American Diabetes Association Standards of Care in Diabetes 2025

CLINICAL PRACTICE GUIDELINES ARE KEY TO IMPROVING POPULATION HEALTH

Glycemic recommendations for many nonpregnant adults with diabetes[a]

A1C <7.0%		Assess glycemic status by A1C and/or appropriate CGM metrics at least every 6 months, or every 3 months for individuals: • Not meeting treatment goals • Whose therapy has recently changed • With frequent or severe hyper- or hypoglycemia • Whose health status has changed • With growth or development in youth
FPG 80-130 mg/dL PPG[b] <180 mg/dL	TIR >70% (70-180 mg/dL)[c] TBR <4% (<70 mg/dL)[c] TAR <25% (>180 mg/dL)[c]	

Cardiometabolic risk management

Hypertension:	Measure BP at every routine clinical visit, or at least every 6 months. Initiate and titrate pharmacologic therapy for individuals with confirmed office-based BP ≥130/80 mm Hg
Dyslipidemia:	Obtain a lipid panel at diagnosis, before initiating statin therapy, 4-12 weeks after initiation, after change of dose, and annually for monitoring. Statins should be initiated with varying intensity depending on CV risk, number of ASCVD risk factors, and age in addition to lifestyle therapy
Overweight and Obesity:	Monitor anthropometric measurements at least annually, or at least every 3 months during active weight management treatment. Individualize initial treatment approaches (ie, lifestyle and nutritional therapy, pharmacologic agents, or metabolic surgery) based on the person's medical history, life circumstances, preferences, and motivation
Chronic Kidney Disease (CKD):	Assess kidney function by UACR and eGFR in all people with T2D regardless of treatment and annually thereafter,[d] or monitor 1-4 times per year in people with established CKD (stage dependent)
Smoking:	Advise all people with diabetes not to use cigarettes and other tobacco products or e-cigarettes; recommend and refer for tobacco/smoking cessation counseling and pharmacological therapy as needed

Microvascular risk management

Diabetic Retinopathy:	Dilated and comprehensive eye exam at diagnosis of T2D,[e] at least annually if retinopathy is present, more frequently if progressing or sight-threatening, and every 1-2 years if there is no evidence of retinopathy and glycemic indicators are within the goal range
Neuropathy:	All people with diabetes should be assessed for diabetic peripheral neuropathy starting at diagnosis of T2D[e] and at least annually thereafter
Foot Care:	Comprehensive foot evaluation at least annually to identify risk factors for ulcers and amputations

ASCVD=atherosclerotic cardiovascular disease; BMI=body mass index; BP=blood pressure; CGM=continuous glucose monitoring;

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: CV and Kidney Risk Reduction in High-Risk Individuals with Type 2 Diabetes*

+ASCVD†

+Indicators of high CVD risk

+HF

Current or prior symptoms of HF with documented HFrEF or HFpEF

+CKD

eGFR <60 mL/min per 1.73 m² OR albuminuria (ACR ≥30 mg/g). Repeat measurement is required to confirm CKD

+ASCVD/indicators of high CVD risk‡

GLP-1 RA[a] with proven CVD benefit **OR** SGLT-2i[b] with proven CVD benefit

If A1C is above goal

- For individuals on a GLP-1 RA, consider adding SGLT-2i with proven CVD benefit or vice versa
- TZD[c]

SGLT-2i [b]

with proven HF benefit in this population

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

SGLT-2i[b] with primary evidence of reducing CKD progression

- SGLT-2i can be started with eGFR ≥20 mL/min per 1.73 m²
- Continue until initiation of dialysis or transplantation
- Glucose-lowering efficacy is reduced with eGFR <45mL/min/1.73 m²

OR

GLP-1 RA[a] with proven CKD benefit

If A1C above goal, for individuals on SGLT-2i, consider incorporating a GLP-1 RA or vice versa

If additional CV and kidney risk reduction, management of other metabolic comorbidities, and/or glycemic lowering is needed

+Mitigating risk of MASLD or MASH

Goal: Achievement and Maintenance of Weight and Glycemic Goals

+Weight management

Efficacy for weight loss

Very high: Specific GLP-1 RA, dual GIP and GLP-1 RA

High: Specific GLP-1 RAs

Intermediate: GLP-1 RA (other than above), SGLT-2i

Neutral: Metformin, DPP-4i

+Achievement and maintenance of glycemic goals

Metformin or other agent (including combination therapy) that provides adequate EFFICACY to achieve and maintain glycemic treatment goals

