## Standards of Care and Clinical Practice Recommendations: Type 2 Diabetes

### Recommendations At-a-Glance

| Component | Care/Test/Screening | Frequency/Which Patients  
|-----------|---------------------|--------------------------|
| **General Recommendations for Care** | Perform diabetes-focused visit  
Review care plan: assess goals/strengths/barriers  
Assess nutrition, physical activity, BMI, and growth in youth | Every 3-6 months  
Each visit, revise as needed  
Each visit |
| **Aspirin or Other Antiplatelet Therapy** | Aspirin therapy 75-162 mg/day (unless contraindicated, including increased risk of bleeding) | Prescribe if known CVD  
Consider if no known CVD but at high risk for CVD (e.g., age ≥ 50 and 1 or more risk factors for CVD) |
| **Autonomic Neuropathy** | Assess CV symptoms; resting tachycardia, exercise intolerance, orthostatic hypotension  
Assess GI symptoms; gastroparesis, constipation, diarrhea  
Assess sexual health/function for men and women | At diagnosis, then annually  
At diagnosis, then annually  
At diagnosis, then annually |
| **Behavioral Health** | Assess emotional health (e.g., depression, substance abuse) | At diagnosis, then annually |
| **Blood Pressure** | Check blood pressure  
Adult goal: <140/<90 mmHg  
Youth goal: Varies with age | Each visit |
| **DSME/S** | Clinical provider and/or diabetes educator provides individualized DSME/S | At diagnosis, then annually or more as needed |
| **Eye Care** | Retinal imaging or dilated eye exam by ophthalmologist or optometrist | At diagnosis, then annually; or as directed by eye specialist |
| **Foot Care** | Visual inspection of feet with shoes and socks off  
Perform comprehensive lower extremity/foot exam  
Screen for PAD (consider ABI) | Each visit; stress daily self-exam  
At diagnosis, then annually  
At diagnosis, then annually |
| **Glycemic Control** | Check A1C, set/review individualized goal  
Ask about medication adherence, hypoglycemia  
Review SMBG results, if prescribed | Every 3-6 months  
Each visit  
Each visit |
| **Hepatitis C Screening** | Screen for hepatitis C with a hepatitis C antibody test | At least once for persons born between 1945-1965 and anyone at higher risk |
| **Immunizations** | Hepatitis B, influenza, pneumococcal, tetanus/diphtheria, zoster | See Immunizations Standard of Care for schedules |
| **Kidney Care** | Check UACR  
Check serum creatinine and estimated GFR  
If HTN/CKD, prescribe ACE Inhibitor or ARB unless contraindicated | At diagnosis, then annually  
At diagnosis, then annually |
| **Lipid Management** | Check lipid profile  
Lifestyle therapy  
Statin therapy | At diagnosis, then annually as needed  
All patients with diabetes  
Patients with diabetes 40-75 years of age and those with CVD regardless of age |
| **Nutrition** | Provide basic nutrition education (health care team)  
Refer to RD for MNT, if available | At diagnosis, then annually or more as needed  
At diagnosis, then annually or more as needed |
| **Oral Care** | Inspection of gums/teeth  
Dental exam by dental professional | At diagnosis, then at least annually  
At diagnosis, then at least annually |
| **Preconception, Pregnancy, and Postpartum Care** | Ask about reproductive intentions/assess contraception  
Provide preconception counseling  
Screen for undiagnosed type 2 diabetes  
Screen for GDM in all women not known to have diabetes  
Screen for type 2 diabetes in women who had GDM | At diagnosis, then each visit  
3-4 months prior to conception  
At first prenatal visit  
At 24-28 weeks gestation  
At 6-12 weeks postpartum, then every 1-3 years lifelong |
| **Tobacco Use** | Assess smoking, oral tobacco use, e-cigarette use, and exposure to secondhand smoke  
For tobacco users, provide cessation counseling | Screen annually  
Each visit |

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