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Changes to ADA Clinical Practice Recommendations

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The American Diabetes Association® has long been a major source of research and evidence for healthcare professionals when making recommendations. Earlier this year, several changes were made to the annually published Clinical Practice Recommendations, now termed the Standards of Medical Care in Diabetes. Although this is a single document, it is divided into 14 different sections to designate the important areas and facilitate navigation.

The information provided below details the 14 major topic areas and revisions made for 2015.

Summary of 2015 Standards Revisions[1]

Section	Title	2014 Recommendations *(Areas Revised for 2015 in Italics)*	2015 Revision
1	Strategies for Improving Care	• Patient-centered communication • Timely, patient-specific, evidence-based treatment decisions • Alignment of care with components of the Chronic Care Model (CCM) • Team-based care, community involvement, patient registries, and decision support tools should all be used when possible	No changes
2	Classification and Diagnosis of Diabetes	**Classification:** • Type 1 diabetes • Type 2 diabetes • Gestational diabetes mellitus (GDM) • Specific types due to other causes **Diagnosis (any one of the following):** • A1C ≥ 6.5% • FPG ≥ 126 mg/dL • 2-h PG ≥ 200 mg/dL during an OGTT • Classic symptoms of hyperglycemia or hyperglycemic crisis **Criteria for testing for diabetes/prediabetes in asymptomatic adults:** • Testing should be considered in all adults who are overweight *(BMI > 25 kg/m^2)* and have additional risk factors • ≥ 45 years of age • Repeat testing a minimum of 3-year intervals	BMI cut point for screening overweight or obese Asian Americans for prediabetes and type 2 diabetes was changed to 23 kg/m^2
3	Initial Evaluation and Diabetes Management Planning	**Complete medical evaluation should be performed at initial visit to:** 1. Classify diabetes 2. Detect diabetes complications 3. Review previous treatment and risk factor control in patients with established diabetes 4. Assist in formulating a management plan 5. Provide a basis for continuing care	No changes

4	Foundations of Care: Education, Nutrition, Physical Activity, Smoking Cessation, Psychosocial Care, and Immunization	**Diabetes self-management education and support:** • People with diabetes should receive diabetes self-management education (DSME) and diabetes self-management support (DSMS) **Medical nutrition therapy:** • Important that all members of the healthcare team be knowledgeable about diabetes nutrition therapy and support its implementation **Physical activity:** • Children with diabetes or prediabetes are encouraged to engage in at least 60 minutes of physical activity • Adults with diabetes should perform at least 150 min/week of moderate-intensity aerobic physical activity spread over 3 days/week and resistance training at least twice per week **Smoking cessation:** • Advise all patients not to smoke or use tobacco products **Psychosocial assessment and care:** • Include assessment of the patient's psychological and social situation as an ongoing part of diabetes management **Immunizations:** • Provide routine vaccinations for children and adults with diabetes as for the general population: Influenza, Hepatitis B, *Pneumovax*®	All individuals should be encouraged to limit the amount of time they spend being sedentary by breaking up extended amounts of time (≥ 90 minutes) spent sitting E-cigarettes are not supported as an alternative to smoking or to facilitate smoking cessation Immunization recommendations were revised to reflect the recent Centers for Disease Control and Prevention Guidelines regarding PCV13 and PPSV23 • PPSV23 to all patients with diabetes ≥ 2 years • Adults ≥ 65 years of age, if not previously vaccinated, should receive PCV13, followed by PPSV23 6-12 months after • Adults ≥ 65 years of age, if previously vaccinated with PPSV23, should receive a follow-up ≥ 12 months with PCV12
5	Prevention or Delay of Type 2 Diabetes	• Lifestyle modifications, pharmacologic interventions, and DSME / DSMS	No changes
6	Glycemic Targets	**Summary of glycemic recommendations for nonpregnant adults with diabetes:** • A1C < 7.0% • Preprandial capillary plasma glucose *70-130 mg/dL* • Peak postprandial capillary plasma glucose < 180 mg/dL	Premeal blood glucose target of 80-130 mg/dL Continuous glucose monitoring used in conjunction with intensive insulin regimens is a useful tool to lower A1C in selected adults (aged ≥ 25 years) with type 1 diabetes and in those with hypoglycemia unawareness and/or frequent hypoglycemic episodes
7	Approaches to Glycemic Treatment	**Type 1 diabetes:** • Most patients require multiple-dose insulin injections of continuous subcutaneous insulin infusion **Type 2 diabetes:** • Most patients should begin with lifestyle changes • Metformin is the preferred initial pharmacological agent for type 2 diabetes • If noninsulin therapy at maximum tolerated dose does not achieve or maintain the A1C target over 3 months, add a second oral agent, a GLP-1 receptor agonist, or basal insulin	Updated type 2 diabetes management algorithm to reflect all of the currently available therapies for diabetes management — the ADA continues to update this plan based on emerging literature

