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.

<table>
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<th>Summary of 2015 Standards Revisions(^1)</th>
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| 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 |
### 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®

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### Prevention or Delay of Type 2 Diabetes

- Lifestyle modifications, pharmacologic interventions, and DSME / DSMS

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### 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

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### 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

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### 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)

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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

- 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

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

Diastolic blood pressure goal is now 90 mmHg for people with diabetes and hypertension
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| 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 education 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 |
| 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 |
| 11   | Children and Adolescents |  
- Individualized — tight glycemic control not recommended |
| 12   | Management of Diabetes in Pregnancy |  
- Diabetes screening and diagnosis recommendations can be found in Section 2 |
| 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 |
| 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." |
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**