ADA STANDARDS OF CARE - 2024

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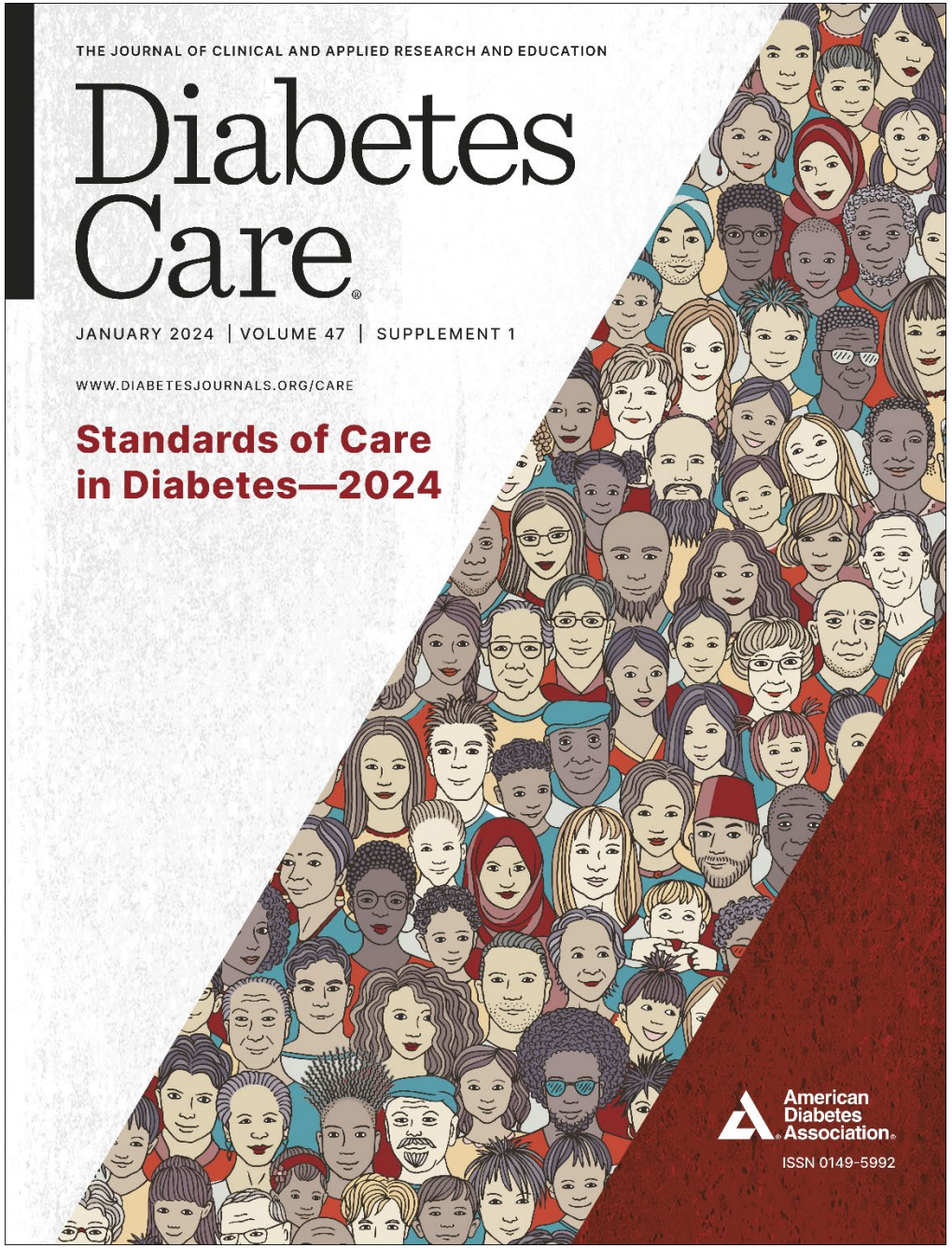
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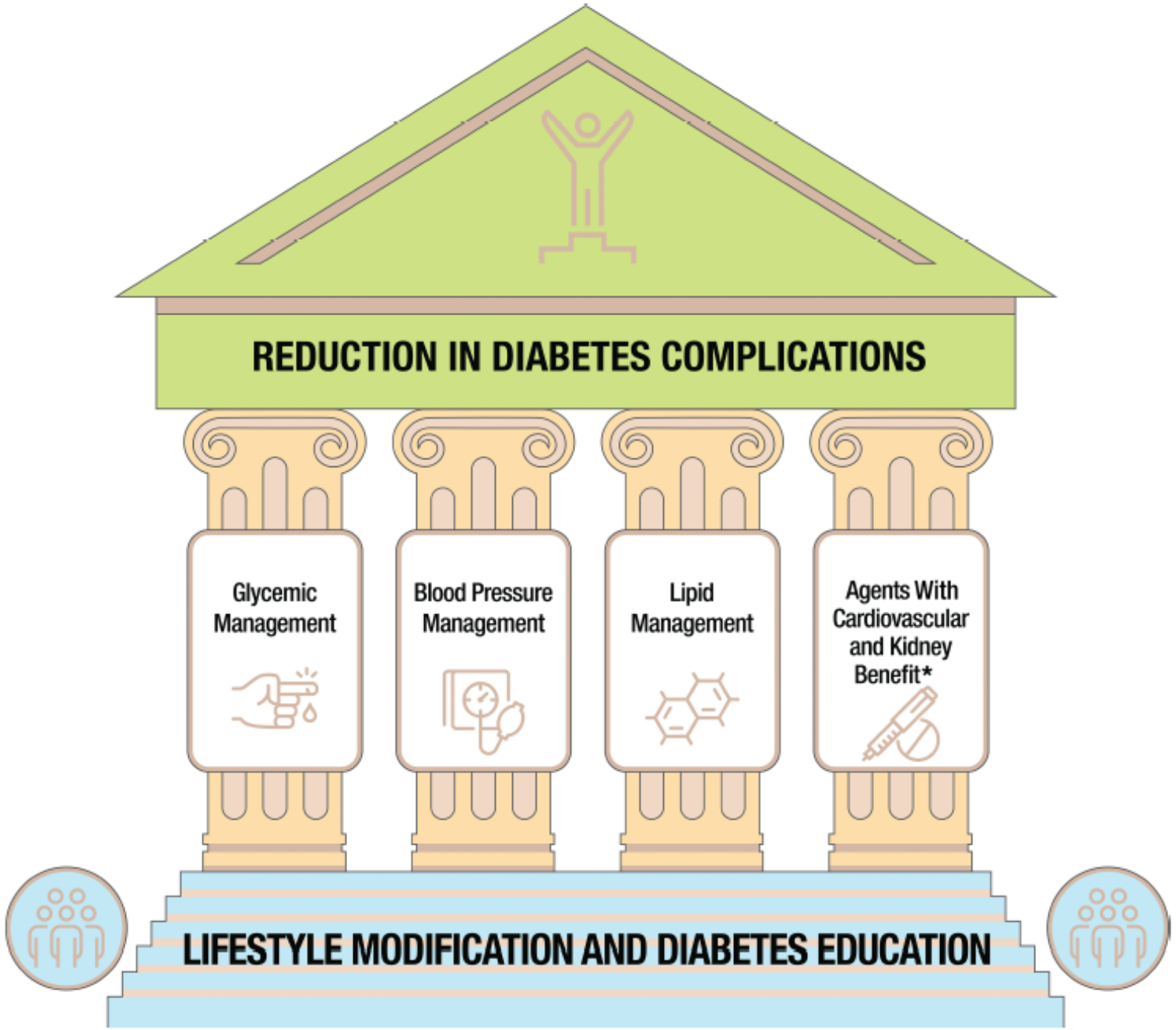

