Complete Summary

GUIDELINE TITLE

Standards of medical care in diabetes. VI. Prevention and management of diabetes complications.

BIBLIOGRAPHIC SOURCE(S)

American Diabetes Association (ADA). Standards of medical care in diabetes. VI. Prevention and management of diabetes complications. Diabetes Care 2008 Jan;31(Suppl 1):S24-33.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Diabetes Association (ADA). Standards of medical care in diabetes. VI. Prevention and management of diabetes complications. Diabetes Care 2007 Jan;30(Suppl 1):S15-24.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Complications of diabetes mellitus including:

- Cardiovascular disease (CVD)
  - Hypertension (HTN)
  - Dyslipidemia
  - Coronary heart disease (CHD)
- Nephropathy

- Retinopathy
- Neuropathy
    - Distal symmetric polyneuropathy (DPN)
    - Autonomic neuropathy
- Foot ulceration

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Risk Assessment
Screening
Treatment

CLINICAL SPECIALTY

Cardiology
Endocrinology
Family Practice
Internal Medicine
Nephrology
Obstetrics and Gynecology
Ophthalmology
Pediatrics
Podiatry
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Dietitians
Nurses
Physician Assistants
Physicians
Podiatrists

GUIDELINE OBJECTIVE(S)

- To provide recommendations for the prevention and management of diabetes complications
- To provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, treatment goals, and tools to evaluate the quality of care

TARGET POPULATION

Patients with type 1 or type 2 diabetes mellitus including pregnant women

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment/Screening/Diagnosis

1. Blood pressure (systolic and diastolic)
2. Serum low-density lipoprotein (LDL) cholesterol, high-density lipoprotein (HDL) cholesterol, and triglyceride concentrations
3. Coronary heart disease screening, including risk factor assessment
4. Annual testing for microalbuminuria and measurement of serum creatinine to estimate glomerular filtration rate (GFR) and stage the level of chronic kidney disease (CKD)
5. Dilated and comprehensive eye exam
6. Screening for distal symmetric polyneuropathy and autonomic neuropathy, with electrophysiological testing, as needed
7. Foot examination
8. Screening for peripheral arterial disease (PAD), including history of claudication, pedal pulses, and ankle-brachial index

Management/Treatment/Prevention

1. Patient education
    - Lifestyle modification (e.g., diet, weight loss, physical activity, smoking cessation)
    - Foot care
2. Drug therapy
    - Angiotensin-converting enzyme (ACE) inhibitors
    - Angiotensin receptor blockers (ARBs)
    - Beta-blockers
    - Diuretics
    - Calcium channel blockers (CCBs)
    - Statins
    - Fibrates
    - Niacin
    - Combination drug therapy
    - Anti-platelet agents, including aspirin and clopidogrel
    - Medications for relieving symptoms of polyneuropathy
3. Laser therapy to reduce the risk of vision loss
4. Referral to specialist

Monitoring

1. Renal function tests
2. Serum potassium levels
3. Glomerular filtration rate

MAJOR OUTCOMES CONSIDERED

- Cardiovascular events
- Lipid levels
- Morbidity and mortality associated with cardiovascular disease
- Progression of microalbuminuria to macroalbuminuria
- Glomerular filtration rate (GFR)
- Risk of retinopathy and vision loss
- Risk of foot ulcers or amputation

- Efficacy and cost-effectiveness of interventions

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

American Diabetes Association's Evidence Grading System for Clinical Practice Recommendations

A

Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including:

- Evidence from a well-conducted multicenter trial
- Evidence from a meta-analysis that incorporated quality ratings in the analysis
- Compelling non-experimental evidence (i.e., "all or none" rule developed by the Center for Evidence Based Medicine at Oxford*)

Supportive evidence from well-conducted randomized, controlled trials that are adequately powered, including:

- Evidence from a well-conducted trial at one or more institutions
- Evidence from a meta-analysis that incorporated quality ratings in the analysis

