Indian Health Service

Division of Diabetes Treatment and Prevention

Leading the effort to treat and prevent diabetes in American Indians and Alaska Natives

Recommendations At-a-Glance

Source: Standards of Care and Clinical Practice Recommendations: Type2 Diabetes [1]

Component	Care/Test/Screening	Frequency/Which Patients ("At diagnosis"=when ***diabetes*** is diagnosed)
General Recommendations for Care	Perform diabetes-focused visit Review care plan: assess goals/strengths/barriers Assess nutrition, physical activity, BMI, and growth in youth	Every 3-6 months Each diabetes visit, revise as needed Each diabetes visit
Self-Management Education (DSME)	Refer to diabetes educator	At diagnosis, then every 6-12 mo., or more as needed
Medical Nutrition Therapy (MNT)	Refer for MNT provided by a registered dietitian	At diagnosis and at least yearly, or more as needed
Glycemic Control	Check A1C, individualize goal: e.g., < 7%, 7-8%, 8-9%, etc. Review goals, medications, side effects If prescribed, review SMBG data	Every 3-6 months Every diabetes visit Every diabetes visit
CVD Risk Reduction	Prescribe statin with lifestyle therapy regardless of LDL level Check lipid profile LDL < 100 mg/dL (optimal goal), LDL < 70 mg/dL (for very high risk) Non-HDL cholesterol < 130 mg/dL, < 100 mg/dL (for very high risk) Assess smoking/oral tobacco use Aspirin therapy 75-162 mg/day (unless contraindicated)	Adults with CVD; age > 40 y. with ≥ 1 CVD risk factor Annually. If abnormal, follow current NCEP guidelines. Each visit: Ask, Advise, Assess, Assist, Arrange Known CVD/PAD; 10-year CVD Risk > 10%
Blood Pressure	Check blood pressure Individualize goal: e.g., < 130/80 mmHg, < 140/90 mmHg Youth goal: Varies with age	Every visit
Kidney Care	Check urine albumin/creatinine ratio (UACR) for albuminuria using a random urine sample (normal < 30 mg/g; micro 30-300 mg/g; macro > 300 mg/g) Check serum creatinine and estimate GFR If HTN, prescribe ACE Inhibitor or ARB unless contraindicated	At diagnosis, then annually At diagnosis, then annually
Eye Care	Retinal camera photo or dilated eye exam by an ophthalmologist or optometrist	At diagnosis, then annually; or as directed by eye specialist
Foot Care	Visual inspection of feet with shoes and socks off Perform comprehensive lower extremity/foot exam Screen for PAD (consider ABI)	Each diabetes visit; stress daily self-exam At diagnosis, then annually At diagnosis, then annually
Oral Care	Inspection of gums/teeth Dental exam by dental professional	At diagnosis, then at diabetes visits At diagnosis, then every 6 -12 months
Autonomic Neuropathy	Assess CV symptoms; resting tachycardia, exercise intolerance, orthostatic hypotension Assess GI symptoms; gastroparesis, constipation, diarrhea Assess sexual health/function for men and women	At diagnosis, then annually At diagnosis, then annually At diagnosis, then annually
Behavioral Health	Assess emotional health (e.g. depression, substance abuse)	At diagnosis, then regularly
Immunizations	Influenza vaccine Pneumococcal vaccine Hepatitis B immunization	Annually Once < 65 y. Re-immunize if ≥65 y. and 1st dose given before age 65 and if vaccine was administered > 5 y. prior. Unvaccinated adults < 60 y.
Preconception, Pregnancy, and Postpartum Care	Ask about reproductive intentions/assess contraception Provide preconception counseling Screen for undiagnosed type 2 diabetes Screen for GDM in all women not known to have diabetes Screen for type 2 diabetes in women who had GDM	At diagnosis, and then every visit 3-4 months prior to conception At first prenatal visit At 24-28 weeks gestation At 6-12 weeks postpartum, then every 1-3 y. lifelong

Adapted with permission from Wisconsin Diabetes Mellitus Essential Care Guidelines. (2011). Quick Reference: 2011 Wisconsin Diabetes Guidelines at a Glance (DHS Publication No. P-49356 Rev.03/2011). Madison, WI: Wisconsin Department of Health

[1] http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=soc