HOLISTIC PERSON-CENTERED APPROACH TO T2DM MANAGEMENT

+CKD (on maximally tolerated dose of ACEi/ARB)

PREFERABLY

SGLT2i with primary evidence of reducing CKD progression

Use SGLT2i in people with an eGFR ≥20 mL/min per 1.73 m^2; once initiated should be continued until initiation of dialysis or transplantation

OR

GLP-1 RA with proven CVD benefit if SGLT2i not tolerated or contraindicated

If additional cardiorenal risk reduction or glycemic control needed, consider combination SGLT2/GLP-1 RA

+HF

SGLT2i with proven HF benefit in this population

+ASCVD/Indicators of High Risk

GLP-1 RA with proven CVD benefit — EITHER/OR — SGLT2i with proven CVD benefit

If additional cardiorenal risk reduction or glycemic control needed, consider combination SGLT2/GLP-1 RA

Cardiorenal Protection - choice of glucose-lowering medication

Medication for Glycemic Management

Glycemic Management: Choose approaches that provide the efficacy to achieve goals:

Metformin OR Agent(s) including COMBINATION therapy that provide adequate EFFICACY to achieve and maintain treatment goals

Consider avoidance of hypoglycemia a priority in high-risk individuals

COMPONENTS OF CARE

PRINCIPLES OF CARE

GOALS OF CARE
- Prevent complications
- Optimize quality of life

Consider local health care setting and resources
Complication surveillance and screening
Health behavior modification
Monitoring and ongoing review
Reducing risk of hypoglycemia
Effective practice and organization of care
Consider underlying physiology
Avoid therapeutic inertia
Social determinants of health
Psychosocial factors
Diabetes structured education and support
Language matters
Shared decision-making

Cardiovascular Risk Factor Management

Ensure strategies are in place to detect and optimize management of CV risk factors[1] including

- CV risk factor screening and surveillance
- BP lowering
- Lipid lowering
- Antithrombotic agents
- Smoking cessation

Weight Management

Achievement and Maintenance of Weight Management Goals:

Set individualized weight management goals

General lifestyle advice: medical nutrition therapy/eating patterns/physical activity

Intensive evidence-based structured weight management program

Consider medication for weight loss

Consider metabolic surgery

When choosing glucose-lowering therapies:

Consider regimen with high-to-very-high dual glucose and weight efficacy

Davies, MJ, et al. *Diabetes Care*. 2022;45:2753-2786

USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES

HEALTHY LIFESTYLE BEHAVIORS; DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT (DSMES); SOCIAL DETERMINANTS OF HEALTH (SDOH)

TO AVOID THERAPEUTIC INERTIA REASSESS AND MODIFY TREATMENT REGULARLY (3–6 MONTHS)

Goal: Cardiorenal Risk Reduction in High-Risk Patients with Type 2 Diabetes (in addition to comprehensive CV risk management)*

+ASCVD†

Defined differently across CVOTs but all included individuals with established CVD (e.g., MI, stroke, any revascularization procedure). Variably included: conditions such as transient ischemic attack, unstable angina, amputation, symptomatic or asymptomatic coronary artery disease.

+Indicators of high risk

While definitions vary, most comprise ≥55 years of age with two or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria)

+ASCVD/Indicators of High Risk

GLP-1 RA# with proven CVD benefit — EITHER/OR — SGLT2i§ with proven CVD benefit

If HbA_{1c} above target

- For patients on a GLP-1 RA consider adding SGLT2i with proven CVD benefit or vice versa
- TZD^

+HF

Current or prior symptoms of HF with documented HFrEF or HFpEF

+HF

SGLT2i§ with proven HF benefit in this population

+CKD

eGFR <60 mL/min per 1.73 m^2 OR albuminuria (ACR ≥3.0 mg/mmol [30mg/g]). These measurements may vary over time; thus, a repeat measure is required to document CKD.

+CKD (on maximally tolerated dose of ACEi/ARB)

PREFERABLY

SGLT2i§ with primary evidence of reducing CKD progression

Use SGLT2i in people with an eGFR ≥20 mL/min per 1.73 m^2; once initiated should be continued until initiation of dialysis or transplantation

OR

GLP-1 RA with proven CVD benefit if SGLT2i not tolerated or contraindicated

If HbA_{1c} above target, for patients on SGLT2i, consider incorporating a GLP-1 RA or vice versa

If additional cardiorenal risk reduction or glycemic lowering needed

Goal: Achievement and Maintenance of Glycemic and Weight Management Goals

Glycemic Management: Choose approaches that provide the efficacy to achieve goals:

Metformin OR Agent(s) including COMBINATION therapy that provide adequate EFFICACY to achieve and maintain treatment goals

Consider avoidance of hypoglycemia a priority in high-risk individuals

In general, higher efficacy approaches have greater likelihood of achieving glycemic goals

Efficacy for glucose lowering

Very High: Dulaglutide (high dose), Semaglutide, Tirzepatide

Insulin

Combination Oral, Combination Injectable (GLP-1 RA/Insulin)

High: GLP-1 RA (not listed above), Metformin, SGLT2i, Sulfonylurea, TZD

Intermediate: DPP-4i

Achievement and Maintenance of Weight Management Goals:

Set individualized weight management goals

- General lifestyle advice: medical nutrition therapy/eating patterns/physical activity
- Intensive evidence-based structured weight management program
- Consider medication for weight loss
- Consider metabolic surgery

When choosing glucose-lowering therapies:

Consider regimen with high-to-very-high dual glucose and weight efficacy

Efficacy for weight loss

Very High: Semaglutide, Tirzepatide

High: Dulaglutide, Liraglutide

Intermediate: GLP-1RA (not listed above), SGLT2i

Neutral: DPP-4i, Metformin

If HbA_{1c} above target

Identify barriers to goals:

- Consider DSMES referral to support self-efficacy in achievement of goals
- Consider technology (e.g., diagnostic CGM) to identify therapeutic gaps and tailor therapy
- Identify and address SDOH that impact achievement of goals

* In people with HF, CKD, established CVD or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT2i with proven benefit should be independent of background use of metformin;† A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high CV risk. Moreover, a higher absolute risk reduction and thus lower numbers needed to treat are seen at higher levels of baseline risk and should be factored into the shared decision-making process. See text for details; ^ Low-dose TZD may be better tolerated and similarly effective; § For SGLT2i, CV/renal outcomes trials demonstrate their efficacy in reducing the risk of composite MACE, CV death, all-cause mortality, MI, HHF, and renal outcomes in individuals with T2D with established/high risk of CVD; # For GLP-1 RA, CVOTs demonstrate their efficacy in reducing composite MACE, CV death, all-cause mortality, MI, stroke, and renal endpoints in individuals with T2D with established/high risk of CVD.

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