**Either all patients died before therapy and at least some survived with therapy, or some patients died without therapy and none died with therapy. Example: use of insulin in the treatment of diabetic ketoacidosis.*

B

Supportive evidence from well-conducted cohort studies, including:

- Evidence from a well-conducted prospective cohort study or registry
- Evidence from a well-conducted meta-analysis of cohort studies

Supportive evidence from a well-conducted case-control study

C

Supportive evidence from poorly controlled or uncontrolled studies, including:

- Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results
- Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)
- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendations have been assigned ratings of A, B, or C, depending on the quality of evidence (see "Rating Scheme for the Strength of the Evidence"). Expert opinion (E) is a separate category for recommendations in which there is as yet no evidence from clinical trials, in which clinical trials may be impractical, or in which there is conflicting evidence. Recommendations with an "A" rating are based on large, well-designed clinical trials or well done meta-analyses. Generally, these recommendations have the best chance of improving outcomes when

applied to the population to which they are appropriate. Recommendations with lower levels of evidence may be equally important but are not as well supported.

COST ANALYSIS

- A number of large randomized clinical trials have demonstrated the efficacy and cost-effectiveness of counseling in changing smoking behavior and reducing tobacco use.
- Consultation with a nephrologist when stage 4 chronic kidney disease (CKD) develops has been found to reduce cost, improve quality of care, and keep people off dialysis longer.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The recommendations were reviewed and approved October 2007 by the Professional Practice Committee and, subsequently, by the Executive Committee of the Board of Directors.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The evidence grading system for clinical practice recommendations (A through C, E) is defined at the end of the "Major Recommendations" field.

Cardiovascular Disease (CVD)

Hypertension (HTN)/Blood Pressure Control

Screening and Diagnosis

- Blood pressure should be measured at every routine diabetes visit. Patients found to have systolic blood pressure $\geq$130 mmHg or diastolic blood pressure $\geq$80 mmHg should have blood pressure confirmed on a separate day. Repeat systolic blood pressure $\geq$130 mmHg or diastolic blood pressure $\geq$80 mmHg confirms a diagnosis of hypertension. (C)

Goals

- Patients with diabetes should be treated to a systolic blood pressure <130 mmHg. (C)
- Patients with diabetes should be treated to a diastolic blood pressure <80 mmHg. (B)

Treatment

- Patients with a systolic blood pressure of 130 to 139 mmHg or a diastolic blood pressure of 80 to 89 mmHg may be given lifestyle therapy alone for a maximum of 3 months and then, if targets are not achieved, be treated with addition of pharmacological agents. (E)
- Patients with more severe hypertension (systolic blood pressure $\geq$140 mmHg or diastolic blood pressure $\geq$90 mmHg) at diagnosis or follow-up should receive pharmacologic therapy in addition to lifestyle therapy. (A)
- Pharmacologic therapy for patients with diabetes and hypertension should be with a regimen that includes either an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB). If one class is not tolerated, the other should be substituted. If needed to achieve blood pressure targets, a thiazide diuretic should be added to those with an estimated glomerular filtration rate (GFR) $\geq$50 ml/min per 1.73 m^2 and a loop diuretic for those with an estimated GFR <50 ml/min per 1.73 m^2. (E)
- Multiple drug therapy (two or more agents at maximal doses) is generally required to achieve blood pressure targets. (B)
- If ACE inhibitors, ARBs, or diuretics are used, kidney function and serum potassium levels should be closely monitored. (E)
- In pregnant patients with diabetes and chronic hypertension, blood pressure target goals of 110 to 129/65 to 79 mmHg are suggested in the interest of long-term maternal health and minimizing impaired fetal growth. ACE inhibitors and ARBs are contraindicated during pregnancy. (E)

Dyslipidemia/Lipid Management

Screening

- In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (low-density lipoprotein [LDL] cholesterol <100 mg/dL, high-density lipoprotein [HDL] cholesterol >50 mg/dL, and triglycerides <150 mg/dL), lipid assessments may be repeated every 2 years. (E)

