Type 2 Diabetes Executive Summary

Approved June 27, 2024

- **Prevention:** Weight loss, healthy eating, physical activity, and smoking cessation are essential in both prevention and treatment of diabetes.
- **Prevention:** Engage patients with overweight/ obesity and high risk of T2D in key prevention strategies, including referral to a Diabetes Prevention Program (DPP).
- **Screening**: Given the high risk nature of Eastern North Carolina (ENC) populations, screen adults annually starting at age 35. Patients who are high risk should be screened annually regardless of age.

Principles of Care:

- First line of treatment includes healthy lifestyle management and metformin unless contraindicated.
- The choice of therapy depends on the patient's cardiac, cerebrovascular, and renal status. Combination therapy is usually required and should involve agents with complementary mechanisms of action.
- Comorbidities must be managed for comprehensive care, including management of lipid and BP abnormalities with appropriate therapies and treatment of other related conditions.
- The A1C target should be individualized based on numerous factors, such as age, life expectancy, comorbid conditions, duration of diabetes, and risk of hypoglycemia and adverse consequences of hypoglycemia, patient motivation, and adherence. An A1C level of ≤6.5% is optimal if it can be achieved in a safe and affordable manner, but higher targets may be appropriate and may change for a given individual over time. We endorse as a minimum standard an A1C of <9%. Minimizing the risk of both severe and non-severe hypoglycemia is a priority.
- Targets should be achieved as soon as possible, with consideration for ease of use and affordability.
- Continuous Glucose Monitoring (CGM) is recommended whenever indicated to assist patients in reaching glycemic goals safely.
- Consider referral to Diabetes Self-Management Education and Support (DSMES) program, Certified Diabetes Care and Education Specialist (CDCES), Medical Nutrition Therapy (MNT), Dietitian, Behavioral Health Professional, and/or Lifestyle Medicine Clinic.
- Annually, perform a complete medical exam including history, physical exam, supporting labs, lifestyle factors, medications and vaccinations, behavioral and diabetes self-management skills, and technology use.
- Assess Social Determinants of Health (SDOH) needs and make referrals as needed.
- When experiencing uncontrolled glucose or unexpected complications, consider referral to appropriate specialists, including endocrinologist/diabetologist, ophthalmologist/ optometrist, nephrologist, podiatrist, dentists, audiologists, and others as needed.
- Utilize effective system for care coordination for complex communication and care delivery.
- Whenever possible, connect the patient with care coordination or case management to assist with the many needs that can impact a patient's ability to engage in their care.
- Initiate goals of care and end of life discussions throughout care to empower the patient to make decisions.

Recommended Follow-Up Intervals

- For those with newly diagnosed T2D, follow up within one month of diagnosis.
- If hospitalized for diabetes, follow up within 7 days and monthly thereafter until stable.
- If A1C is >9%, follow up every 6 weeks – 2 months.
- If A1C is 7-9%, follow up every 3 months.
- Once A1C is at goal and stable, we recommend a minimum 6-month follow up for all patients for glycemic management.

We endorse as a **minimum standard an A1C level of <9%** consistent with the Coastal Plains Quality Metric, while adopting the AACE Principles of Management which state an A1C of ≤6.5% is optimal, And <7% is often appropriate per the ADA standards.