REDUCTION IN DIABETES COMPLICATIONS
Glycemic Management
Blood Pressure Management
Lipid Management
Agents With Cardiovascular and Kidney Benefit*
LIFESTYLE MODIFICATION AND DIABETES EDUCATION

Diagnostic Criteria

	Pre-Diabetes	Diabetes
Hemoglobin A1C	5.7–6.4%	≥6.5%
Fasting plasma glucose	100-125 mg/dL	≥126 mg/dL
2h-plasma glucose during OGTT	140-199 mg/dL	≥200 mg/dL
Classic symptoms+Random plasma glucose	-	≥200 mg/dL

Glycemic Goals

Table 6.3—Summary of glycemic recommendations for many nonpregnant adults with diabetes	
A1C	<7.0% (<53 mmol/mol)*†
Preprandial capillary plasma glucose	80–130 mg/dL* (4.4–7.2 mmol/L)
Peak postprandial capillary plasma glucose‡	<180 mg/dL* (<10.0 mmol/L)

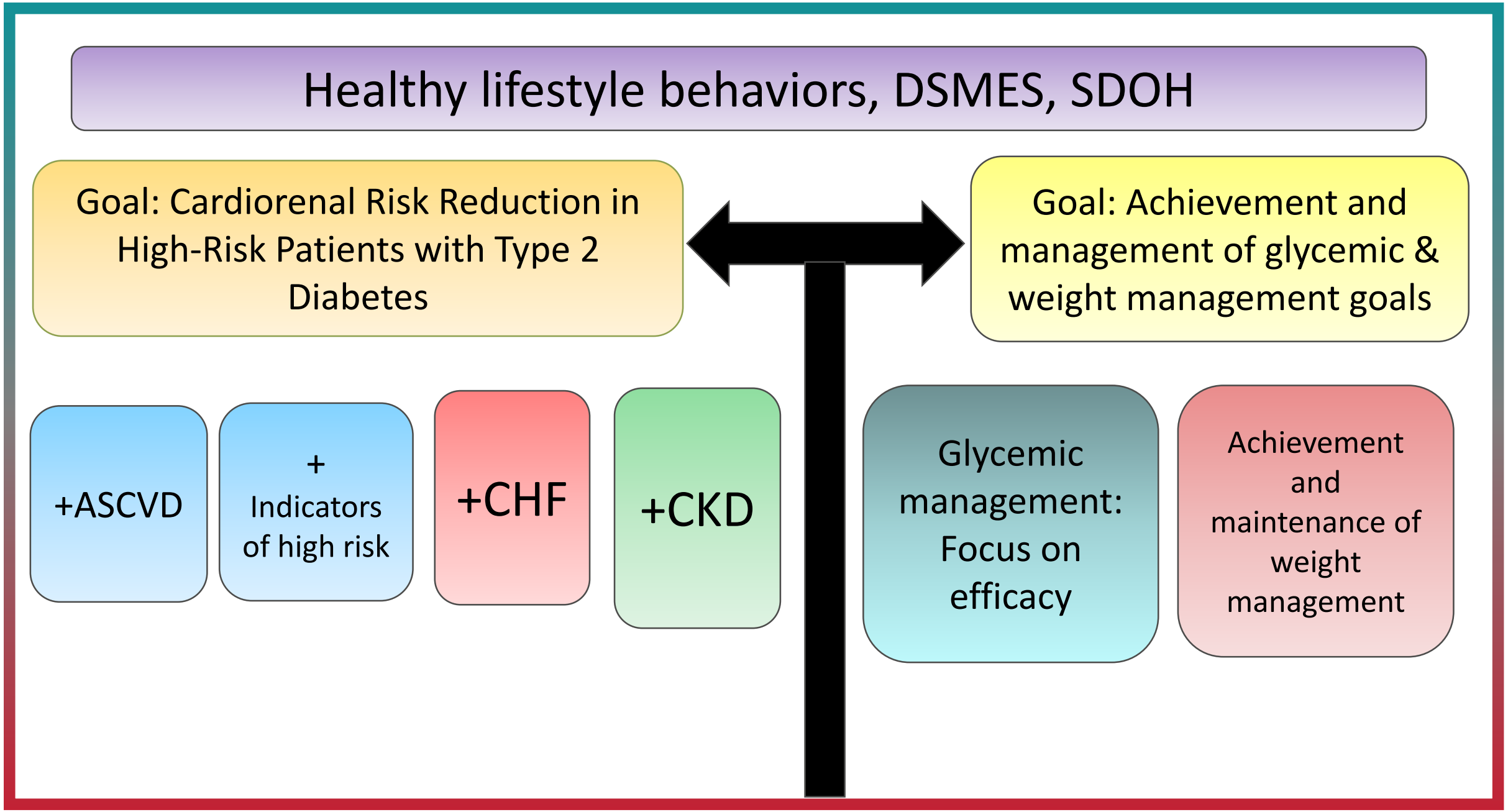
Screening

- Consider screening for prediabetes or diabetes if on certain medications such as glucocorticoids, statins, thiazide diuretics, some HIV medications, and second-generation antipsychotic medications.

- Monitor preclinical type 1 diabetes for progression:
  - HbA1C - every 6 months
  - 75-g oral glucose tolerance test - annually

Screening

- Second-generation antipsychotic medications: baseline and 12–16 weeks after medication initiation and annually.
- Acute pancreatitis: within 3–6 months and annually thereafter.
- Chronic pancreatitis: screen annually


Healthy lifestyle behaviors, DSMES, SDOH
Goal: Cardiorenal Risk Reduction in High-Risk Patients with Type 2 Diabetes
Goal: Achievement and management of glycemic & weight management goals
+ASCVD
+ Indicators of high risk
+CHF
+CKD
Glycemic management: Focus on efficacy
Achievement and maintenance of weight management

