



Wisconsin Essential Diabetes Mellitus Care Guidelines

The Wisconsin Essential Diabetes Mellitus Care Guidelines was reviewed and approved by Unity's Clinical Quality Improvement Committee (CQIC) on July 15, 2011. The guideline was previously approved by CQIC on November 19, 2010; January 16, 2009; January 19, 2007; September 15, 2006; September 16, 2005; January 21, 2009; November 13, 2003; January 9, 2003; and March 5, 2001. The Wisconsin Diabetes Advisory Group participated in the development and revision of this guideline. The task force was a multidisciplinary work group comprised of physicians, pharmacists, nurses, and dieticians.

2011 Wisconsin Diabetes Guidelines at a Glance

For details and references for each specific area, as well as the disclaimer, please refer to the supporting documents and implementation tools in the full-text *Guidelines* available via the Internet at <http://dhs.wisconsin.gov/health/diabetes/guidelines.htm> or telephone: (608) 261-6855.

Concern	Care/Test	Frequency
General Recommendations for Care	<ul style="list-style-type: none"> ◆ Perform diabetes-focused visit..... ◆ Review management plan; assess barriers and goals ◆ Assess physical activity level ◆ Assess nutrition/weight/growth 	<p><i>Type 1:</i> Every 3 months❖ <i>Type 2:</i> Every 3 – 6 months❖</p> <p>Each focused visit; revise as needed</p> <p>Each focused visit</p> <p>Each focused visit</p>
Self-Management Education	<ul style="list-style-type: none"> ◆ Refer to diabetes educator, preferably a CDE in an ADA Recognized or AADE Accredited Program 	At diagnosis, then every 6 – 12 months, or more as needed
Medical Nutrition Therapy	<ul style="list-style-type: none"> ◆ Refer for medical nutrition therapy (MNT) provided by a registered dietitian (RD), preferably one who is also a CDE..... 	At diagnosis or first referral to RD: 3 to 4 visits, completed in 3 to 6 months; then, 1-2 hours of routine RD visits annually. RD determines additional visits based on needs/goals.
Glycemic Control	<ul style="list-style-type: none"> ◆ Check A1C, general goal: < 7.0% (individualize; see Table 4-2)..... ◆ Review goals, medications, side effects, and frequency of hypoglycemia ◆ Assess self-blood glucose monitoring schedule 	<p><i>Type 1:</i> Every 3 months❖ <i>Type 2:</i> Every 3 – 6 months❖</p> <p>Each focused visit</p> <p>Each focused visit, 2 – 4 times/day, or as recommended</p>
Cardiovascular Care	<ul style="list-style-type: none"> ◆ Check fasting lipid profile..... Adult goals: Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL HDL ≥ 40 mg/dL (men) HDL ≥ 50 mg/dL (women) Non-HDL (Cholesterol) < 130 mg/dL Non-HDL (Cholesterol) < 100 mg/dL (for very high risk) LDL < 100 mg/dL (optimal goal) LDL < 70 mg/dL (for very high risk) ◆ Start statin with ongoing lifestyle changes ◆ Check blood pressure Adult goal: < 130/80 mmHg ◆ Assess smoking/tobacco use status ◆ Start aspirin prophylaxis (unless contraindicated) 	<p><i>Children:</i> After age 2 but before age 10. Repeat annually if abnormal, repeat in 3 – 5 years if normal. <i>Adults:</i> Annually. If abnormal, follow NCEP III guidelines.</p> <p>Adults with CVD; Age > 40 yrs with one or more risk factors for CVD <i>Children:</i> Each focused visit; follow National High Blood Pressure Education Program recommendations for Children and Adolescents <i>Adults:</i> Each focused visit</p> <p>Each visit; (5As: Ask, Advise, Assess, Assist, Arrange) Age > 50 yrs for men and > 60 yrs for women with diabetes and at least one other major risk factor; Men ≤ 50 yrs and women ≤ 60 yrs, individualize based on risk</p>
Kidney Care	<ul style="list-style-type: none"> ◆ Check albumin/ creatinine ratio for microalbuminuria using a random urine sample, Goal < 30 mg/g ◆ Check serum creatinine and estimate GFR ◆ Perform routine urinalysis 	<p><i>Type 1:</i> At puberty or 5 years after diagnosis, then annually <i>Type 2:</i> At diagnosis, then annually</p> <p>At diagnosis, then annually</p> <p>At diagnosis, then as indicated</p>
Eye Care	<ul style="list-style-type: none"> ◆ Dilated eye exam by an ophthalmologist or optometrist 	<p><i>Type 1:</i> If age ≥ 10 yrs within 5 years after diagnosis, then annually <i>Type 2:</i> At diagnosis, then annually; two exceptions exist</p>
Neuropathies and Foot Care	<ul style="list-style-type: none"> ◆ Assess/screen for neuropathy (autonomic/DPN) ◆ Visual inspection of feet with shoes and socks off ◆ Perform comprehensive lower extremity/foot exam..... ◆ Screen for PAD (consider ABI) 	<p><i>Type 1:</i> Five years after diagnosis, then annually <i>Type 2:</i> At diagnosis, then annually</p> <p>Each focused visit; stress daily self-exam</p> <p>At diagnosis, then annually</p> <p>At diagnosis, then annually</p>
Oral Care	<ul style="list-style-type: none"> ◆ Simple inspection of gums and teeth for signs of periodontal disease ◆ Dental exam by general dentist or periodontal specialist..... 	<p>At diagnosis, then each focused visit</p> <p>At diagnosis, then every 6 months (if dentate) or every 12 months (if edentate); more often as needed</p>
Emotional and Sexual Health Care	<ul style="list-style-type: none"> ◆ Assess emotional health; screen for depression ◆ Assess sexual health concerns..... 	<p>Each focused visit</p> <p>Each focused visit</p>
Influenza and Pneumococcal Immunizations	<ul style="list-style-type: none"> ◆ Provide influenza vaccine ◆ Provide pneumococcal vaccine 	<p>Annually, if age ≥ 6 months</p> <p>Once; then per Advisory Committee on Immunization Practices</p>
Preconception, Pregnancy, and Postpartum Care	<ul style="list-style-type: none"> ◆ Ask about reproductive intentions/assess contraception ◆ Provide preconception counseling/assessment..... ◆ Screen for undiagnosed type 2 diabetes in women with known risk..... ◆ Screen for GDM in all women not known to have diabetes ◆ Screen for type 2 diabetes in women who had GDM..... 	<p>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 at least every 3 years lifelong</p>
Assessing Risk and Prevention of Type 2 Diabetes	<ul style="list-style-type: none"> ◆ Check A1C test, fasting plasma glucose test, or oral glucose tolerance test ◆ Assess lifestyle management and diabetes risk status..... 	<p>Test all adults ≥ age 45 yrs or with BMI ≥ 25 kg/m² and one other risk factor. If normal, retest in 3 years or less. (See full <i>Guidelines</i> for testing of type 2 diabetes in children and adolescents)</p> <p>At each visit; refer to community resources as appropriate.</p>

