

## Diabetes Care

Care	Objective	Target & Goals									
Self-management	<ul style="list-style-type: none"> <li>Assess &amp; discuss self-management goals, challenges &amp; progress.</li> <li>Offer diabetes/risk management education.</li> </ul>	<ul style="list-style-type: none"> <li>Informed patient who is actively involved in care decisions.</li> <li>Development of mutually acceptable management plans.</li> </ul>									
Blood glucose control over time	Measure A1C every three months. (Note that results are now reported as percent, e.g., 7.0% formerly expressed as 0.070).	Target for most patients including those with cardiovascular disease (CVD): A1C $\leq$ 7.0%. For patients with no CVD and in whom it can safely be achieved: A1C $\leq$ 6.0%									
Blood glucose monitoring	<ul style="list-style-type: none"> <li>Reinforce patient's responsibility for regular monitoring as appropriate.</li> <li>Ensure patients can use glucose meter, interpret results &amp; modify treatment as needed.</li> <li>Develop a blood glucose-monitoring schedule with patient &amp; review records.</li> </ul>	Target for most patients: <u>Premeal:</u> 4.0 – 7.0 mmol/L <u>2h Postmeal:</u> 5.0 – 10.0 mmol/L  For patients in whom it can safely be achieved: <u>Premeal:</u> 4.0 – 6.0 mmol/L <u>2h Postmeal:</u> 5.0 – 8.0 mmol/L									
Hypoglycemia	Review episodes of hypoglycemia at every visit	Eliminate or minimize hypoglycemia									
Blood glucose meter accuracy	Verify accuracy of glucose meter annually.	Simultaneous fasting glucose meter/lab comparison within 20%.									
Blood pressure	Measure and record at diagnosis and regularly thereafter. (Refer to <i>Detection &amp; Diagnosis of Hypertension</i> )	Less than 130/80 Blood pressure control is a priority									
Lipid profile	<ul style="list-style-type: none"> <li>Measure fasting lipid profile (total cholesterol, HDL-C, LDL-C, triglycerides) every one to three years as clinically indicated.</li> </ul> <b>CHD ten year risk:</b> Use UK prospective diabetes (UKPDS) risk calculator or table provided to calculate/estimate 10-y risk of CHD available at: <a href="http://www.dtu.ox.ac.uk/riskengine/">www.dtu.ox.ac.uk/riskengine/</a>	Targets and goals must relate to calculated risk <div style="text-align: center;"> <table style="margin: auto;"> <thead> <tr> <th></th> <th style="text-align: center;">LDL-C(mmol/L)</th> <th style="text-align: center;">TC:HDL-C</th> </tr> </thead> <tbody> <tr> <td><b>High risk</b> (<math>\geq</math>20% 10 y risk)</td> <td style="text-align: center;">&lt; 2.5</td> <td style="text-align: center;">&lt; 4.0</td> </tr> <tr> <td><b>Moderate risk</b> (&lt;20% 10 y risk)</td> <td style="text-align: center;">&lt; 3.5</td> <td style="text-align: center;">&lt; 5.0</td> </tr> </tbody> </table> </div>		LDL-C(mmol/L)	TC:HDL-C	<b>High risk</b> ( $\geq$ 20% 10 y risk)	< 2.5	< 4.0	<b>Moderate risk</b> (<20% 10 y risk)	< 3.5	< 5.0
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Body mass index & waist circumference	Calculate BMI (mass in kilograms/height in metres <sup>2</sup> ). (See table on back of flow sheet.)	Healthy body weight (target BMI 18.5-24.9 kg/m <sup>2</sup> ) Waist F $\leq$ 88 cm; M $\leq$ 102 cm									
Further vascular protection	<ul style="list-style-type: none"> <li>Promote lifestyle modifications (exercise, stress reduction).</li> <li>Consider low dose ASA &amp; ACEI/ARB as clinically indicated</li> </ul>	Reduction of risk									
Exercise	Discuss & encourage aerobic resistance exercise	Aerobic: 2.5 hrs/week (50 min 3 x /wk) Resistance: 3 sessions/week									
Smoking	Encourage patient to stop at each visit; provide support as needed.	Smoking cessation <b>Helpline: 1 877 455-2233</b>									
Foot examination	Examine feet at least annually, more frequently for those at high risk. Reinforce patient's responsibility for regular self-examination.	Prevention of ulceration, infection, gangrene and amputation.									
Nephropathy	<ul style="list-style-type: none"> <li>Screen for macroscopic proteinuria &amp; non-renal disease with dipstick.</li> <li>For protein-negative dipstick patients measure albumin/creatinine ratio (ACR).</li> <li>If ACR is equivocal, repeat collection.</li> <li>Treat ACR if persistently above normal threshold</li> <li>Measure SCr (lab will report eGFR) at least annually. See <i>Identification, Evaluation and Management of Patients with Chronic Kidney Disease</i></li> </ul> Treatment may not normalize subsequent ACRs or eGFR	To detect macroscopic proteinuria & non-diabetic renal disease  ACR testing thresholds: mg/mmol Normal: < 2.0 males; < 2.8 females Equivocal: 2-20 males; 2.8-28 females Abnormal: > 20 males; > 28 females  Measure SCr at least annually. Normal eGFR $\geq$ 90									
Neuropathy check	Check annually for symptoms or findings such as peripheral anesthesia or pain, erectile dysfunction or gastrointestinal disturbance.	Early detection and treatment									
Retinopathy – eye exam	Ensure patient receives dilated pupil retinal examination at diagnosis, then every one to two years or as indicated.	Early detection and treatment									
Influenza vaccination	Annual vaccination	Prevention of influenza									
Pneumococcal vaccination	Vaccination. A single repeat vaccination is recommended if: <ul style="list-style-type: none"> <li>patient &gt; 65 <u>and</u></li> <li>previous vaccination more than 5 yrs ago</li> </ul>	Prevention of pneumococcal disease									