EBM GUIDELINES FOR TREATMENT OF AODM, TYPE II

P3 Health Partners Nevada
Built by Doctors. Loved by Patients.

Diagnosis:

Type 2 Diabetes (T2DM): A1c ≥ 6.5 (alternative diagnosis FBS > 125 or random glucose level >200 in patient with classic symptoms.)

Prediabetes: A1c 5.7-6.4 (alternative diagnosis FBS 100-124)

Treatment Goals:

A1c ≤ 6.5 * (Unless patient has co-morbid conditions, older age, or limited life expectancy making risk of hypoglycemia unacceptable. Adjustment in goals is then done on case-by-case basis)

Lipid * LDL < 100 and use of a statin (with co-morbid CAD, LDL <70 may be more appropriate)

Blood Pressure * BP < 140/80 and use of ACE or ARB; Systolic BP <130 if achievable without side effects. BP< 130/80 when diabetic nephropathy and proteinuria are present

Tobacco usage: * Complete cessation of all tobacco products

Monitoring: Annual checks for Nephropathy * (urine micro albumin) and screening for Retinopathy * (annual exam with eye care provider)

**** Quality measure in one or more current AzCC contracts***

Initial Treatment:

Dietary Management (Medical Nutritional Therapy) for weight loss and weight maintenance

Physical Exercise program (Minimum of 150 minutes per week of moderate intensity aerobic activity or 30 minutes a day for 5 days a week)

Diabetes Self Management Education

Medications Treatment should incorporate **Metformin** as first line treatment. The American Diabetes Association and the European Association for the Study of Diabetes currently recommend **initiating Metformin when diabetes is first diagnosed.** If patient has known cardiovascular disease, consider addition of SGLT2 Empagliflozin as well with decreased dose for lower eGFR if indicated. All patients with diabetes should be on a statin cholesterol lowering medication unless contraindicated.

Next Step Therapy:

Medication: the next two oral medications for consideration that are most cost-effective are sulfonylureas and thiazolidinedione taking into consideration their risk of hypoglycemia and weight gain respectively. There are numerous other classes

including DPP-4 inhibitors, GLP-1 receptor agonist, SGLT2 inhibitors and insulins that can be utilized based on specific patient characteristics and cost/formulary.

If A1C target not achieved after 3 months of triple therapy, consider moving to basal insulin if not on it already. If they are optimally titrated on basal insulin, consider adding GLP-1 receptor agonist or mealtime insulin.

Once on basal and mealtime insulin, maintain metformin therapy but any other agents can be discontinued on an individual basis to avoid unnecessary confusion or cost.

Monitoring with A1C should be quarterly in patients whose therapy has changed or are not to goal and then twice yearly in stable patients.

Choosing Wisely Campaign:

Do not recommend daily home self monitoring blood glucose in patients with Type 2 diabetes mellitus not using insulin. AACE, Endocrine Society and Society of General Internal Medicine all agree that "there is no benefit to self monitoring blood glucose in patients with T2DM who are not on insulin or medications associated with hypoglycemia". Self monitoring blood glucose should be reserved for patients on insulin, during the titration of their medication doses or during periods of changes in patients' diet and exercise routines.

Web Resources

American Diabetes Association	www.diabetes.org
Journey for Control	www.journeyforcontrol.com