

Table 2 (continued)

R 15.7	CGM may be considered under special regulatory allowance during the time of coronavirus disease 2019 (COVID-19) to reduce staff exposure and use of personal protective equipment and assist with glycemic monitoring of persons in the hospital setting. Grade C; BEL 2
R 15.8	Specialized inpatient DM teams and/or CDCES, if available, should be used to improve outcomes in hospitalized persons with DM or hyperglycemia. The use of virtual consults may be considered an alternative to support hospitals lacking these services. Grade B; BEL 1
R 15.9	For critically ill persons, IV insulin infusion is recommended to treat persistent hyperglycemia in the ICU using validated protocols that allow adjustment of insulin dose for glycemic excursions based on prespecified glucose targets. For those receiving IV insulin, POC testing should be performed every 30 to 120 min. Grade A; BEL 1
R 15.10	A glucose target of 140 to 180 mg/dL is recommended for most critically ill persons in the hospital setting. More intensive targets between 110 to 140 mg/dL may be appropriate in select populations, particularly critically ill persons postcardiothoracic or other surgeries, while minimizing the risk of hypoglycemia. Grade A; BEL 1
R 15.11	For most noncritically ill persons in the hospital setting, a glucose target of 140 to 180 mg/dL is recommended. For hospitalized persons who are able to achieve and maintain glycemic control without hypoglycemia, a lower target range (100 to 140 mg/dL) may be reasonable. For persons in a hospital setting with high clinical complexity, terminal illness, limited life expectancy, or high risk for hypoglycemia, less stringent targets are appropriate. Grade B; BEL 1
R 15.12	Insulin therapy following approved protocols is recommended as the preferred therapy for managing hyperglycemia in the hospital. For noncritically ill hospitalized persons with T2D, an individualized approach is recommended for consideration of noninsulin agents alone or in combination with insulin (see also R 15.16). Grade A; BEL 1
R 15.13	The insulin regimen for hospitalized persons with satisfactory meal intake should include basal, prandial, and correction doses. For those without adequate food intake, a regimen of basal, prandial, and correction doses should be used as necessary for glycemic control. Exclusive use of “sliding-scale” insulin should only be used for those whose glucoses are in the target range most of the time, and only occasionally exceed it. Grade A; BEL 1
R 15.14	The management of hyperglycemic emergencies, including DKA and hyperosmolar state, should include fully adequate fluid resuscitation to correct fluid deficits, electrolyte replacement (potassium), and insulin therapy. Simultaneous continued infusion of insulin and dextrose solutions after correction of hyperglycemia is often required until DKA resolves to avoid hypoglycemia. Grade A; BEL 1
R 15.15	Transition from IV insulin in the ICU to a subcutaneous insulin regimen is typically required when acidosis is resolved, and a person is no longer critically ill. A proactive regimen with scheduled subcutaneous insulin therapy, with basal, nutritional/prandial, and/or correctional doses, is recommended for most persons. Grade A; BEL 1
R 15.16	For hospitalized persons with T2D and mild admission hyperglycemia (glucose <180 mg/dL), a personalized approach is recommended for the use of noninsulin agents alone or in combination with basal insulin, aiming for the most efficacious regimen with the lowest hypoglycemic risk. For some hospitalized persons with T2D, DPP-4 inhibitors plus correction doses with rapid-acting insulin, or basal insulin plus DPP-4 inhibitors may be sufficient. Grade A; BEL 1
R 15.17	A hospital-wide standardized plan should be in place to prevent hypoglycemia. Each hypoglycemic episode should be documented, and appropriate adjustments should be made to prevent recurrence. Grade B; BEL 2
R 15.18	It is recommended to start discharge planning soon after hospital admission and to provide and document appropriate individualized plans for transition to an ambulatory setting and follow-up care at discharge for all persons with DM or newly diagnosed hyperglycemia. Grade A; BEL 1

Q 16: How should diabetes mellitus in pregnancy be managed?

R 16.1	For women with GDM, the following treatment goals are recommended: preprandial glucose concentration ≤ 95 mg/dL and either a 1-h postmeal glucose ≤ 140 mg/dL or a 2-h postmeal glucose ≤ 120 mg/dL to decrease adverse fetal outcomes. Grade C; BEL 4 and expert opinion of task force
R 16.2	All women with preexisting DM (T1D, T2D, or previous GDM) need access to preconception care and counseling to ensure adequate nutrition, healthy weight, and glucose control before conception, during pregnancy, and in the postpartum period. Grade B; BEL 2
R 16.3	Rapid-acting insulin analogs (insulin-lispro, insulin-aspart) should be used to treat postprandial hyperglycemia in pregnant women. Grade B; BEL 1
R 16.4	Options for basal insulin include long-acting insulin (eg, NPH, detemir, or glargine) or rapid-acting insulin via a CSII. Regular insulin, although not recommended as first-line therapy, is acceptable to use in managing pregnant women with DM when rapid-acting insulin analogs are not available. Grade B; BEL 1
R 16.5	Insulin is the preferred therapeutic choice for pregnant women with GDM or T2D, but metformin has been given a category B for pregnancy with accumulating clinical evidence of metformin's safety during the first trimester and beyond. Metformin has been shown to improve pregnancy and fetal outcomes except for increased rates of infants with SGA and later onset of obesity. The prescriber should discuss the potential risks and benefits of oral agent therapy during pregnancy as well as the need for longer-term outcome studies. Grade B; BEL 1

Section 4. Education and Other Topics**Q 17: What education interventions have been shown to be most effective in management of persons with diabetes mellitus?**

R 17	Comprehensive individualized DSMES is recommended at the time of DM diagnosis and subsequently as appropriate. Therapeutic lifestyle management must be discussed with all persons with DM or prediabetes at the time of diagnosis and throughout their lifetime. This includes MNT (with reduction and modification of caloric and fat intake to achieve weight loss in those who are overweight or obese), appropriately prescribed physical activity, avoidance of tobacco products, and adequate sleep quantity and quality. Additional topics commonly taught in DSMES programs outline principles of glycemia treatment options; BGM; insulin dosage adjustments; acute complications of DM; and prevention, recognition, and treatment of hypoglycemia. Grade A; BEL 1
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Q 18: What are the key nonpharmacological components of a comprehensive diabetes care plan for children and adolescents?

R 18.1	T1D and T2D in children and adolescents should be managed in close consultation with the patient and their family members, involving school and daycare personnel whenever possible. Grade B; BEL 2
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