COMMUNITY CARE, INC.
PRIMARY CARE DIABETES MELLITUS GUIDELINES
PACE/Partnership Programs

The following Clinical Guideline is designed to assist physicians, clinicians, and members in making decisions about appropriate care in the diagnosis and management of Diabetes. Guidelines are not intended either to replace a clinician's judgment or to establish a strict protocol for all members in a particular situation. Member "Goals of Care" and comorbid conditions must be taken into consideration as care and treatment decisions are made.

Recommended Intervention	Pre-Diabetes	Pregnancy/Gestational	Standard Therapy	Goal: Longevity	Goal: Functional	Goal: Comfort
Screening/Diagnosis	1. History and physical 2. Fasting blood glucose 100 mg/dL-125 mg/dL **OR** impaired glucose tolerance – 2 hr oral glucose tolerance test 140 mg/dL-199mg/dL **OR** A1c 5.7-6.4%	1. History and physical 2. Fasting blood glucose > 126 mg/dL on 2 occasions **OR** A1c > 6.5%, 2 hr. post prandial glucose $\geq$ 200 mg/dL **OR** classic symptoms plus random blood glucose $\geq$ 200mg/dL	1. History and physical 2. Fasting blood glucose > 126 mg/dL on two occasions **OR** A1c ≥ 6.5%, 2 hr. post prandial glucose ≥200 mg/dL **OR** classic symptoms plus random blood glucose ≥200 mg/dL	1. History and physical 2. Fasting blood glucose > 126 mg/dL on two occasions **OR** A1c ≥6.5%, 2 hr post prandial glucose ≥200 mg/dL **OR** classic symptoms plus random blood glucose ≥200 mg/dL	1. History and physical 2. Fasting blood glucose > 126 mg/dL on two occasions **OR** A1c ≥6.5%, 2 hr post prandial glucose ≥200 mg/dL **OR** classic symptoms plus random blood glucose ≥200 mg/dL	1. History and physical
Glycemic Management						
Fasting blood glucose Goal	70-130mg/dL; Postprandial < 180 mg/dL	≤95 mg/dL **AND** either $\leq$140mg/dL 1 hr. post meal or $\leq$ 120 mg/dL 2 hrs. post meal	90 – 130 mg/dL	90 – 130 mg/dL	90-150mg/dL	100-180 mg/dL or Focus on signs and symptoms as appropriate
HbgA1C Goal	No target	No Target	< 7.0%	< 7.0%	< 8.0% Or the lowest A1c attainable without symptomatic hypoglycemia.	< 9.0% Focus on signs and symptoms which indicate need for tighter control of blood glucose or intolerance to regimen.

Created: 4/4/2014 Owner: PC Director of Mid-Level Providers
Author: Chris Brand Review date: Annually

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HbgA1C testing:	In asymptomatic people < 45 years old with BMI > 25 and who have one or more risk factors for Diabetes, and all people over 45. If normal A1c, at least every 3 years.At least every 3 years;	Lifelong screening for Diabetes—at least every 3 years	At least q 6 months if not controlled; annually if controlled.	At least q 6 months if not controlled; annually if controlled.	At least q 6 months if not controlled. Annually A1c if controlled. Consider patient's ability to tolerate regimen.without symptomatic hypoglycemia.	Consider
Lipid Management						
LDL assessment		No Target	Hyperlipidemia: a. LDL of 100 mg/dL or less recheck lipid status at least every 2 yrs b. LDL 100-129 mg/dL, consider medical nutrition therapy, exercise, and recheck FLP at least annually. If LDL of less than 100 mg/dL is not achieved within 6 months, consider pharmacologic treatment. c. LDL 130 mg/dL or higher consider pharmacologic therapy and recheck at least annually	Hyperlipidemia: a. LDL of 100 mg/dL or less recheck lipid status at least every 2 yrs b. LDL 100-129 mg/dL, consider medical nutrition therapy, exercise, and recheck FLP at least annually. If LDL of less than 100 mg/dL is not achieved within 6 months, consider pharmacologic treatment c. LDL 130 mg/dL or higher consider pharmacologic therapy and recheck at least annually	Hyperlipidemia: Measure lipids/ECG if appropriate.	Focus on signs and symptoms may maintain current schedule as long as possible
Blood Pressure (B/P)	If Hypertensive: goal	Screen for and consider	Screen for and treat for	Screen for and consider	Screen for and consider	

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Management	≤140/90 mm/Hg	treating hypertension. Goal BP 110-128/66-78 mm/Hg	Hypertension. Goal of 140/90 mm/Hg	treating for Hypertension. Goal of 140/90 mm/Hg. For the Frail or elderly, may consider less aggressive goal of 150-160/90-100	treating for Hypertension. Goal of 150/90 mm/Hg. For the Frail or elderly, may consider less aggressive goal of 150-160/90-100	
Medications						
Aspirin 75-325 mg/day		No	ASA therapy (81 mg/day) if Framingham estimated 10 year risk > 10%	ASA therapy (81mg/day) unless there are contraindications or intolerance.	Consider if patient will benefit	No recommendation
ACEI or ARB	If evidence of nephropathy/positive quantitative urine albumin, then Yes, unless contraindicated or intolerance	Not recommended adding during pregnancy	Yes, unless there are contraindication or intolerance	Yes unless there are contraindication or intolerance.	Consider if patient will benefit	No recommendation
Statins		Not recommended adding during pregnancy	Yes, unless there are contraindications or intolerance.	Yes, unless there are contraindications or intolerance.	Consider if patient will benefit	
Oral and injectable Therapies	Consider benefit of Metformin to prevent progression: If impaired fasting glucose, A1c 5.7-6.4% and BMI >35 kg/m^2 and women with prior gestational diabetes.	Insulin is only FDA approved		Avoid use of sliding scale insulin and glyburide in members over age 65	Avoid use of sliding scale insulin and glyburide in members over age 65	Focus on signs and symptoms