❖ Consider more often if A1C is ≥ 7.0% and/or individual risk and/or complications exist
 ◆ Consider referring to provider experienced in care of women with diabetes during pregnancy

Frequency of Essential Tests for People with Diabetes

This quick reference provides the frequency of essential tests to assist in prevention, early detection, and treatment of complications associated with diabetes.

Frequency	Type 1 Diabetes	Type 2 Diabetes
Every 3 months	<ul style="list-style-type: none"> ◆ Perform diabetes-focused visit ❖ ◆ Check A1C goal: < 7.0% (always individualize) ◆ Check blood pressure: Adult goal: < 130/80 mmHg ◆ Assess nutrition/weight/growth ◆ Assess emotional and sexual health ◆ Assess lifestyle management at each visit 	See 3-6 months for type 2 recommendations
Every 3-6 months	<ul style="list-style-type: none"> ◆ Dental exam by general dentist or periodontal specialist at diagnosis, then every 6 months (if dentate) or every 12 months (if edentate); more often as needed 	<ul style="list-style-type: none"> ◆ Perform diabetes-focused visit ❖ ◆ Check A1C goal: < 7.0% (always individualize) ◆ Dental exam by general dentist or periodontal specialist at diagnosis, then every 6 months (if dentate) or every 12 months (if edentate); more often as needed ◆ Check blood pressure: Adult goal: < 130/80 mmHg ◆ Assess nutrition/weight/growth ◆ Assess emotional and sexual health ◆ Assess lifestyle management each visit
	<ul style="list-style-type: none"> ◆ Check fasting lipid profile Adult goals: Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL HDL ≥ 40 mg/dL (men) HDL ≥ 50 mg/dL (women) Non-HDL (Cholesterol) < 130 mg/dL Non-HDL (Cholesterol) < 100 mg/dL (for very high risk) LDL < 100 mg/dL (optimal goal) LDL < 70 mg/dL (for very high risk) Children: After age 2 but before age 10. Repeat annually if abnormal, repeat in 3 – 5 years if normal. ◆ Monitor albumin/creatinine ratio using a random urine sample to check for microalbuminuria, at puberty or after 5 years duration, then annually ◆ Check serum creatinine and estimated GFR at diagnosis, then annually ◆ Dilated eye exam by an ophthalmologist or optometrist (if age ≥ 10 yrs, within 5 years of onset, then annually) ◆ Assess/screen for neuropathy (autonomic/DPN) ◆ Assess immunization status and provide influenza vaccination 	<ul style="list-style-type: none"> ◆ Check fasting lipid profile Adult goals: Total Cholesterol < 200 mg/dL Triglycerides < 150 mg/dL HDL ≥ 40 mg/dL (men) HDL ≥ 50 mg/dL (women) Non-HDL (Cholesterol) < 130 mg/dL Non-HDL (Cholesterol) < 100 mg/dL (for very high risk) LDL < 100 mg/dL (optimal goal) LDL < 70 mg/dL (for very high risk) Children: After age 2 but before age 10. Repeat annually if abnormal, repeat in 3 – 5 years if normal. ◆ Monitor albumin/creatinine ratio using a random urine sample to check for microalbuminuria, at puberty or after 5 years duration, then annually ◆ Check serum creatinine and estimated GFR at diagnosis, then annually ◆ Dilated eye exam by an ophthalmologist or optometrist at diagnosis, then annually; two exceptions exist ◆ Assess/screen for neuropathy (autonomic/DPN) ◆ Assess immunization status and provide influenza vaccination
Frequency	Care/Tests for Women during Pregnancy and Postpartum	
Preconception, Pregnancy, and Postpartum Care <ul style="list-style-type: none"> ◆ At diagnosis and every visit ◆ 3 to 4 months prior to conception ◆ At first prenatal visit ◆ At 24–28 weeks gestation ❖ ◆ At 6–12 weeks postpartum 	<ul style="list-style-type: none"> ◆ Ask about reproductive intentions/assess contraception ◆ Provide preconception counseling/assessment ◆ Screen all women for undiagnosed type 2 diabetes with known risk ◆ Screen for GDM all women not known to have diabetes ◆ Screen for type 2 diabetes post-GDM then lifelong screening at least every 3 years 	

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❖ Consider referring to provider experienced in care of women with diabetes during pregnancy