

Indiana Consensus Guidelines for Diabetes Care

Care is a partnership between the patient, family, and the diabetes team, which includes: the primary care provider, diabetes educator, nurse, dietitian, pharmacist and other specialists.

Measure	Consensus Guidelines (Frequency)	Treatment Goals
General Care:		
<ul style="list-style-type: none"> Physical Activity 	<ul style="list-style-type: none"> Assess every regular visit 	
<ul style="list-style-type: none"> Weight (BMI)* 	<ul style="list-style-type: none"> Assess every regular visit Re-evaluate for continued weight loss 	Initial Goal: Weight loss for overweight patients 5-7% of starting weight
Glycemic Control:		
<ul style="list-style-type: none"> A1C 	Twice a year, at least 3 months apart for patients meeting treatment goals (recommend quarterly in patients not meeting A1C goals and if treatment changes are ongoing)	A1C <7.0%
Eye Care:		
<ul style="list-style-type: none"> Dilated Eye Exam (or a Digital Retinal Exam) 	Type 1: After 5 years duration, then annually Type 2: At diagnosis, then annually	
Kidney Care:		
<ul style="list-style-type: none"> Microalbuminuria 	<ul style="list-style-type: none"> Annually 	
<ul style="list-style-type: none"> Serum Creatinine 	<ul style="list-style-type: none"> Annually for estimation of GFR 	
Foot Care		
<ul style="list-style-type: none"> Visual Foot Exam 	<ul style="list-style-type: none"> Inspect feet every regular visit Lower extremity mono-filament exam annually 	
Cardiovascular Care:		
<ul style="list-style-type: none"> Lipid Profile 	<ul style="list-style-type: none"> Annually 	Cholesterol <200 mg/dl LDL <100 mg/dl HDL > 40 (Men) >50 (Women) Triglycerides < 150 mg/dl
<ul style="list-style-type: none"> Blood Pressure 	<ul style="list-style-type: none"> Every visit 	Blood pressure < 130/80
<ul style="list-style-type: none"> Smoking 	<ul style="list-style-type: none"> Counsel to stop every visit 	
<ul style="list-style-type: none"> Aspirin Therapy 	<ul style="list-style-type: none"> Daily if not contraindicated 	
Self-Management Education	Refer to diabetes educator, preferably a Certified Diabetes Educator (CDE); at diagnosis, then every 6 to 12 months, or as needed	
Medical Nutrition Therapy	Refer to registered dietitian, preferably a CDE; at diagnosis, then every 6 to 12 months, or as needed	
Dental Exam	<ul style="list-style-type: none"> Annually by dentist 	
Immunizations:		
<ul style="list-style-type: none"> Influenza Vaccine 	<ul style="list-style-type: none"> Annually 	
<ul style="list-style-type: none"> Pneumococcal Vaccine 	<ul style="list-style-type: none"> Initial and revaccination if indicated** 	

Criteria for Diagnosis of Pre-Diabetes and Diabetes

Diagnosis	Measure	Treatment Goals
Pre-Diabetes (Impaired Fasting Glucose IFG)	Fasting Plasma Glucose Test (FPG): 100-125 mg/dl	<ul style="list-style-type: none"> Moderate physical activity (e.g. walking 30 minutes 5x/week) Diet modification Weight loss, if overweight, at least 5 - 7% of current body weight Test Glucose annually
Pre-Diabetes (Impaired Glucose Tolerance IGT)	Oral Glucose Tolerance Test (OGTT): 140-199 mg/dl 2-hour plasma glucose following a 75-gram oral glucose load	
Diabetes	FPG: ≥ 126 mg/dl OGTT: ≥ 200 mg/dl	See above table

* BMI < 25 for adults; for children aged 2 to 20 years, BMI for age < 85th percentile. For calculating children's BMI, see: http://www.cdc.gov/nccdphp/dnpa/growthcharts/bmi_tools.htm.

** High-risk older children and adults should be reimmunized 5 years or more after being initially immunized with pneumococcal polysaccharide vaccine. Reimmunization once only is recommended.

Adapted from American Diabetes Association Clinical Practice Guidelines 2007

These guidelines were developed to provide guidance to primary care providers and are not intended to replace or preclude clinical judgment.

Adopted June 2007 ISDH/Indiana Diabetes Advisory Council/IRHA



Indiana Diabetes
Advisory Council

