



# New Mexico Adult Diabetes 2020 Practice Guideline

Every visit			
Take interval history	<ul style="list-style-type: none"> <li>Review glucose log; assess frequency of hypoglycemia and awareness. Glucose goals: 80-130 mg/dL pre-meal, &lt;180 mg/dL peak post-meal for most individuals. Assess for tobacco use. Advise not to smoke; offer tobacco cessation assistance to those who smoke. Inquire about concerns related to medication costs.</li> </ul>		
Measure blood pressure	<ul style="list-style-type: none"> <li>Patient should be seated with feet flat on floor for 5 minutes before blood pressure is measured with an appropriate size cuff. An elevated reading should be confirmed by a second reading, and, if still elevated, should be confirmed on a separate day. If &gt;120/&gt;80, advise on lifestyle changes to reduce blood pressure. Patients with diabetes and hypertension should monitor blood pressure at home. See "Assess Cardiovascular Risk Factors" for blood pressure goals.</li> </ul>		
Obtain weight and counsel on weight and physical activity	<ul style="list-style-type: none"> <li>Weigh; for patients with a high level of weight-related distress, make accommodations to ensure privacy. Calculate BMI. If BMI <math>\geq 25</math> (<math>\geq 23</math> for Asian Americans), offer options to achieve 5% weight loss. Consider medical therapy as appropriate.</li> <li>Assess physical activity status regarding aerobic and resistance exercise. Tailor recommendations to individual risk factors.</li> </ul>		
Perform foot assessment	<ul style="list-style-type: none"> <li>Inspect feet of high-risk patients; educate about proper foot care.</li> </ul>		
Consult with patient and review, adjust and/or administer drug therapy	<ul style="list-style-type: none"> <li>Glucose lowering agents; metformin recommended as initial pharmacological agent for type 2 diabetes if not contraindicated.</li> <li>Consider GLP1-RA or SGLT2i with proven cardiac patients for patients with type 2 diabetes and CVD.</li> <li>Hypertension therapy with ACEI, ARB, thiazide diuretic or dihydropyridine CCB.*</li> <li>ACEI/ARB for albumin/creatinine ratio &gt;300 mg/g creatinine.</li> <li>Statin drugs as indicated (see "Assess Cardiovascular Risk Factors").</li> <li>Evaluate for ASCVD and heart failure.</li> <li>Aspirin as secondary prevention if established atherosclerotic cardiovascular disease; consider aspirin therapy for primary prevention for patients over age 50 with one or more risk factors who do not have increased bleeding risk.</li> <li>Consider use of pregabalin, duloxetine or gabapentin for patients with peripheral neuropathy.*</li> </ul>		
Assess vaccine status	<ul style="list-style-type: none"> <li>Vaccines: influenza, pneumococcal, hepatitis B (refer to current CDC guidelines**).</li> </ul>		
Quarterly to semi-annually			
Test A1C	<ul style="list-style-type: none"> <li>Measure A1C every three months or twice yearly if A1C is in goal range and stable.</li> <li>Goal should be individualized and reevaluated periodically. &lt;7% is appropriate for most adults. &lt;6.5% can be considered if achieved in a safe and affordable way without increasing risk of hypoglycemia. &lt;8% or 8.5% may be appropriate for patients with a history of hypoglycemia, limited life expectancy, advanced diabetes complications, difficulty achieving lower targets, and/or older adults with multiple comorbid conditions, cognitive impairment, or functional dependence.* Consider continuous glucose monitoring (CGM) if access to education, training and ongoing support are available. CGM metrics can be used to provide a personalized diabetes care plan.</li> </ul>		
At least once each year			
Review patient knowledge of nutrition and self-management	<ul style="list-style-type: none"> <li>Provide or refer for diabetes self-management education and support, medical nutrition therapy, encourage physical activity to reduce sedentary periods of &gt;90 minutes spent sitting, and family planning for women of reproductive age. Review glucose monitoring technique and insulin injection technique if appropriate.</li> <li>Assess barriers to achieving any treatment goals not met.</li> <li>Assess quality of life indicators (sleep, diabetes distress, anxiety, disordered eating behaviors, symptoms of depression) and perform psychosocial assessment including social determinants of health.</li> <li>Counsel on the importance of scheduling regular dental exams.</li> </ul>		
Annually			
Perform complete foot assessment	<ul style="list-style-type: none"> <li>Inspect feet, check pulses and ankle reflexes, perform vibration and pin prick testing, and conduct monofilament exam. Refer patients who smoke, have loss of protective sensation/structural abnormalities, or history of leg/foot complications to foot care specialists. Prescribe therapeutic footwear for high-risk patients.*</li> </ul>		
