Diagnosing Diabetes. Diabetes may be confirmed in the presence of one or more of the following criteria:
- \( A1C \geq 6.5 \% \)
- Fasting plasma glucose \( \geq 126 \text{ mg/dL} \)
- 2-hour plasma glucose in the 75-g OGTT \( \geq 200 \text{ mg/dL} \)
- Random plasma glucose \( \geq 200 \text{ mg/dL} \) when classic symptoms of hyperglycemia are present

Types of increased risk for diabetes. In the presence of one or more criteria below, prediabetes may be confirmed:
- Fasting plasma glucose 100 mg/dL to 125 mg/dL (impaired fasting glucose)
- 2-hour plasma glucose in the 75-g OGTT 140 mg/dL to 199 mg/dL (impaired glucose tolerance)
- \( A1C 5.7–6.4\% \) (prediabetes)

Testing for diabetes in adults who do not exhibit symptoms. Adults with a BMI of 25kg/m2 or more (23 kg/m2 or more in Asian Americans) with one or more of the following risk factors should be screened for diabetes:
- Sedentary lifestyle
- Immediate family member with diabetes
- Persons of Native American, African American, Latino, Asian American, or Pacific Islander descent
- History of gestational diabetes or delivering a baby that weighed more than 9 pounds
- Blood pressure greater than 140/90 mmHg or taking antihypertensives
- HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and/or a triglyceride level > 250 mg/dL (2.82 mmol/L)
- History of polycystic ovary syndrome
- History of prediabetes, Impaired Glucose Tolerance or Impaired Fasting Glucose
- Severe obesity or other conditions related to insulin resistance
- History of coronary artery disease

In the absence of the above risk factors, testing for diabetes should begin for all individuals who are overweight or obese. If results are normal, testing may be repeated at least at 3-year intervals, with consideration of more-frequent testing depending on initial results (those with prediabetes should be tested yearly) and risk status.
Summary of recommendations for glycemic and blood pressure control for many adults with diabetes. More stringent or less stringent goals may be appropriate for selected individual patients

- A1C < 7.0%
- Blood pressure < 140/90 mmHg

A1C testing. A1c values should be obtained at least twice a year in all individuals with diabetes.

Recommendations for hypertension/blood pressure measurement. Record blood pressure at every visit. If elevated, the blood pressure should be re-checked on another day.

Recommendations for dyslipidemia/lipid management. A lipid profile should be obtained at the time of diagnosis or initial office visit. It should be repeated at least every 5 years unless needed more frequently. Lifestyle modifications, including diet, exercise and weight management should be recommended as needed to improve the lipid profile. For patients with diabetes who have CVD, add high-intensity statin therapy. Consider statin therapy, regardless of baseline lipid levels, for diabetics < 40 years old with CVD risk factors and for all diabetics ≥ 40 years old. The recommended intensity of the statin treatment varies with risk (refer to full ADA guideline on page S63 for specific recommendations).

Recommendations for smoking cessation. Encourage diabetics to not smoke. For those who do smoke, use a combination of smoking cessation counseling and other treatment modalities to encourage cessation. E-cigarettes have not been established as a healthy alternative to smoking/tobacco use nor have they been proven as an effective smoking/tobacco cessation aid.

Recommendations for coronary artery disease (CAD) screening. In patients who do not exhibit symptoms of CAD and do not have risk factors for CAD, screening for CAD is not recommended because it is not proven to improve outcomes.

Recommendations for diabetic kidney disease screening. All patients should be screened for urine albumin excretion and estimated GFR. Individuals with type II diabetes should receive screening tests at the time of diagnosis and then yearly. Individuals with type I diabetes should receive screening tests within five years of diagnosis and then annually. Lastly, individuals with type I or type II diabetes who also have hypertension should receive screening tests at the time of diagnosis and then yearly.

Recommendations for retinopathy screening. All patients should have a dilated and comprehensive eye examination by an ophthalmologist or optometrist starting at diagnosis of type II diabetes and within five years of diagnosis of type I diabetes and at least annually thereafter. Less-frequent exams (every 2 years) may be considered following one or more normal eye exams.

Recommendations for neuropathy screening. Screen all patients annually for diabetic peripheral neuropathy (DPN) upon diagnosis of type II diabetes and no less than five years after the diagnosis of type I diabetes. Screening can be performed with simple tests such as a monofilament.

Recommendations for foot care. Annually perform a foot examination that includes inspection, evaluation of pulses, and assessment of neurologic status. This exam should be performed at every visit for those with foot deformity, impaired sensation in the feet, or foot ulcers.

General recommendations for medical nutrition therapy (MNT). Individuals who have diabetes should receive individualized MNT as needed to achieve treatment goals, preferably provided by a registered dietitian familiar with the components of diabetes MNT.

Recommendations for overweight and obesity. Assess and document body mass index (BMI) at every patient visit. Promotion of weight loss through behavior modification, increased physical activity, and a healthful eating pattern that includes a reduction of caloric intake is recommended for overweight or obese individuals who have or are at risk for diabetes.
**Recommendations for diabetes self-management education (DSME) and support (DSMS).** DSME and DSMS should be provided to people with diabetes upon diagnosis and as needed thereafter. Key outcomes of DSME and DSMS include effective self-management and quality of life. Psychosocial issues and emotional well-being should also be addressed to promote optimal outcomes.

**Recommendations for physical activity.** A minimum of 150 minutes/week of moderate-intensity exercise (50 – 70 % of maximum heart rate) is recommended for adults with diabetes. The exercise should be performed over a minimum of three days/week (no more than two consecutive days without exercise). Sedentary activity of ninety minutes or more should be interrupted with brief activity.

**Recommendations for Immunizations.** Immunize per the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) recommendations for the following vaccines:
- Influenza
- Pneumococcal
- Hepatitis B

**Recommendations for psychosocial assessment and care.** Psychological and social situation assessment should be included in the medical management for diabetes. Routinely screen for depression and condition-related distress, anxiety, eating disorders, and cognitive impairment. Psychosocial screening should also include attitudes about the condition, expectations of diabetes management and outcomes, affect and mood, quality of life, resources (financial, social, and emotional), and psychiatric history. Perform routine screening when diabetes is diagnosed, during follow-up visits and hospitalizations, when new complications are diagnosed, and when problems with diabetes control or diabetes self-management arise.