Standards of Medical Care in Diabetes—2016: Summary of Revisions

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GENERAL CHANGES

In alignment with the American Diabetes Association's (ADA's) position that diabetes does not define people, the word "diabetic" will no longer be used when referring to individuals with diabetes in the "Standards of Medical Care in Diabetes." The ADA will continue to use the term "diabetic" as an adjective for complications related to diabetes (e.g., diabetic retinopathy).

*Although 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—2016" contains, in addition to many minor changes that clarify recommendations or reflect new evidence, the following more substantive revisions.*

SECTION CHANGES

Section 1. Strategies for Improving Care

This section was revised to include recommendations on tailoring treatment to vulnerable populations with diabetes, including recommendations for those with food insecurity, cognitive dysfunction and/or mental illness, and HIV, and a discussion on disparities related to ethnicity, culture, sex, socioeconomic differences, and disparities.

Section 2. Classification and Diagnosis of Diabetes

The order and discussion of diagnostic tests (fasting plasma glucose, 2-h plasma glucose after a 75-g oral glucose tolerance test, and A1C criteria) were revised to make it clear that no one test is preferred over another for diagnosis.

To clarify the relationship between age, BMI, and risk for type 2 diabetes and prediabetes, the ADA revised the screening recommendations. The recommendation is now to test all adults beginning at age 45 years, regardless of weight.

Testing is also recommended for asymptomatic adults of *any age* who are overweight or obese and who have one or more additional risk factors for diabetes. Please refer to Section 2 for testing recommendations for gestational diabetes mellitus.

For monogenic diabetes syndromes, there is specific guidance and text on testing, diagnosing, and evaluating individuals and their family members.

Section 3. Foundations of Care and Comprehensive Medical Evaluation

Section 3 "Initial Evaluation and Diabetes Management Planning" and Section 4 "Foundations of Care: Education, Nutrition, Physical Activity, Smoking Cessation, Psychosocial Care, and Immunization" from the 2015 Standards were combined into one section for 2016 to reflect the importance of integrating medical evaluation, patient engagement, and ongoing care that highlight the importance of lifestyle and behavioral modification. The nutrition and vaccination recommendations were streamlined to focus on those aspects of care most important and most relevant to people with diabetes.

Section 4. Prevention or Delay of Type 2 Diabetes

To reflect the changing role of technology in the prevention of type 2 diabetes, a recommendation was added encouraging the use of new technology such as apps and text messaging to affect lifestyle modification to prevent diabetes.

Section 5. Glycemic Targets

Because of the growing number of older adults with insulin-dependent diabetes, the ADA added the recommendation that people who use continuous glucose monitoring and insulin pumps should have continued access after they turn 65 years of age.

Section 6. Obesity Management for the Treatment of Type 2 Diabetes

This new section, which incorporates prior recommendations related to bariatric surgery, has new recommendations related to the comprehensive assessment of weight in diabetes and to the treatment of overweight/obesity with behavior modification and pharmacotherapy.

This section also includes a new table of currently approved medications for the long-term treatment of obesity.

Section 7. Approaches to Glycemic Treatment

Bariatric surgery was removed from this section and placed in a new section entitled "Obesity Management for the Treatment of Type 2 Diabetes."

Section 8. Cardiovascular Disease and Risk Management

"Atherosclerotic cardiovascular disease" (ASCVD) has replaced the former term "cardiovascular disease" (CVD), as ASCVD is a more specific term.

A new recommendation for pharmacological treatment of older adults was added.

To reflect new evidence on ASCVD risk among women, the recommendation to consider aspirin therapy in women aged >60 years has been changed to include women aged ≥50 years. A recommendation was also added to address antiplatelet use in patients aged <50 years with multiple risk factors.

A recommendation was made to reflect new evidence that adding ezetimibe

to moderate-intensity statin provides additional cardiovascular benefits for select individuals with diabetes and should be considered.

A new table provides efficacy and dose details on high- and moderate-intensity statin therapy.

Section 9. Microvascular Complications and Foot Care

"Nephropathy" was changed to "diabetic kidney disease" to emphasize that, while nephropathy may stem from a variety of causes, attention is placed on kidney disease that is directly related to diabetes. There are several minor edits to this section. The significant ones, based on new evidence, are as follows:

Diabetic kidney disease: guidance was added on when to refer for renal replacement treatment and when to refer to physicians experienced in the care of diabetic kidney disease.

Diabetic retinopathy: guidance was added on the use of intravitreal anti-VEGF agents for the treatment of center-involved diabetic macular edema, as they were more effective than monotherapy or combination therapy with laser.

Section 10. Older Adults

The scope of this section is more comprehensive, capturing the nuances of diabetes care in the older adult population. This includes neurocognitive function, hypoglycemia, treatment goals, care in skilled nursing facilities/nursing homes, and end-of-life considerations.

Section 11. Children and Adolescents

The scope of this section is more comprehensive, capturing the nuances of diabetes care in the pediatric population. This includes new recommendations addressing diabetes self-management education and support, psychosocial issues, and treatment guidelines for type 2 diabetes in youth.

The recommendation to obtain a fasting lipid profile in children starting at age 2 years has been changed to age 10 years, based on a scientific statement on type 1 diabetes and cardiovascular disease from the American Heart Association and the ADA.

Section 12. Management of Diabetes in Pregnancy

The scope of this section is more comprehensive, providing new recommendations on pregestational diabetes, gestational diabetes mellitus, and general principles for diabetes management in pregnancy.

A new recommendation was added to highlight the importance of discussing family planning and effective contraception with women with preexisting diabetes.

A1C recommendations for pregnant women with diabetes were changed, from a recommendation of $<$6% (42 mmol/mol) to a target of 6–6.5% (42–48 mmol/mol), although depending on hypoglycemia risk the target may be tightened or relaxed.

Glyburide in gestational diabetes mellitus was deemphasized based on new data suggesting that it may be inferior to insulin and metformin.

Section 13. Diabetes Care in the Hospital

This section was revised to focus solely on diabetes care in the hospital setting. This comprehensive section addresses hospital care delivery standards, more detailed information on glycemic targets and antihyperglycemic agents, standards for special situations, and transitions from the acute care setting.

This section also includes a new table on basal and bolus dosing recommendations for continuous enteral, bolus enteral, and parenteral feedings.

Section 14. Diabetes Advocacy

"Diabetes Care in the School Setting: A Position Statement of the American Diabetes Association" was revised in 2015. This position statement was previously called "Diabetes Care in the School and Day Care Setting." The ADA intentionally separated these two populations because of the significant differences in diabetes care between the two cohorts.