Perform diabetic kidney disease screening	<ul style="list-style-type: none"> <li>Assess urine albumin excretion. Normal: &lt;30 mg of albumin per gram of creatinine.</li> <li>Measure serum creatinine/e-GFR. Measure serum potassium in those taking an ACEI, ARB or diuretic.</li> <li>Measure urine albumin excretion twice yearly if &gt;30mg albumin/gm creatinine or eGFR &lt;60 mL/min/1.73 m<sup>2</sup>. If diabetic kidney disease is present, treat and monitor.</li> <li>Refer to a nephrologist to evaluate for non-diabetic kidney disease and if eGFR is &lt;30 mL/min/1.73 m<sup>2</sup>.</li> </ul>		
Assess cardiovascular risk factors (obesity/overweight, hypertension, dyslipidemia, smoking, family history of premature coronary disease, chronic kidney disease, and presence of albuminuria)	<table border="0"> <tr> <td style="vertical-align: top;"> <p><b>For patients without ASCVD:</b> Perform assessment of 10-year ASCVD risk using the American College of Cardiology/American Heart Association ASCVD risk calculator (Risk Estimator Plus).</p> </td> <td style="vertical-align: top;"> <p><b>For all patients:</b></p> <ul style="list-style-type: none"> <li>Assess food availability and motivation. Recommend lifestyle modifications (diet, exercise) for weight loss, hypertension control and lipid management*.</li> <li>Assess blood pressure control and review home blood pressure readings. Consider goal of &lt;130/&lt;80 for patients with known ASCVD and patients with an estimated 10-year ASCVD risk of &gt;15% and goal of &lt;140/&lt;90 if risk is &lt;15%. Prescribe lifestyle modifications and pharmacotherapy as above to achieve blood pressure goals.</li> <li>Obtain lipid profile yearly for those 40+ years and every 5 years for those &lt;40. Consider high-intensity statin therapy for patients with known ASCVD and statins as primary prevention for those 40-75 years.*</li> <li>Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with history of atherosclerotic cardiovascular disease.</li> </ul> </td> </tr> </table>	<p><b>For patients without ASCVD:</b> Perform assessment of 10-year ASCVD risk using the American College of Cardiology/American Heart Association ASCVD risk calculator (Risk Estimator Plus).</p>	<p><b>For all patients:</b></p> <ul style="list-style-type: none"> <li>Assess food availability and motivation. Recommend lifestyle modifications (diet, exercise) for weight loss, hypertension control and lipid management*.</li> <li>Assess blood pressure control and review home blood pressure readings. Consider goal of &lt;130/&lt;80 for patients with known ASCVD and patients with an estimated 10-year ASCVD risk of &gt;15% and goal of &lt;140/&lt;90 if risk is &lt;15%. Prescribe lifestyle modifications and pharmacotherapy as above to achieve blood pressure goals.</li> <li>Obtain lipid profile yearly for those 40+ years and every 5 years for those &lt;40. Consider high-intensity statin therapy for patients with known ASCVD and statins as primary prevention for those 40-75 years.*</li> <li>Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with history of atherosclerotic cardiovascular disease.</li> </ul>
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Arrange retinal eye exam	<ul style="list-style-type: none"> <li>Dilated retinal exam by eye care professional every 1 to 2 years if normal in the past and glucose is well controlled; yearly if any eye disease of if glucose is poorly controlled.*</li> </ul>		
Driving guideline	<ul style="list-style-type: none"> <li>Discuss the risk of driving with low blood glucose.</li> </ul>		
Consider diabetes-associated conditions	<ul style="list-style-type: none"> <li>Assess and treat for hearing impairment, obstructive sleep apnea, fatty liver disease, low testosterone in men, periodontal disease, certain cancers, fractures, cognitive impairment, depression and arthritis. Refer to specialist if indicated.</li> </ul>		

This guideline is based on recommendations of the American Diabetes Association and summarizes core care elements appropriate to most adults with diabetes. This guideline should not be construed as representing standards of care nor a substitute for individualized evaluation and treatment.

\* Detailed recommendations on this complex topic are available at [diabetes.org](http://diabetes.org). Recommendations for medications for neuropathy are found in the 2020 ADA Guideline.  
 \*\* CDC guidelines - influenza: [cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html](http://cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html); pneumococcal: [cdc.gov/vaccines/vpd/pneumo/index.html](http://cdc.gov/vaccines/vpd/pneumo/index.html); hepatitis B: [cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html](http://cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html).