once unless immunocompromised or given more than 5 years before age 65	
Preconception and family-planning counseling	As needed. Women with gestational diabetes should be screened for diabetes 6 to 12 weeks postpartum and should have a subsequent screening for the development of diabetes or prediabetes.	
Self-care education	At least once; update as needed	
Self-monitored blood glucose Goals for plasma values[2] Preprandial glucose 70-130 mg/dl Peak postprandial glucose < 180 mg/dl	Three or more times daily for patients using multiple insulin injections or insulin pump therapy	As needed to maintain glycemic control; may need to check postprandially for glucose
Aspirin therapy 75-162 mg/day	For all with type 1 or type 2 with increased cardiovascular risk for primary prevention, including men > age 50 and women > age 60; as secondary prevention for all with history of CVD.	
Smoking cessation	Aid patient in nicotine cessation each visit, if indicated	
Review self-management goals	Each visit	
Hypothyroidism screening	Screen for thyroid peroxidase and thyroglobulin antibodies at diagnosis. TSH should be rechecked every 1-2 years or with symptoms of thyroid dysfunction. Free T4 should be measured if TSH abnormal.	

* Standards of Medical Care in Diabetes- 2013. National Standards for Diabetes Self Management Education and Support 2013.

† Source: HEDIS.

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Minimal standards

Exam/test	Type 1	Type 2
Monogenic diabetes syndromes	Consider genetic testing on children in the following settings: 1) diagnosis in the first six months of life, 2) with strong family history of diabetes but without typical features of type 2 diabetes (nonobese, low-risk ethnic group), 3) with mild fasting hyperglycemia (100-150 mg/dl), especially if young and nonobese, 4) with diabetes but without signs of obesity or insulin resistance.	
Transition from pediatric to adult care	Coordinate planning for seamless transition of all youth from pediatric to adult health care. Resources available at http://ndep.nih.gov/transitions/	
Diagnosis of gestational diabetes (GDM) • Screen for undiagnosed type 2 diabetes at the first prenatal visit in those with risk factors, using standard diagnostic criteria • In pregnant women not known to have diabetes, screen for GDM at 24-28 weeks of gestation, using a 75-g 2-h oral glucose tolerance test using the following cut points: Diagnostic cut points: Fasting: ≥ 92 mg/dl 1 hour: ≥ 180 mg/dl 2 hours: ≥ 153 mg/dl • To make a diagnosis of GDM, at least two of the following plasma glucose values must be found: Fasting: ≥ 95 mg/dl 1 hour: ≥ 180 mg/dl 2 hours: ≥ 153 mg/dl	Women found to have diabetes at their initial prenatal visit using standard criteria (A1C ≥ 6.5%, FPG ≥ 126 mg/dl, two-hour plasma glucose during OGTT ≥ 200mg/dl, random plasma glucose ≥ 200mg/dl, or symptoms of hyperglycemia) should receive a diagnosis of overt, not gestational, diabetes. Screen women with GDM for persistent diabetes 6 to 12 weeks postpartum. Women with GDM should have lifelong screening for the development of diabetes or prediabetes at least every 3 years.	

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