

# Type 2 Diabetes Care Guide

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CALIFORNIA CORRECTIONAL  
HEALTH CARE SERVICES

*Information contained in the Care Guide is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient.*

*Refer to "Disclaimer Regarding Care Guides" for further clarification.*

*<https://cchcs.ca.gov/clinical-resources/>*

## SUMMARY

### GOALS

#### A1C:

Target goal of <7% if can be achieved w/out significant hypoglycemia (6 - 7% recommended for patients with a life expectancy >10–15 years and no/mild microvascular complications) Target range of 7.0%–8.5% appropriate (if can be safely achieved) for most persons with micro or macrovascular complications, comorbid conditions, or life expectancy of 5–10 years GLP-1/SGLT-2 is indicated in ASCVD or high risk - independent of A1C and other med tx

#### Blood pressure: (See page 11)

- Target of ≤130/80 mmHg-patients with existing atherosclerotic cardiovascular disease [ASCVD] or 10-year ASCVD risk ≥15%
- Target of <140/90 mmHg with DM and 10- year ASCVD risk <15%

#### Lipid management: Primary Prevention (See page 13)

- **Moderate-intensity** statin therapy if age 40–75 years without ASCVD
- **High intensity** statin if at higher risk, especially those with multiple ASCVD risk factors or aged 50–70

### ALERTS

- Review and investigate hypoglycemia events at every encounter
- Glucose 15-20 g is preferred treatment for hypoglycemia (blood glucose <70 mg/dL) for the conscious individuals.
- Symptomatic patients with new diagnosis of T2D, blood glucose of > 300 mg/dL, A1C > 10% treatment with Insulin and GLP-1 should be considered (see algorithm 2, page 8)

### DIAGNOSTIC CRITERIA

Screening: US Preventative Services Task Force recommends screening all adults age 35-70 with overweight or obesity (BMI ≥25 kg/m<sup>2</sup> or ≥23 kg/m<sup>2</sup> in Asian Americans) and in those who have one or more of the following risk factors including: First-degree relative with DM, High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander), H/O CVD or HTN and others (See page 2).

Test	Pre-Diabetes	Diabetes (DM)	Gestational Diabetes
A1C	5.7 - 6.4%	≥ 6.5%	-
Fasting Plasma Glucose*	100 - 125 mg/dl	≥ 126 mg/dl	≥ 92 mg/dl 1 hr ≥ 180 mg/dl 2 hr ≥ 153 mg/dl
Random Plasma Glucose	-	≥ 200 mg/dl	-

\*In the absence of unequivocal hyperglycemia, results should be confirmed by repeat testing. Only diagnostic in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis.

### INITIAL EVALUATION

<b>History</b>	<ul style="list-style-type: none"> <li>• Complete clinical history including Cardiovascular Risk (CV) factors and 10 year CV risk calculation (See page 11)</li> <li>• End organ sequelae: Retinopathy, nephropathy, neuropathy, ASCVD, Peripheral Vascular Disease (PVD), Coronary artery disease (CAD) Cerebrovascular Disease/Accident (CVA)</li> </ul>	<ul style="list-style-type: none"> <li>• Fingerstick blood sugar (FSBS) logs</li> <li>• Symptoms of hypoglycemia</li> <li>• Patient self-management capacity</li> <li>• Medications</li> <li>• Patient concerns/compliance with medications</li> </ul>
<b>Physical Exam</b>	<ul style="list-style-type: none"> <li>• Vitals: BP and Body Mass Index (BMI) kg/m<sup>2</sup></li> <li>• Fundoscopic examination (Refer to Optometrist)</li> <li>• Cardiovascular exam, Peripheral pulses (PVD)</li> </ul>	<ul style="list-style-type: none"> <li>• Thyroid palpation</li> <li>• Skin examination/acanthosis nigricans, insulin injection/lipodystrophy</li> <li>• Comprehensive Foot Exam –annually (See Attachment 1)</li> </ul>

<b>Diagnostics</b>	<ul style="list-style-type: none"> <li>• Baseline A1C</li> <li>• Lipid panel</li> <li>• Urine Albumin to Creatinine Ratio (UACR)</li> </ul>	<ul style="list-style-type: none"> <li>• Serum creatinine (Cr) and estimated glomerular filtration rate eGFR;</li> <li>• TSH; Liver function tests; Vitamin B12 if on Metformin for ≥ 1 year</li> <li>• Serum potassium levels in patients on ACE inhibitors, ARBs or diuretics.</li> </ul>
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## TREATMENT OPTIONS

**Lifestyle** intervention consists of weight loss when indicated, a Dietary Approaches to **Hypertension (DASH)**-style (medical nutrition therapy) eating pattern, and increased physical activity (See page 10)

**Medications:** (See pages 16-21) New American Diabetes Association guidelines (2022) anchor on assessment of ASCVD risk <sup>3</sup>

- Use of insulin is de-emphasized. If insulin is used, it should be used with a GLP-1
- Patients with ASCVD conditions (CAD/**PVD/CVA**, CKD, Heart Failure) or at high risk for ASCVD; use GLP-1\* and/or SGLT-2\*\* with known CV effect
- Patients without the above ASCVD factors, glycemic medication choice is based on comorbidities, goals to minimize hypoglycemia and minimize weight gain (promote loss)

\*Glucagon-like peptide-1 receptor agonists (GLP-1 RA) (GLP-1)

\*\*Sodium-glucose co-transporter 2 inhibitors (SGLT-2 inhibitors) (SGL2)

## MONITORING

- PCP/Care Team visits as clinically appropriate
- Assess glycemic status A1C at least every 180 days in patients who are meeting treatment goals (and who have stable glycemic control)
- Assess glycemic status A1C at least every 90 days and as needed in patients whose therapy has recently changed and/or who are not meeting glycemic goals
- Utilize Dietician and available diabetes education classes for patient education