# *Guidelines for Adult Diabetes Care*

Guidelines provided by the Massachusetts Department of Public Health.* These guidelines are intended for community-dwelling adults and are not intended to replace the clinical judgment of healthcare providers.

| Type of Care | | Frequency | Description/Comments |
|---|---|---|---|
| **History & Physical** | Blood pressure, height, and weight | Every 3-6 months | If blood pressure is >130/80 mm Hg, initiate measures to lower. |
| | Dilated eye exam | Annually[1] | Refer to ophthalmologist or optometrist. |
| | Foot exam | Every 3-6 months | Perform visual exam without shoes and socks every routine diabetes visit. |
| | Comprehensive lower extremity sensory exam | Initially and annually[2] | Teach protective foot behavior if sensation is diminished. Refer to podiatrist if indicated. |
| | Dental exam | Every 6 months | Refer to dentist. |
| | Smoking status | Ongoing | Check every visit and encourage smoking cessation. |
| **Laboratory Tests** | Glycosylated hemoglobin (HbA1c) | Every 3-6 months[3] | Ideal goal is <7% or <1% above lab norm.[4] Make changes in regimen if HbA1c is >8%. |
| | Fasting/casual blood glucose | As indicated | Compare lab results with glucose self-monitoring. |
| | Fasting lipid profile | Annually[5] | Initiate cardiovascular risk reduction regimen. |
| | Urine microalbumin/ creatinine | Initially and annually[6] | If abnormal, recheck twice in a 3-month period; then treat if 2 out of 3 collections show elevated levels. |
| | Serum creatinine | Initially and as indicated | |
| | ECG | Initially | Perform if patient is older than 40 years or has had diabetes 10 years or longer. |
| | Thyroid assessment | Initially and as indicated | Palpate thyroid and check thyroid function test(s) if indicated. |
| **Recommended Immunizations** | Flu | Every Fall | |
| | Pneumovax | Recommended 1 time | Revaccinate 1 time if patient is 65 years or older and 1st vaccine was 5 or more years ago *and* patient was younger than 65 years at the time of 1st vaccine. |
| **Self-management** | Review self-management skills. | Initially and ongoing | |
| | Review treatment plan. | Initially and ongoing | Check self-monitoring log book, diet, exercise, and medications. |
| | Review education plan. | Initially and ongoing | Refer for diabetes self-management training if indicated. |

*Diabetes Guidelines Work Group. Diabetes Prevention and Control Program, Bureau of Family and Community Health, Massachusetts Department of Public Health. Massachusetts guidelines for adult diabetes care. Boston, MA: Massachusetts Health Promotion Clearinghouse; June 2005.

| Type of Care | | Frequency | Description/Comments |
|---|---|---|---|
| **Counseling** | Review nutrition plan. | Initially and ongoing | Refer for medical nutrition therapy if indicated. |
| | Review physical activity plan. | Initially and ongoing | Assess and prescribe based on patient's health status. |
| | Review tobacco use. | Annually and ongoing | Assess readiness for cessation, counsel cessation, or refer to smoking cessation program. |
| | Discuss psychosocial adjustment. | Initially and ongoing | Suggest diabetes support group, counsel, or refer. |
| | Discuss sexuality, impotence, and erective dysfunction. | Annually and ongoing | Discuss diagnostic evaluation and therapeutic options. |

[1]Type 1: Initial examination after 3-5 years' disease duration. Type 2: Initial examination shortly after diagnosis.

[2]Every 3-6 months if patient has high-risk foot conditions.

[3]Twice per year for stable glycemic control; 4 times/year if change in therapy or if not meeting glycemic goals.

[4]More stringent goals, including a normal HbA1c of <6% can be considered in individual patients.

[5]If values fall in lower risk levels, assessment may be repeated every 2 years.

[6]Initial urinalysis at diagnosis of type 2 diabetes. In patients with type 1 diabetes, screen for microalbumin after 5 years of disease. Screen microalbumin annually thereafter.