+ASCVD

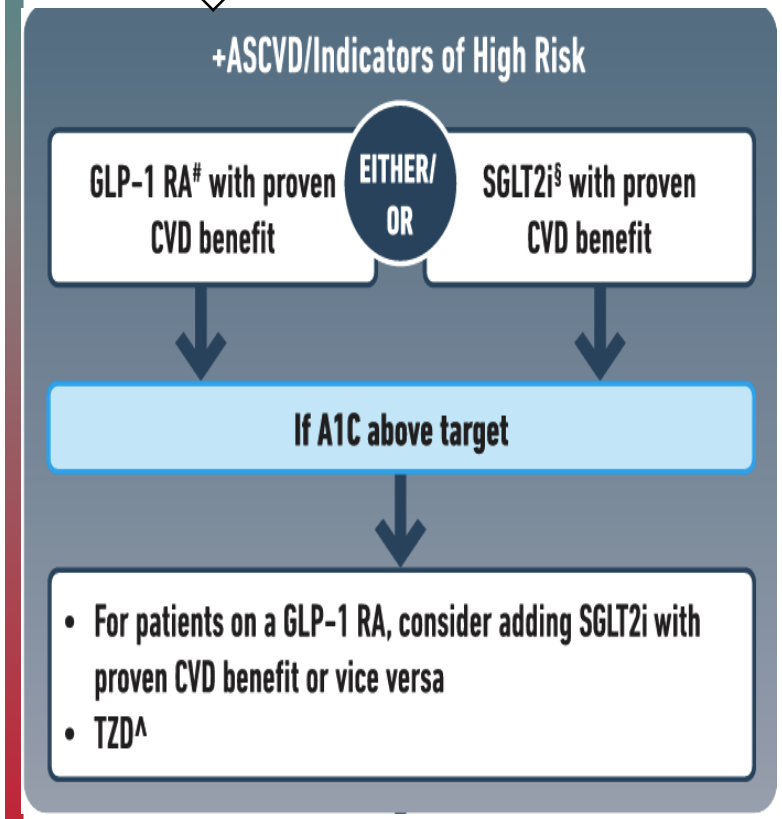
\+
Indicators of high risk

+CHF

+CKD

Glycemic management: Focus on efficacy

Achievement and maintenance of weight management



SGLT2i

Use SGLT2i in people with an eGFR ≥ 20 mL/min

----------OR----------

GLP-1 RA if SGLT2i is not tolerated or C/I

+ASCVD

+ Indicators of high risk

+CHF

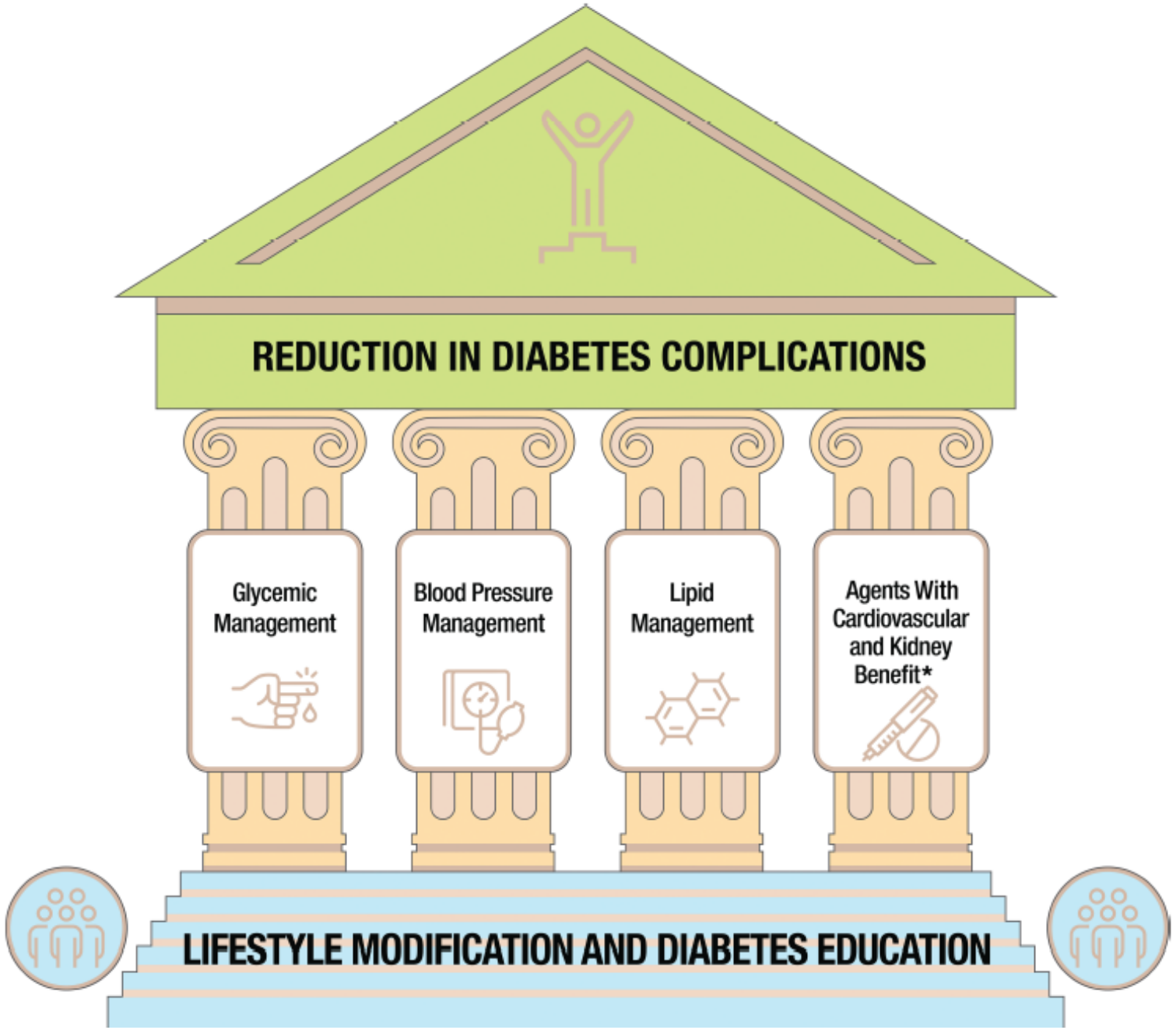
+CKD

Glycemic management: Focus on efficacy

Very High
Dulaglutide, Semaglutide, Tirzepatide,
Insulin, Combination injectable (GLP-1 RA/Insulin)
High
GLP-1 (Not listed above), MTF, SGLT-2i, SU, TZD
Intermediate
DPP-4i

