Who has gotten a chance to read/look through the ADA standards of care 2023?

- Extensive literature search over the past year
- Recommendations revised based on new evidence
- Professional Practice Committee
- Invited and ADA scientific review
- ADA's Board of Directors review
- Living Standards
- Funded out of ADA's general revenues
- Does not use industry support
The utility of point-of-care A1C testing for diabetes screening and diagnosis.

Point-of-care A1C testing for diabetes screening and diagnosis should be restricted to U.S. Food and Drug Administration–approved devices at laboratories proficient in performing testing of moderate complexity or higher by trained personnel.
More intensive preventative approaches

More intensive preventative approaches should be considered in individuals who are at particularly high risk of progression to diabetes:

- BMI >35 kg/m²
- Higher glucose levels (e.g., fasting plasma glucose 110–125 mg/dL, 2-h post challenge glucose 173–199 mg/dL, A1C >6.0%)
- History of GDM

Role of Pharmacotherapy

Pharmacotherapy (e.g., for weight management, minimizing the progression of hyperglycemia, CV risk reduction) may be considered to support person-centered care goals.
Statin Therapy and Diabetes Prevention

- Statin therapy may increase the risk of type 2 diabetes in people at high risk of developing type 2 diabetes.

- In such individuals, glucose status should be monitored regularly, and diabetes prevention approaches reinforced.

- It is not recommended that statins be discontinued.

Comprehensive Medical Evaluation and Assessment of Comorbidities

“Nonalcoholic Fatty Liver Disease” (NAFLD)
Themes

1. Diagnosis and Prevention
2. Weight Management
3. Cardiovascular Risk
4. The Team

Obesity and Weight Management for the Prevention and Treatment of Type 2 Diabetes

Emphasis on obesity as a disease
Consideration of small and larger weight loss goals on a case-by-case basis

PWD + overweight/obesity may benefit from modest or larger magnitudes of weight loss.

Relatively small weight loss (~3–7% of baseline weight) improves glycemia and other intermediate CV risk factors.

Larger, sustained weight losses (>10%) usually confer greater benefits, including disease-modifying effects and possible remission of T2D, and may improve long-term CV outcomes and mortality.


Pharmacologic Approaches to Glycemic Treatment

Alignment with the report on management of hyperglycemia in type 2 diabetes by the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD).
Heathy lifestyle behaviors, DSMES, SDOH

Goal: Cardiorenal risk reduction in high-risk patients with type 2 diabetes (in addition to comprehensive cardiorenal risk management)

Goal: Achievement and management of glycemic & weight management goals

Indicators of high risk + ASCVD + CHF + CKD

Glycemic management: Focus on efficacy

Achievement and maintenance of weight management

Considerations for a GLP-1 receptor agonist prior to prandial insulin
A new hypertension definition

A Hypertension is defined as a systolic blood pressure $\geq 130$ mmHg or a diastolic blood pressure $\geq 80$ mmHg based on an average of $>2$ measurements obtained on $>2$ occasions.

Individuals with blood pressure $\geq 180/110$ mmHg and cardiovascular disease could be diagnosed with hypertension at a single visit.
Blood pressure treatment goals

The on-treatment target blood pressure goal is <130/80 mmHg, if it can be safely attained.

Cindy

- 64 y/o female with T2D presents for follow-up visit. (semaglutide 1 mg weekly + dapagliflozin)
- PMH: NSTEMI (8 months ago), dyslipidemia, hypertension, obesity, CKD stage 2
- Lipid-lowering therapy: Simvastatin 40 mg qday
- Follows low-saturated fat diet and exercises at a local gym 30-45 min 3-4 x a week.
- Lipids: LDL-C 97 mg/dL, HDL-C 48 mg/dL, triglycerides 120 mg/dL, total-C 160 mg/dL.
- A1c 7.1

What is an appropriate next step?

- A. Continue current regimen
- B. Maximize statin therapy or add ezetimibe or a PCSK9 inhibitors for an LDL goal of < 70 mg /dl
- C. Maximize statin therapy or add ezetimibe or a PCSK9 inhibitors for an LDL goal of < 55 mg /dl
- D. Discontinue simvastatin and start ezetimibe
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- D. Discontinue simvastatin and start ezetimibe

Diabetes + Established Atherosclerotic Cardiovascular Disease lipids goals

High intensity statin therapy is recommended to target an LDL cholesterol reduction of >50% from baseline and an LDL cholesterol goal of < 55 mg/dl. Ezetimibe or a PCSK9 inhibitor with proven benefit in this population is recommended if this goal is not achieved on maximum tolerated statin therapy.

High-intensity statin therapy in PWD 40–75 years at higher risk

High intensity statin therapy to reduce LDL cholesterol by >50% of baseline and to target and LDL cholesterol goal of < 70 mg/dL. May be reasonable to add ezetimibe or a PCSK9 inhibitor to maximum tolerated statin therapy.
Statin therapy in those > 75 years

If already on statin therapy, it is reasonable to continue statin treatment.  

