

Care	Objective	Target
Self-monitoring of blood glucose (SMBG)	Ensure patient can use glucose meter, interpret SMBG results and modify treatment as needed. Develop an SMBG schedule with patient and review records. Inquire about hypoglycemia at each visit: estimate of cause, frequency, symptoms, recognition, severity of treatment and driving	Premeal (mmol/L) = 4.0–7.0 for most patients 2-hour postmeal (mmol/L) = 5.0–10.0 for most patients 5.0–8.0 if not achieving A1C target
Blood glucose control	Measure A1C every 3 months for most adults. Consider testing at least every 6 months in adults during periods of treatment and lifestyle stability when glycemic targets are being consistently achieved.	A1C ≤7.0% for most patients . Individualized based on life expectancy, functional dependency, extensive coronary artery disease at high risk of ischemia, multiple comorbidities, recurrent severe hypoglycemia, hypoglycemia unawareness, longstanding diabetes unable to achieve A1C ≤7% despite best efforts (including intensifying insulin)
Hypoglycemia	Enquire about hypoglycemia at each visit. Discuss recognition and treatment of hypoglycemia and risk/benefit of hypoglycemia and pharmacologic management.	Avoidance of hypoglycemia especially in the elderly, those with hypoglycemia unawareness, and those with criteria for less stringent control.
Blood glucose meter accuracy	Compare meter results with laboratory measurements at least annually , and when indicators of glycemic control do not match meter.	Simultaneous fasting glucose/meter lab comparison within 20%
Hypertension	Measure BP at diagnosis of diabetes and at every diabetes clinic visit.	<130/80 mm Hg
Waist circumference	Measure as an indicator of abdominal fat.	Central obesity defined as: WC M ≥102cm; F ≥88cm (North America)
Body mass index (BMI)	Calculate BMI (mass in kg/height in m ²)	Healthy body weight target: BMI: 18.5–24.9 kg/m²
Nutrition	Encourage nutritional therapy (by a Registered Dietician) as an integral part of treatment and self-management.	Meet nutritional needs following Canada's Food Guide
Physical activity	Discuss and encourage aerobic and resistance exercise. Evaluate those with possible CAD or microvascular complications undertaking exercise substantially more vigorous than brisk walking.	Aerobic: ≥150 minutes/week Resistance: 3 sessions/week
Smoking	Encourage patient to stop at each visit; provide support as needed	Smoking cessation
Chronic kidney disease (CKD)	Identification of CKD requires screening for proteinuria using random urine ACR (2 out of 3 samples over 3 months) and assessment of renal function using a serum creatinine converted to eGFR . Type 1 diabetes - screen at 5 years duration and then annually if no CKD. Type 2 diabetes - Screen at diagnosis and then yearly if no CKD.	Normal ACR <2.0 mg/mmol Normal eGFR >60mL/min Give patients with CKD “sick day” medication list that outlines which meds to hold during episodes of acute illness
Retinopathy	Type 1 diabetes - Screen age ≥15 and 5 years duration, then rescreen yearly. Type 2 diabetes - Screen at diagnosis then every 1–2 years if no retinopathy present. The interval for follow-up assessment should be tailored to the severity of the retinopathy. Screening should be conducted by an experienced eye care professional.	Early detection and treatment
Neuropathy/Foot Examination Using a tool such as <i>Inlow's 60-second Diabetic Foot Screen</i>	Type 1 diabetes - Screen after 5 years postpubertal duration then annually, or more frequently if high risk. Type 2 diabetes - Screen at diagnosis then annually, or more frequently if high risk. Screen for neuropathy assessing: history of current or previous foot ulcers; sensation with 10-g monofilament or 128-Hz tuning fork at dorsum of great toe; structural and biomechanical abnormalities; circulation; and self-care behaviour and knowledge.	Early detection and treatment If peripheral neuropathy present: require foot care education, specialized footwear, smoking cessation, and intensive glycemic control. If ulcer present: manage by multidisciplinary team with expertise
Coronary Vascular Disease (CCD)	Conduct CCD risk assessment periodically: CV history, lifestyle, duration of diabetes, sexual function, abdominal obesity, lipid profile, BP, reduced pulses, bruits, glycemic control, retinopathy, eGFR, ACR. Baseline ECG and every 3-5 years if: age > 40 years; > 30 years and duration of diabetes > 15 years; end organ damage; ≥ 1 CVD risk factors. Low dose ASA therapy in those with established CVD.	Vascular protection: first priority in prevention of diabetes complications is reduction of CV risk by vascular protection through a comprehensive multifaceted approach. All people with DM: optimize BP, glycemic control and lifestyle. Statin if: CVD, age ≥40 years OR macrovascular disease OR microvascular disease OR long duration of DM (DM >15 years and age >30 years). ACEi or ARB if: CVD, age ≥55years with additional CV risk factor OR EOD OR microvascular complications.
Dyslipidemia	Fasting or non-fasting lipid levels (TC, HDL, TG, calculated LDL, &/or apoB or non-HDL) at diagnosis, then repeat every 1-3 years based on CV risk. Repeat testing in 3-6 months after treatment initiation to verify if target(s) being met.	Lipid targets for those who need therapy: Primary target: LDL <2.0 mmol/L or >50% reduction Alternate primary target: apo B <0.8 g/L or non-HDL-C <2.6 mmol/L
Care objectives: People with diabetes will have better outcomes if primary healthcare providers: 1) identify patients with diabetes in their practice; 2) encourage self-management and use of interdisciplinary team approach to attain care objectives; 3) schedule diabetes-focused visits; and 4) use diabetes patient care flow sheets and systematic recall for visits.		