Achievement and maintenance of weight management

Very High
Semglutide, Tirzepatide
High
Dulaglutide, Liraglutide
Intermediate
SGLT2i, GLP-1 RA (not listed above)
Neutral
DPP-4i, Metformin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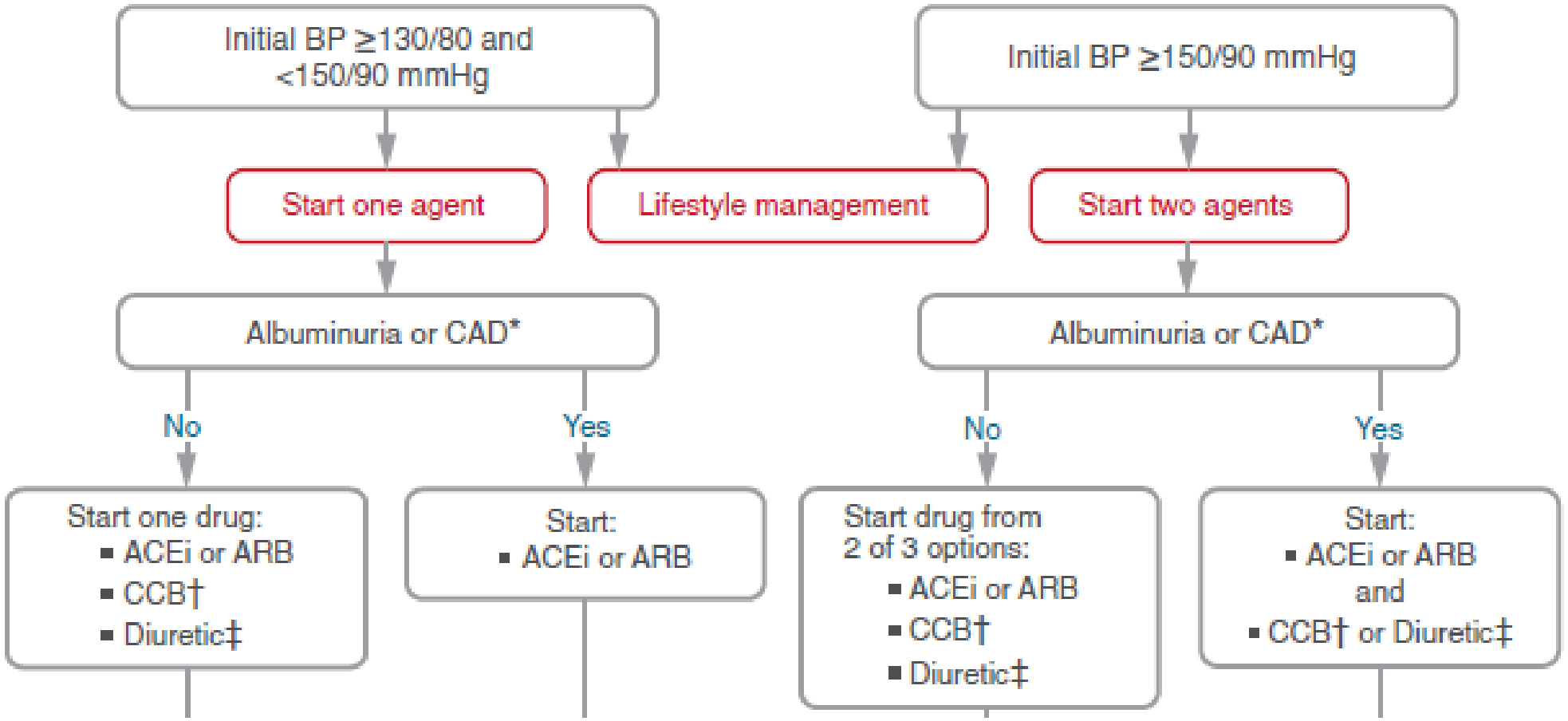
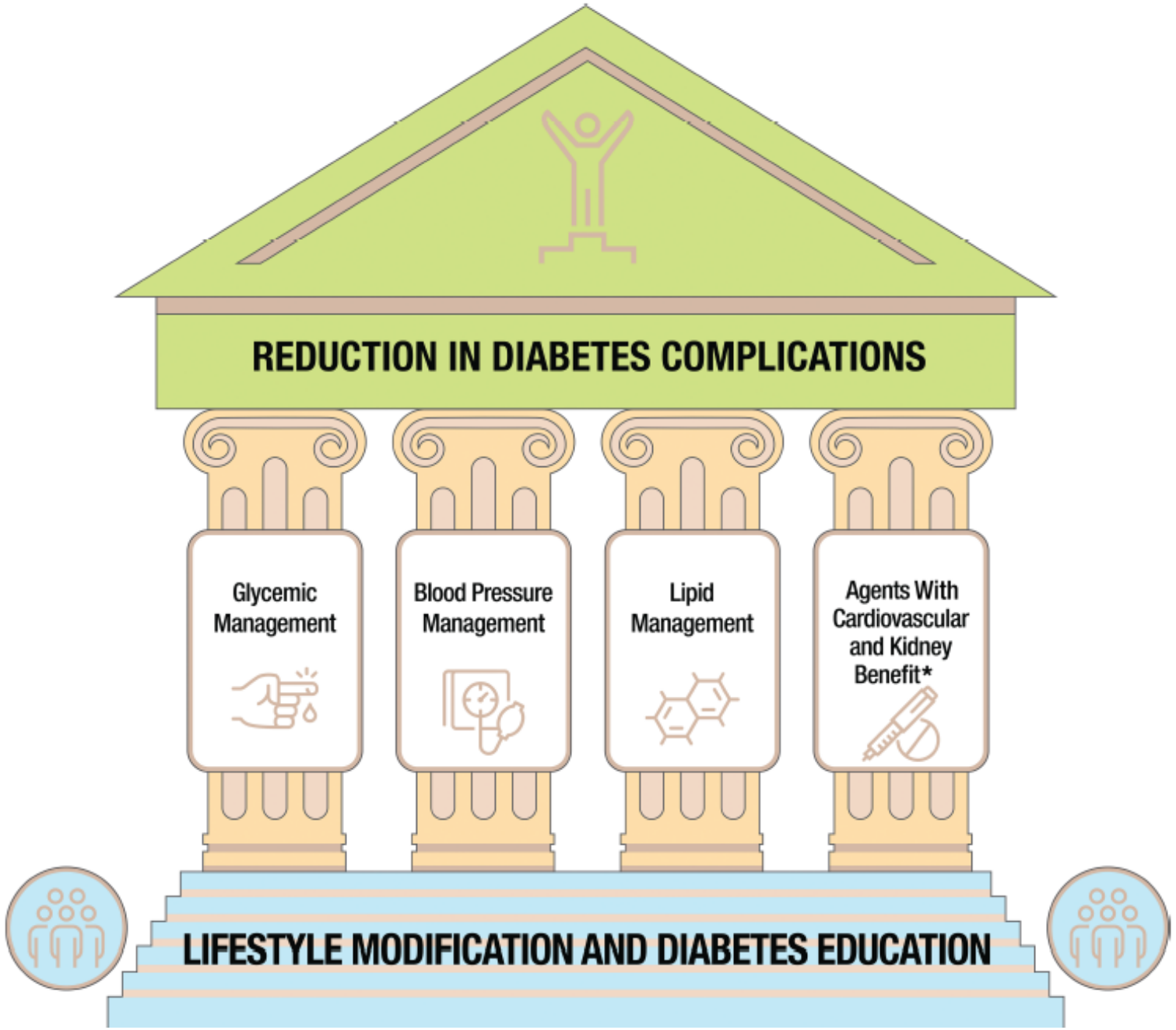
Recommendations for the Treatment of Confirmed Hypertension in Nonpregnant People With Diabetes