Treatment Recommendations and Goals

- Lifestyle modification focusing on the reduction of saturated fat, *trans* fat, and cholesterol intake; weight loss (if indicated); and increased physical activity has been shown to improve the lipid profile in patients with diabetes. (A)
- Statin therapy should be added to lifestyle therapy, regardless of baseline lipid levels, for diabetic patients:
    - With overt cardiovascular disease (CVD) (A)
    - Without CVD who are over the age of 40 and have one or more other CVD risk factors. (A)
- For lower-risk patients than those specified above (e.g., without overt CVD and under the age of 40), statin therapy should be considered in addition to lifestyle therapy if LDL cholesterol remains >100 mg/dL or in those with multiple CVD risk factors. (E)
- In individuals without overt CVD, the primary goal is an LDL cholesterol <100 mg/dL (2.6 mmol/l). (A)
- In individuals with overt CVD, a lower LDL cholesterol goal of <70 mg/dl (1.8 mmol/l), using a high dose of a statin, is an option. (E)

- If drug-treated patients do not reach the above targets on maximal tolerated statin therapy, a reduction in LDL cholesterol of ~40% from baseline is an alternative therapeutic goal. (A)
- Triglycerides levels <150 mg/dL (1.7 mmol/l) and HDL cholesterol >40 mg/dL (1.0 mmol/l) in men and >50 mg/dL (1.3 mmol/l) in women are desirable. However, LDL cholesterol-targeted statin therapy remains the preferred strategy. (C)
- Combination therapy using statins and other lipid-lowering agents may be considered to achieve lipid targets but has not been evaluated in outcomes studies for either CVD outcomes or safety. (E)
- Statin therapy is contraindicated in pregnancy. (E)

Anti-platelet Agents

- Use aspirin therapy (75 to 162 mg/day) as a secondary prevention strategy in those with diabetes with a history of CVD. (A)
- Use aspirin therapy (75 to 162 mg/day) as a primary prevention strategy in those with type 1 and 2 diabetes at increased cardiovascular risk, including those who are >40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria) (A)
- Aspirin therapy is not recommended in people under 30 years of age, due to lack of evidence of benefit, and is contraindicated in patients under the age of 21 years because of the associated risk of Reye's syndrome. (E)
- Combination therapy using other antiplatelet agents such as clopidogrel in addition to aspirin should be used in patients with severe and progressive CVD. (C)
- Other antiplatelet agents may be a reasonable alternative for high-risk patients with aspirin allergy, with bleeding tendency, who are receiving anticoagulant therapy, with recent gastrointestinal bleeding, and with clinically active hepatic disease who are not candidates for aspirin therapy. (E)

Smoking Cessation

- Advise all patients not to smoke. (A)
- Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care. (B)

Coronary Heart Disease (CHD) Screening and Treatment

Screening

- In asymptomatic patients, evaluate risk factors to stratify patients by 10-year risk, and treat risk factors accordingly. (B)

Treatment

- In patients with known CVD, ACE inhibitor, aspirin, and statin therapy (if not contraindicated) should be used to reduce the risk of cardiovascular events. (A)

- In patients with a prior myocardial infarction, add beta-blockers (if not contraindicated) to reduce mortality. (A)
- In patients >40 years of age with another cardiovascular risk factor (hypertension, family history, dyslipidemia, microalbuminuria, cardiac autonomic neuropathy, or smoking), ACE inhibitor, aspirin, and statin therapy (if not contraindicated) should be used to reduce the risk of cardiovascular events. (B)
- In patients with treated congestive heart failure (CHF), metformin and thiazolidinedione (TZD) use are contraindicated. (C)

Nephropathy Screening and Treatment

General Recommendations

- To reduce the risk or slow the progression of nephropathy, optimize glucose control. (A)
- To reduce the risk or slow the progression of nephropathy, optimize blood pressure control. (A)

Screening

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of $\geq$5 years and in all type 2 diabetic patients, starting at diagnosis. (E)
- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate glomerular filtration rate (GFR) and stage the level of chronic kidney disease (CKD), if present. (E)