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Vaccinations	-Pneumovax; if vaccinated prior to age 65 and > 5 years ago, one-time revaccination. -Annual influenza -Hepatitis B: ages 19-59 if not previously vaccinated. If $\geq$ 60, consider.	Per OB/GYN recommendations	-Pneumovax; if vaccinated prior to age 65 and > 5 years ago, one-time revaccination. -Annual influenza -Hepatitis B: ages 19-59 if not previously vaccinated. If $\geq$ 60, consider.	-Pneumovax; if vaccinated prior to age 65 and > 5 years ago, one-time revaccination. - Annual influenza -Hepatitis B: ages 19-59 if not previously vaccinated. If $\geq$ 60, consider.	-Pneumovax; if vaccinated prior to age 65 and > 5 years ago, one-time revaccination. - Annual influenza -Hepatitis B: ages 19-59 if not previously vaccinated. If $\geq$ 60, consider.	
Smoking cessation assistance	Yes	Yes	Yes	Yes	Yes	No
Dietary and Diabetic Education	-Balanced diet -Weight reduction if appropriate. (Target: loss of 7% of body weight) -Lifestyle modification: exercise target at least 50 min/week of moderate activity.	-Medical nutrition therapy -If indicated SMBG -Exercise per OB/GYN recommendations	-Medical nutrition therapy, DASH diet, weight reduction if appropriate. -SMBG, Hypoglycemia management -Lifestyle modifications as indicated: exercise	-Medical nutrition therapy, DASH diet, weight reduction if appropriate. -SMBG, Hypoglycemia management -Lifestyle modifications as indicated: exercise	-Medical nutrition therapy, DASH diet, weight reduction if appropriate. -SMBG, Hypoglycemia management -Lifestyle modifications as indicated: exercise	Consider
Eye Exam	Annual by optometrist or ophthalmologist if high risk. Biannual exam by optometrist or ophthalmologist if low risk.	During 1st trimester by optometrist or ophthalmologist with follow ups throughout pregnancy and 1 year postpartum	Annual by optometrist or ophthalmologist if high risk. Biannual exam by optometrist or ophthalmologist if low risk.	Annual by optometrist or ophthalmologist if high risk. Biannual exam by optometrist or ophthalmologist if low risk.	Annual by optometrist or ophthalmologist if high risk. If low risk, consider biannual exam by optometrist.	Not indicated
Foot examination	As indicated		-Foot examination at least semi-annually.	-Foot examination at least semi-annually.	-Foot examination at least semi-annually.	Foot examination at least semi-annually.

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			-Monofilament evaluation for neuropathy with every foot inspection. -Foot screening tool must be completed annually.	-Monofilament evaluation for neuropathy with every foot inspection. -Foot screening tool must be completed annually.	-Monofilament evaluation for neuropathy with every foot inspection. -Foot screening tool must be completed annually.	Foot screening tool must be completed annually.
Other Laboratory testing						
Nephropathy screening by measurement of quantitative urine albumin excretion		Per OB/GYN	Annual if not on ACE or ARB and without established renal disease.	Annual if not on ACE or ARB and without established renal disease.	Consider if not on ACE or ARB and without established renal disease.	No
Other Screenings	Within 12 weeks of initiation or dose increase of statin or niacin, or fibrate, then annually		Monitor liver enzymes	-Monitor liver enzymes -Screen for cognitive impairment -Evaluate for urinary incontinence	-Screen for cognitive impairment -Evaluate for urinary incontinence -Screen for and treat depression -If appropriate, discuss the concept of palliative care for advanced disease	-Screen for and treat depression -If appropriate, discuss the concept of palliative care for advanced disease.

Metformin

Should be initiated at time of diagnosis unless contraindicated

Men with SCr ≥1.5 mg/dL and women with SCr ≥1.4 mg/dL

CrCl ≤50 mL/min

(For individuals ≥80 years or older or have reduced muscle mass, use timed urine collection for measurement of CrCl)

Insulin

Consider use if marked elevation in BG or A1C or uncontrolled with metformin

Other oral agents and GLP1 agonist

Consider adding second oral agent or GLP1 agonist to metformin therapy if goal BG/A1C not achieved over 3-6 months

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References

National Pace Association NPA Primary Care Committee 2009 Diabetes Mellitus Model Practice

Standards of Medical Care in Diabetes – 2014 American Diabetes Association, *Diabetes Care*. January 2014; Vol. 37 Suppl 1:S118-9.

The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers criteria for potentially inappropriate medication use in older adults. *JAGS*. 2012;1-15.

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