WELL-AHEAD

Project ECHO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Lipid Management

- Age 40-75 y + DM + high CV risk →high intensity statin to
  - 1. ↓ LDL by >50% and
  - 2. target LDL <70 mg/dL
- If not at goal, add ezetimibe or PCSK9 inhibitor to maximum tolerated statin

- Age 40-75 y + DM + CAD → high intensity statin to
  - 1. ↓ LDL by >50% and
  - 2. target LDL <55 mg/dL
- If not at goal, add ezetimibe or PCSK9 inhibitor to maximum tolerated statin

WELL-AHEAD

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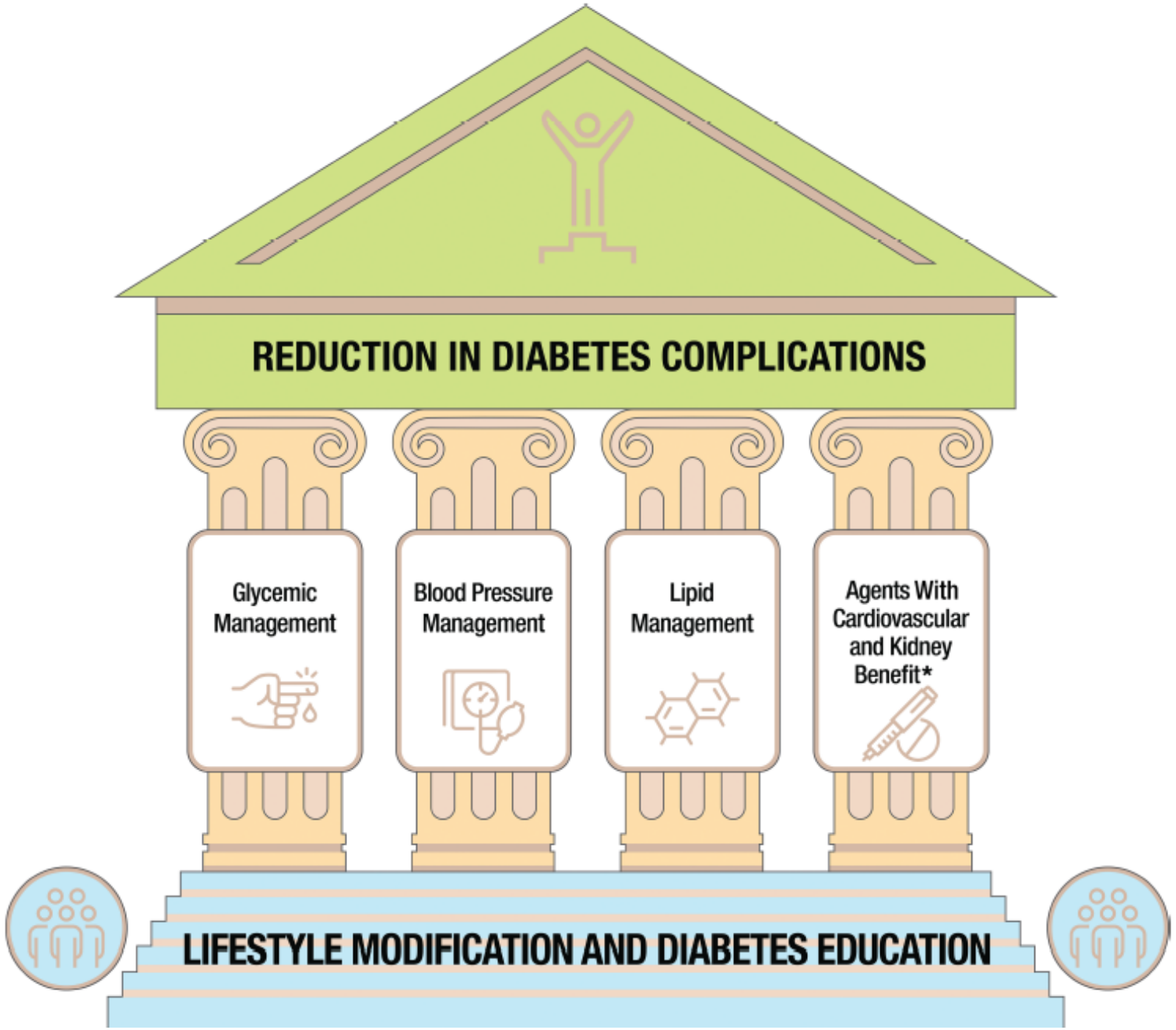
Lipid Management