Treatment

- In the treatment of the nonpregnant patient with micro- and macroalbuminuria, either ACE inhibitors or ARBs should be used. (A)
- While there are no adequate head-to-head comparisons of ACE inhibitors and ARBs, there is clinical trial support for each of the following statements:
    - In patients with type 1 diabetes, with hypertension and any degree of albuminuria, ACE inhibitors have been shown to delay the progression of nephropathy. (A)
    - In patients with type 2 diabetes, hypertension, and microalbuminuria, both ACE inhibitors and ARBs have been shown to delay the progression to macroalbuminuria. (A)
    - In patients with type 2 diabetes, hypertension, macroalbuminuria, and renal insufficiency (serum creatinine >1.5 mg/dL), ARBs have been shown to delay the progression of nephropathy. (A)
    - If one class is not tolerated, the other should be substituted. (E)
- Reduction of protein intake to 0.8 to 1.0 g/kg body wt/day in individuals with diabetes and the earlier stages of CKD and to 0.8 g/kg body wt/day in the later stages of CKD may improve measures of renal function (e.g., urine albumin excretion rate and GFR) and is recommended. (B)
- When ACE inhibitors, ARBs, or diuretics are used, monitor serum creatinine and potassium levels for the development of acute kidney disease and hyperkalemia.(E)

- Continued monitoring of urine albumin excretion to assess both response to therapy and progression of disease is recommended. (E)
- Consider referral to a physician experienced in the care of kidney disease when there is uncertainty about the etiology of kidney disease (active urine sediment, absence of retinopathy, rapid decline in GFR), difficult management issues, or advanced kidney disease. (B)

Retinopathy Screening and Treatment

General Recommendations

- To reduce the risk or slow the progression of retinopathy, optimize glycemic control. (A)
- To reduce the risk or slow the progression of retinopathy, optimize blood pressure control. (A)

Screening

- Adults and adolescents with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2 to 3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B)
- Women with pre-existing diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. Eye examinations should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B)

Treatment

- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A)
- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A)

Neuropathy Screening and Treatment

- All patients should be screened for distal symmetric polyneuropathy (DPN) at diagnosis and at least annually thereafter, using simple clinical tests. (B)
- Electrophysiological testing is rarely needed, except in situations where the clinical features are atypical. (E)
- Educate all patients about self-care of the feet. For those with DPN, facilitate enhanced foot care education and refer for special footwear. (B)
- Screening for signs and symptoms of autonomic neuropathy should be instituted at diagnosis of type 2 diabetes and 5 years after the diagnosis of type 1 diabetes. Special testing is rarely needed and may not affect management or outcomes. (E)
- Medications for the relief of specific symptoms related to DPN and autonomic neuropathy are recommended, as they improve the quality of life of the patient. (E)

Foot Care

- For all patients with diabetes, perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination can be accomplished in a primary care setting and should include the use of a monofilament, tuning fork, palpation, and a visual examination. (B)
- Provide general foot self-care education to all patients with diabetes (B)
- A multidisciplinary approach is recommended for individuals with foot ulcers and high-risk feet, especially those with a history of prior ulcer or amputation. (B)
- Refer patients who smoke, have loss of protective sensation and structural abnormalities, or have history of prior lower-extremity complications to foot care specialists for ongoing preventive care and life-long surveillance. (C)
- Initial screening for peripheral arterial disease (PAD) should include a history for claudication and an assessment of the pedal pulses. Consider obtaining an ankle-brachial index (ABI), as many patients with peripheral arterial disease are asymptomatic. (C)
- Refer patients with significant claudication or a positive ABI for further vascular assessment and consider exercise, medications, and surgical options. (C)

Definitions:

American Diabetes Association's Evidence Grading System for Clinical Practice Recommendations

A

Clear evidence from well-conducted, generalizable, randomized controlled trials that are adequately powered, including:

- Evidence from a well-conducted multicenter trial
- Evidence from a meta-analysis that incorporated quality ratings in the analysis
- Compelling non-experimental evidence (i.e., "all or none" rule developed by the Center for Evidence Based Medicine at Oxford*)