If not on statin therapy: May be reasonable to initiate moderate-intensity statin therapy after discussion of potential benefits and risks.  

SGL2Ti in individuals with type 2 diabetes and established heart failure

In people with type 2 diabetes and established heart failure with either preserved or reduced ejection fraction, a sodium–glucose cotransporter 2 inhibitor with proven benefit in this patient population.

Chronic Kidney Disease and Risk Management
The role of finerenone in T2D and CKD with albuminuria

For people with T2D + CKD + albuminuria treated with maximum tolerated doses of ACE inhibitor or angiotensin receptor blocker, addition of mineralocorticoid receptor antagonist shown to be effective in clinical trials (finerenone) is recommended to improve cardiovascular outcomes and reduce the risk of chronic kidney disease progression. A


Initiation of SGLT2i in type 2 diabetes and diabetic kidney disease

For people with type 2 diabetes and diabetic kidney disease, use of a sodium–glucose cotransporter 2 inhibitor is recommended to reduce chronic kidney disease progression and cardiovascular events in patients with an estimated glomerular filtration rate ≥ 20 mL/min/1.73 m² and urinary albumin ≥ 200 mg/g creatinine. A

SGLT2i might also be effective in a range urinary albumin of normal to 200 mg/g creatinine

For people with type 2 diabetes and diabetic kidney disease, use of a sodium–glucose cotransporter 2 inhibitor is recommended to reduce chronic kidney disease progression and cardiovascular events in patients with an estimated glomerular filtration rate ≥ 25 mL/min/1.73 m² and urinary albumin ranging from normal to 200 mg/g creatinine. B

Cardiovascular Risk Reduction in T2D with DKD

In people with type 2 diabetes and diabetic kidney disease, consider use of

- Sodium–glucose cotransporter 2 inhibitors (if estimated glomerular filtration rate is ≥ 20 mL/min/1.73 m²)
- Glucagon-like peptide 1 agonist
- Nonsteroidal mineralocorticoid receptor antagonist (if estimated glomerular filtration rate is ≥ 25 mL/min/1.73 m²) additionally for cardiovascular risk reduction.

A
The Team

Social determinants of health in the design and delivery of diabetes self-management education and support (DSMES)

The Role of Community Health Care Workers in Diabetes Care

Consider the involvement of community health workers to support the management of diabetes and cardiovascular risk factors, especially in underserved communities and health care systems.
Screening for food insecurity by all diabetes team members

Screening for food insecurity by any members of the health care team was added to the nutrition section.

Behavioral health strategies for all diabetes care members

Consider screening for sleep health in people with diabetes, including symptoms of sleep disorders, disruptions to sleep due to diabetes symptoms or management needs, and worries about sleep. Refer to sleep medicine and/or a qualified behavioral health professional as indicated.
Themes

1. Diagnosis and Prevention
2. Weight Management
3. Cardiovascular Risk
4. The Team

Standards of Care Resources

- Full version available
- Abridged version for PCPs
- Free app, with interactive tools
- Pocket cards with key figures
- Free webcast for continuing education credit
- Stay tuned for new visuals!

Professional.Diabetes.org/SOC

Glycemic Goals
More relaxed goals for those with frailty and high risk of hypoglycemia

If using ambulatory glucose profile/glucose management indicator to assess glycemia, for those with frailty or at high risk of hypoglycemia, a target of >50% time in range with < 1% time below range is recommended.

Diabetes Technology

Substances interfering with CGM accuracy

Continuous glucose monitoring device users should be educated on potential interfering substances and other factors that may affect accuracy.
CGM interfering substances

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Systems affected</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Medtronic Guardian</td>
<td>Higher sensor readings than actual glucose</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Medtronic Guardian</td>
<td>Higher sensor readings than actual glucose</td>
</tr>
<tr>
<td>Hydralazine</td>
<td>Medtronic Guardian</td>
<td>Higher sensor readings than actual glucose</td>
</tr>
<tr>
<td>Isoniazid</td>
<td>Sensormedics</td>
<td>Sensor bias within therapeutic concentration range</td>
</tr>
<tr>
<td>Metformin</td>
<td>Sensormedics</td>
<td>Sensor bias within therapeutic concentration range</td>
</tr>
<tr>
<td>Thiazide diuretics</td>
<td>Sensormedics</td>
<td>Sensor bias within therapeutic concentration range</td>
</tr>
</tbody>
</table>

Access to uninterrupted CGM supplies

In people with diabetes on multiple daily injections or continuous subcutaneous insulin infusion, real-time continuous glucose monitoring devices should be used as close to daily as possible for maximal benefit. A

Intermittently scanned continuous glucose monitoring devices should be scanned frequently, at a minimum once every 8 h. A

People with diabetes should have uninterrupted access to their supplies to minimize gaps in continuous glucose monitoring. A

Referral to nephrology

- Continuously increasing UACR and/or continuously decreasing eGFR
- If the eGFR is < 30 mL/min/1.73 m²

UACR = Urinary albumin to creatinine ratio

eGFR = estimated glomerular filtration rate