- Intolerance to statin therapy: Bempedoic acid

- May not be statin intolerant: switching to another agent, starting at a lower dose or alternate day therapy regimen.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Cardiovascular Disease Screening

- Consider screening adults with diabetes with natriuretic peptide (B-type natriuretic peptide [BNP]) or N-terminal pro-BNP [NTproBNP]) to facilitate prevention of stage C heart failure.

- In asymptomatic individuals with diabetes and abnormal natriuretic peptide levels, echocardiography is recommended to identify stage B heart failure.

WELL-AHEAD

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Cardiovascular Disease Screening

- Age ≥50 y + Diabetes+ microvascular disease in any location/foot complications/end-organ damage: Screen for PAD with ankle-brachial index.

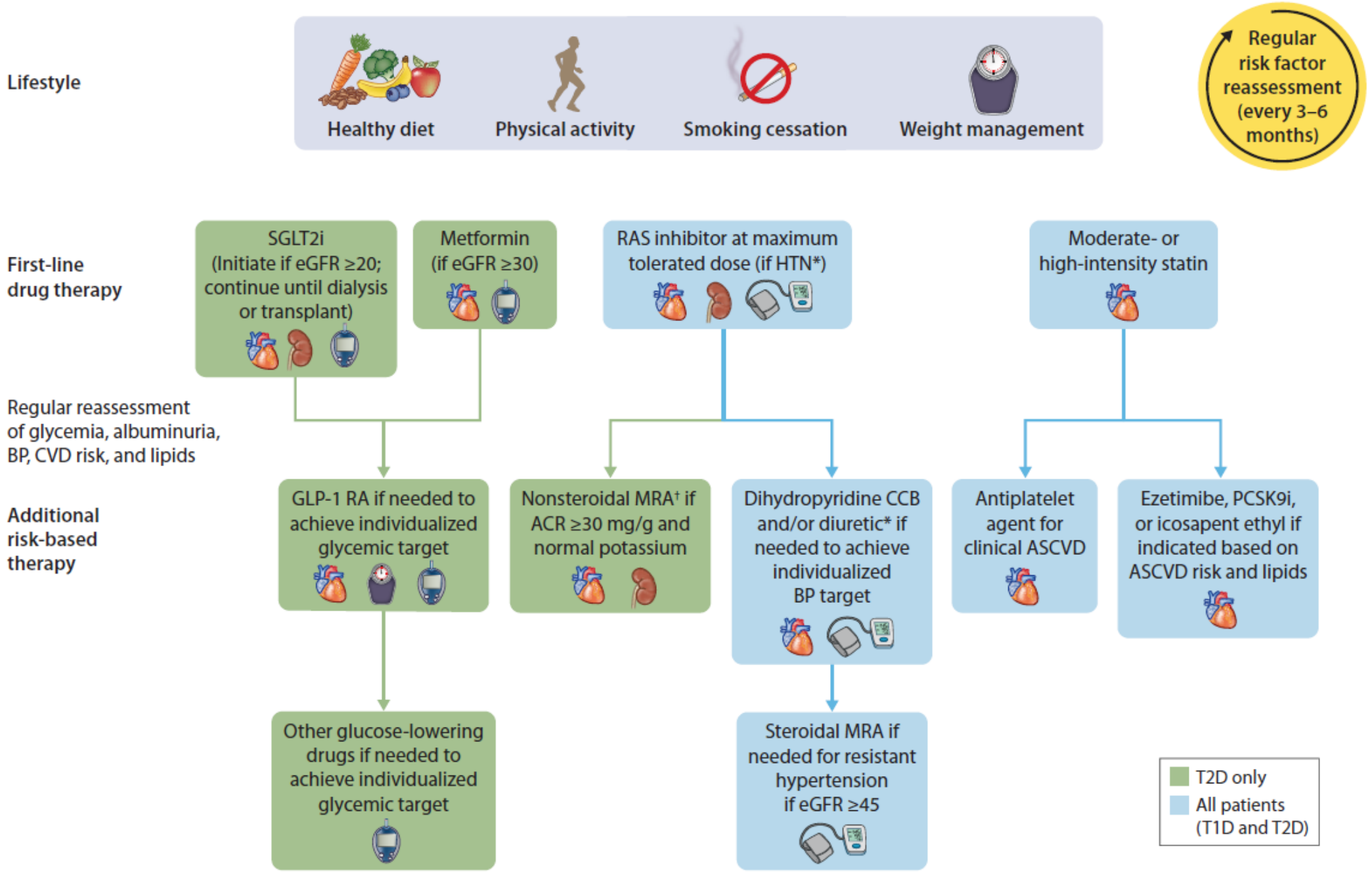
- Diabetes duration ≥ 10 years: Consider screening for PAD.