Supportive evidence from well-conducted randomized, controlled trials that are adequately powered, including:

- Evidence from a well-conducted trial at one or more institutions
- Evidence from a meta-analysis that incorporated quality ratings in the analysis

**Either all patients died before therapy and at least some survived with therapy, or some patients died without therapy and none died with therapy. Example: use of insulin in the treatment of diabetic ketoacidosis.*

B

Supportive evidence from well-conducted cohort studies, including:

- Evidence from a well-conducted prospective cohort study or registry
- Evidence from a well-conducted meta-analysis of cohort studies

Supportive evidence from a well-conducted case-control study

C

Supportive evidence from poorly controlled or uncontrolled studies, including:

- Evidence from randomized clinical trials with one or more major or three or more minor methodological flaws that could invalidate the results
- Evidence from observational studies with high potential for bias (such as case series with comparison with historical controls)
- Evidence from case series or case reports

Conflicting evidence with the weight of evidence supporting the recommendation

E

Expert consensus or clinical experience

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate prevention and management of diabetes complications

POTENTIAL HARMS

- Combination therapy, with a statin and a fibrate or statin and niacin, may be efficacious for patients needing treatment for all three lipid fractions, but this combination is associated with an increased risk for abnormal transaminase levels, myositis, or rhabdomyolysis. The risk of rhabdomyolysis is higher with higher doses of statins and with renal insufficiency, and seems to be lower when statins are combined with fenofibrate than gemfibrozil.
- Given the risk of a modest loss of visual acuity and of contraction of visual field from panretinal laser surgery, such therapy has been primarily recommended for eyes approaching or reaching high-risk characteristics.
- Measurement of spot urine for albumin only, whether by immunoassay or by using a dipstick test specific for microalbumin, without simultaneously measuring urine creatinine, is somewhat less expensive but susceptible to false-negative and –positive determinations as a result of variation in urine concentration due to hydration and other factors.

CONTRAINDICATIONS

CONTRAINDICATIONS

- During pregnancy, treatment with angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs) is contraindicated, since they are likely to cause fetal damage.
- Statin therapy is contraindicated in pregnancy.
- In patients with treated congestive heart failure (CHF), metformin and thiazolidinedione (TZD) use is contraindicated.
- Aspirin therapy should not be recommended in people under 30 years of age and is contraindicated in patients under the age of 21 years because of the associated risk of Reye's syndrome.
- People with aspirin allergy, with bleeding tendency, who are receiving anticoagulant therapy, with recent gastrointestinal bleeding, and with clinically active hepatic disease are not candidates for aspirin therapy.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Evidence is only one component of clinical decision-making. Clinicians care for patients, not populations; guidelines must always be interpreted with the needs of the individual patient in mind. Individual circumstances, such as comorbid and coexisting diseases, age, education, disability, and, above all, patient's values and preferences, must also be considered and may lead to different treatment targets and strategies. Also, conventional evidence

hierarchies, such as the one adapted by American Diabetes Association, may miss some nuances that are important in diabetes care. For example, while there is excellent evidence from clinical trials supporting the importance of achieving glycemic control, the optimal way to achieve this result is less clear. It is difficult to assess each component of such a complex intervention.

- While individual preferences, comorbidities, and other patient factors may require modification of goals, targets that are desirable for most patients with diabetes are provided. These standards are not intended to preclude more extensive evaluation and management of the patient by other specialists as needed.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

In recent years, numerous health care organizations, ranging from large health care systems such as the U.S. Veteran's Administration to small private practices have implemented strategies to improve diabetes care. Successful programs have published results showing improvement in process measures such as measurement of A1C, lipids, and blood pressure. Successful interventions have been focused at the level of health care professionals, delivery systems, and patients. Features of successful programs reported in the literature include:

- Improving health care professional education regarding the standards of care through formal and informal education programs.
- Delivery of diabetes self-management education (DSME), which has been shown to increase adherence to standard of care.
- Adoption of practice guidelines, with participation of health care professionals in the process. Guidelines should be readily accessible at the point of service, such as on patient charts, in examining rooms, in "wallet or pocket cards," on personal digital assistants (PDAs), or on office computer systems. Guidelines should begin with a summary of their major recommendations instructing health care professionals what to do and how to do it.
- Use of checklists that mirror guidelines have been successful at improving adherence to standards of care.
- Systems changes, such as provision of automated reminders to health care professionals and patients, reporting of process and outcome data to providers, and especially identification of patients at risk because of failure to achieve target values or a lack of reported values.
- Quality improvement programs combining Continuous Quality Improvement (CQI) or other cycles of analysis and intervention with provider performance data.
- Practice changes, such as clustering of dedicated diabetes visits into specific times within a primary care practice schedule and/or visits with multiple health care professionals on a single day and group visits.
- Tracking systems either with an electronic medical record or patient registry have been helpful at increasing adherence to standards of care by prospectively identifying those requiring assessments and/or treatment modifications. They likely could have greater efficacy if they suggested specific therapeutic interventions to be considered for a particular patient at a particular point in time.

- A variety of non-automated systems, such as mailing reminders to patients, chart stickers, and flow sheets, have been useful to prompt both providers and patients.
- Availability of case or (preferably) care management services, usually by a nurse. Nurses, pharmacists, and other non-physician health care professionals using detailed algorithms working under the supervision of physicians and/or nurse education calls have also been helpful. Similarly dietitians using medical nutrition therapy (MNT) guidelines have been demonstrated to improve glycemic control.
- Availability and involvement of expert consultants, such as endocrinologists and diabetes educators.

Evidence suggests that these individual initiatives work best when provided as components of a multifactorial intervention. Therefore, it is difficult to assess the contribution of each component; however, it is clear that optimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of health care professionals.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Diabetes Association (ADA). Standards of medical care in diabetes. VI. Prevention and management of diabetes complications. Diabetes Care 2008 Jan;31(Suppl 1):S24-33.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 (revised 2008 Jan)

GUIDELINE DEVELOPER(S)

American Diabetes Association - Professional Association

SOURCE(S) OF FUNDING

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GUIDELINE COMMITTEE

Professional Practice Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Irl Hirsch, MD, Chair; Martin Abrahamson, MD; Andrew Ahmann, MD; Lawrence Blonde, MD; Silvio Inzucchi, MD; Mary T. Korytkowski, MN, MD, MSN; Melinda Maryniuk, MEd, RD, CDE; Elizabeth Mayer-Davis, MS, PhD, RD; Janet H. Silverstein, MD; Robert Toto, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: American Diabetes Association (ADA). Standards of medical care in diabetes. VI. Prevention and management of diabetes complications. Diabetes Care 2007 Jan;30(Suppl 1):S15-24.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Introduction. Diabetes Care 31:S1-S2, 2008.
- Summary of revisions for the 2008 clinical practice recommendations. Diabetes Care 31:S3-S4, 2008.

- Executive summary: standards of medical care in diabetes. Diabetes Care 31:S5-S11, 2008.
- Strategies for improving diabetes care. Diabetes Care 31:S44, 2008.

Electronic copies: Available from the American Diabetes Association (ADA) Web site.

The following are also available:

- Diagnosis and classification of diabetes mellitus. Diabetes Care 2008 Jan; 31 Suppl 1:S55-60. Electronic copies: Available from the American Diabetes Association (ADA) Web site.
- 2008 clinical practice recommendations standards of care. Personal digital assistant (PDA) download. Available from the American Diabetes Association (ADA) Web site.

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on November 1, 1998. The information was verified by the guideline developer on December 15, 1998. It was updated by ECRI on April 1, 2000, April 2, 2001, March 14, 2002, July 29, 2003, May 26, 2004, July 1, 2005, and March 17, 2006, and April 25, 2007. This summary was updated most recently by ECRI Institute on March 31, 2008. The updated information was verified by the guideline developer on May 15, 2008.

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