Standards of Medical Care in Diabetes—2015: Summary of Revisions

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GENERAL CHANGES

Diabetes Care Supplement 1 was previously called *Clinical Practice Recommendations* and included the "Standards of Medical Care in Diabetes" and key American Diabetes Association (ADA) position statements. The supplement has been renamed *Standards of Medical Care in Diabetes* ("Standards") and contains a single ADA position statement that provides evidence-based clinical practice recommendations for diabetes care.

Whereas the "Standards of Medical Care in Diabetes—2015" should still be viewed as a single document, it has been divided into 14 sections, each individually referenced, to highlight important topic areas and to facilitate navigation.

The supplement now includes an index to help readers find information on particular topics.

SECTION CHANGES

Although the levels of evidence for several recommendations have been updated, these changes are not included below as the clinical recommendations have remained the same. Changes in evidence level from, for example, **C** to **E** are not noted below. The "Standards of Medical Care in Diabetes—2015" contains, in addition to many minor changes that clarify recommendations or reflect new evidence, the following more substantive revisions.

Section 2. Classification and Diagnosis of Diabetes

The BMI cut point for screening overweight or obese Asian Americans for prediabetes and type 2 diabetes was changed to 23 kg/m^2 (vs. 25 kg/m^2) to reflect the evidence that this population is at an increased risk for diabetes at lower BMI levels relative to the general population.

Section 4. Foundations of Care: Education, Nutrition, Physical Activity, Smoking Cessation, Psychosocial Care, and Immunization

The physical activity section was revised to reflect evidence that all individuals, including those with diabetes, should be encouraged to limit the amount of time they spend being sedentary by breaking up extended amounts of time (>90 min) spent sitting.

Due to the increasing use of e-cigarettes, the Standards were updated to make clear that e-cigarettes are not supported as an alternative to smoking or to facilitate smoking cessation.

Immunization recommendations were revised to reflect recent Centers for Disease Control and Prevention guidelines regarding PCV13 and PPSV23 vaccinations in older adults.

Section 6. Glycemic Targets

The ADA now recommends a premeal blood glucose target of 80–130 mg/dL, rather than 70–130 mg/dL, to better reflect new data comparing actual average glucose levels with A1C targets.

To provide additional guidance on the successful implementation of continuous glucose monitoring (CGM), the Standards include new recommendations on assessing a patient's readiness for CGM and on providing ongoing CGM support.

Section 7. Approaches to Glycemic Treatment

The type 2 diabetes management algorithm was updated to reflect all of the currently available therapies for diabetes management.

Section 8. Cardiovascular Disease and Risk Management

The recommended goal for diastolic blood pressure was changed from 80 mmHg to 90 mmHg for most people with diabetes and hypertension to better reflect evidence from randomized clinical trials. Lower diastolic targets may still be appropriate for certain individuals.

Recommendations for statin treatment and lipid monitoring were revised after consideration of 2013 American College of Cardiology/American Heart Association guidelines on the treatment of blood cholesterol. Treatment initiation (and initial statin dose) is now driven primarily by risk status rather than LDL cholesterol level.

With consideration for the new statin treatment recommendations, the Standards now provide the following lipid monitoring guidance: a screening lipid profile is reasonable at diabetes diagnosis, at an initial medical evaluation and/or at age 40 years, and periodically thereafter.

Section 9. Microvascular Complications and Foot Care

To better target those at high risk for foot complications, the Standards emphasize that all patients with insensate feet, foot deformities, or a history of foot ulcers have their feet examined at every visit.

Section 11. Children and Adolescents

To reflect new evidence regarding the risks and benefits of tight glycemic control in children and adolescents with diabetes, the Standards now recommend a target A1C of <7.5% for all pediatric age-groups; however, individualization is still encouraged.

Section 12. Management of Diabetes in Pregnancy

This new section was added to the Standards to provide recommendations related to pregnancy and diabetes, including recommendations regarding preconception counseling, medications, blood glucose targets, and monitoring.