Cardiovascular disease - Treatment

- Diabetes + multiple ASCVD risk factors or established ASCVD:
  - SGLT2 inhibitor or GLP-1 receptor agonist with demonstrated cardiovascular benefit to ↓ risk of major adverse cardiovascular events.

Cardiovascular disease - Treatment

- Diabetes + heart failure with either preserved or reduced ejection fraction: SGLT2 inhibitor with proven benefit to improve symptoms, physical limitations, heart failure hospitalization and quality of life.


Lifestyle
Healthy diet
Physical activity
Smoking cessation
Weight management
Regular risk factor reassessment (every 3–6 months)
First-line drug therapy
SGLT2i (Initiate if eGFR ≥20; continue until dialysis or transplant)
Metformin (if eGFR ≥30)
RAS inhibitor at maximum tolerated dose (if HTN*)
Moderate- or high-intensity statin
Regular reassessment of glycemia, albuminuria, BP, CVD risk, and lipids
Additional risk-based therapy
GLP-1 RA if needed to achieve individualized glycemic target
Nonsteroidal MRA† if ACR ≥30 mg/g and normal potassium
Dihydropyridine CCB and/or diuretic* if needed to achieve individualized BP target
Antiplatelet agent for clinical ASCVD
Ezetimibe, PCSK9i, or icosapent ethyl if indicated based on ASCVD risk and lipids
Other glucose-lowering drugs if needed to achieve individualized glycemic target
Steroidal MRA if needed for resistant hypertension if eGFR ≥45
T2D only
All patients (T1D and T2D)

Finerenone

- For people with type 2 diabetes and chronic kidney disease with albuminuria treated with maximum tolerated doses of ACE inhibitor or ARB, addition of finerenone is recommended to improve cardiovascular outcomes and reduce the risk of chronic kidney disease progression.

Bone Health

- Fracture risk should be assessed in older adults with diabetes as a part of routine care in diabetes clinical practice, according to risk factors and comorbidities. A

Bone Health

- Monitor bone mineral density using dual-energy X-ray absorptiometry of high-risk older adults with diabetes (>65 years) and younger individuals with diabetes and multiple risk factors every 2–3 years. A

Table 4.5—General and diabetes-specific risk factors for fracture

General risk factors

- Prior osteoporotic fracture
- Age >65 years
- Low BMI
- Sex
- Malabsorption
- Recurrent falls
- Glucocorticoid use
- Family history
- Alcohol/tobacco abuse
- Rheumatoid arthritis

Diabetes-specific risk factors

- Lumbar spine or hip T-score ≤−2.0
- Frequent hypoglycemic events
- Diabetes duration >10 years
- Diabetes medications: insulin, thiazolidinediones, sulfonylurea
- A1C >8%
- Peripheral and autonomic neuropathy
- Retinopathy and nephropathy

Bone Health

- Consider potential adverse impact on bone health when selecting pharmacological options - increased fracture risk with TZDs, Insulin and SU.

- Advise on adequate calcium and vitamin D intake.

Bone Health

- Consider antiresorptive medications and osteoanabolic agents for people with diabetes who have low bone mineral density with T-score ≤ -2.0 or fragility fractures. B

Metabolic Surgery

- Consider metabolic surgery as weight and glycemic management approach in people with diabetes with BMI ≥30.0 kg/m2 (or ≥27.5 kg/m2 in Asian American individuals) who are otherwise good surgical candidates. A

Metabolic Surgery

- Monitor individuals who have undergone metabolic surgery for insufficient weight loss or weight recurrence at least every 6–12 months. E

Metabolic Surgery

- In those who have insufficient weight loss or experience weight recurrence, assess for potential predisposing factors and, if appropriate, consider additional weight loss interventions (e.g.obesity pharmacotherapy). C

Thank you!