8	Cardiovascular Disease and Risk Management	**Hypertension / blood pressure control:**
		• Screening and diagnosis
		  ○ Blood pressure should be measured at every routine visit
		• Goals
		  ○ SBP <140 mmHg
		  ○ *DBP <80 mmHg*
		• Treatment
		  ○ BP > 120/80: lifestyle changes
		  ○ BP > 140/90: lifestyle changes, pharmacologic therapy (ACEi/ARB)
			Diastolic blood pressure goal is now 90 mmHg for people with diabetes and hypertension

		Dyslipidemia / lipid management: • Treatment decisions based on LDL cholesterol level	Statin treatment and lipid monitoring are now driven primarily by atherosclerotic cardiovascular disease risk status — a screening lipid profile should be performed at diabetes diagnosis, initial medical evaluation, and/or at age 40 years, and periodically thereafter
9	Microvascular Complications and Foot Care	**Foot care:** • Perform an annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations • Provide general foot self-care educations to all patients with diabetes • Utilize a multidisciplinary approach for individuals with foot ulcers and high-risk feet • Refer high risk patients to foot care specialists • Initial screening for peripheral arterial disease should include history of claudication and an assessment for pedal pulses	Patients with insensate feet, foot deformities, and ulcers should have their feet examined at every visit
10	Older Adults	• Glycemic goals for some older adults might be reasonably relaxed • Other cardiovascular risk factors should be treated in older adults with consideration of the time frame of benefit in the individual patient • Individualized screening • Adults ≥65 years of age should be considered a high-priority population for depression screening and treatment	No changes
11	Children and Adolescents	• *Individualized — tight glycemic control not recommended*	Target A1C ≤ 7.5% for all pediatric age groups; however, individualization is still encouraged
12	Management of Diabetes in Pregnancy	• Diabetes screening and diagnosis recommendations can be found in Section 2	Provide preconception counseling with emphasis on A1C goal < 7% — < 6% if this can be achieved without hypoglycemia Avoid potentially teratogenic medications in women of childbearing age GDM should be managed first with diet and exercise Women with pregestational diabetes should have a baseline ophthalmology exam in the first trimester
13	Diabetes Care in the Hospital, Nursing Home, and Skilled Nursing Facility	• Diabetes discharge planning should start at hospital admission, and clear diabetes management instructions should be provided at discharge • The sole use of sliding scale insulin in the inpatient hospital setting is strongly discouraged • All patients with diabetes admitted to the hospital should have their diabetes type clearly identified in the medical record **Glucose targets:** • Critically ill: 140-180 mg/dL • Noncritcally ill — premeal: < 140 mg/dL • Noncritically ill — random: < 180 mg/dL	No changes
14	Diabetes Advocacy	"By advocating for the rights of those with diabetes at all levels, the American Diabetes Association can help ensure that they live a healthy and productive life."	No changes

Many aspects of the Standards have remained the same; however, this document was intended to highlight the important areas of change. For additional questions, please see link below to the full text from *Diabetes Care*.

References

1. Standards of Medical Care in Diabetes—2015: Summary of Revisions. *Diabetes Care*. 2015; 38 (Supplement 1). http://care.diabetesjournals.org/content/38/Supplement_1/S4.full.pdf. Accessed February 12, 2015.