Prioritize avoidance of hypoglycemia in high-risk individuals

Efficacy for glucose lowering

Very high: Specific GLP-1 RAs, dual GIP and GLP-1 RA, insulin Combination oral, combination injectable (GLP-1 RA and insulin)

High: GLP-1 RA (other than above), metformin, TZD, SGLT-2i, sulfonylurea

Intermediate: DPP-4i

If A1C is above goal or significant hypoglycemia or hyperglycemia or barriers to care are identified

- **Refer to DSMES to support self-efficacy in achievement of treatment goals**
- **Consider technology (eg, diagnostic or personal CGM) to identify therapeutic gaps and tailor therapy**
- **Identify and address SDOH that impact achievement of treatment goals**

Please see full algorithm for more information.

*In people with HF, CKD, established CVD, or multiple risk factors for CVD, the decision to use a GLP-1 RA or SGLT-2i with proven benefit (label indication) should be made irrespective of background use of metformin or A1C.

†ASCVD: defined differently across CVOTs but all included individuals with established CVD (eg, MI, stroke, arterial revascularization procedure) and variably included conditions such as TIA, unstable angina, amputation, and symptomatic or asymptomatic CAD. Indicators of high risk: while definitions vary, most comprise ≥ 55 years of age with 2 or more additional risk factors (including obesity, hypertension, smoking, dyslipidemia, or albuminuria). ‡A strong recommendation is warranted for people with CVD and a weaker recommendation for those with indicators of high-risk CVD. §For GLP-1 RA, CVOTs demonstrate their efficacy in real-world composite [illegible]

ACEi=angiotensin-converting enzyme inhibitor; **ACR**=albumin/creatinine ratio; **ARB**=angiotensin receptor blocker; **ASCVD**=atherosclerotic cardiovascular disease; **CAD**=coronary artery disease; **CGM**=continuous glucose monitoring; **CKD**=chronic kidney disease; **CVD**=cardiovascular disease; **CVOT**=cardiovascular outcomes trial; **DPP-4i**=dipeptidyl peptidase 4 inhibitor; **eGFR**=estimated glomerular filtration rate; **GIP**=glucose-dependent insulinotropic polypeptide; **GLP-1 RA**=glucagon-like peptide-1 receptor agonist; **HF**=heart failure; **HFpEF**=HF [illegible]; **HFrEF**=HF with reduced ejection fraction; **HHF**=hospitalization for HF


Improving
Medication-Taking
Behaviors

What are the greatest challenges

that exist with your patients with type 2 diabetes?

- ABCs goals
- Medication taking
- Cardiovascular disease
- Hypoglycemia
- Overweight or obesity

novo nordisk®

Impact of Medication Taking on Treatment Outcomes

novo nordisk®

Medication taking is a critical aspect of type 2 diabetes management

- **For medications to work, people must take them as prescribed or instructed[1]**
- **The full benefits of medications are often not realized if the regimen is not followed as directed[2]**
- **Improving medication taking behavior can have a greater impact on individual outcomes than a specific medication alone[2]**

1. Food and Drug Administration. Accessed March 21, 2023. https://www.fda.gov/drugs/special-features/why-you-need-take-your-medications-prescribed-or-instructed. **2.** Brown MT, Bussell JK. *Mayo Clin Proc.* 2011;86(4):304-314.

novo nordisk®

What warning signs or predictors of poor medication taking do you see in your patients?

What do you do when you see these signs?

novo nordisk®

Strategies for Promoting Medication Adherence

novo nordisk®

What do you hear from your patients

about why they don't take their medications?

novo nordisk®

Financial limitations

~2.3x higher
medical expenditures for people with diabetes[1]

What you can ask

"Can we talk about how your diabetes medicines are fitting into your budget?"

"How often have you taken less medicine to try and make it last longer?"

What you can do

- **Check formulary status before prescribing**
- **Ensure patients receive copay cards, if applicable**
- **Discuss how high-deductible plans may not be optimal[2]**
- **Direct individuals to get more information on patient assistance programs**

1. American Diabetes Association. Accessed March 21, 2023. https://www.diabetes.org/resources/statistics/cost-diabetes. **2.** Health Affairs. Accessed March 21, 2023. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=152.

novo nordisk®

Remember to take or obtain medication

Almost ⅓ forget to take medications[1,a]

What you can ask

"How many times in a given week do you miss taking your medicines?

"What has helped you remember to take medicines in the past?"

"May I tell you what others have tried?"

What you can do

Help patients set up prompts and cues[2]

Refill reminders or sticky notes

Suggest to anchor to existing routine[3,4]

For daily medications: take in the morning, when possible, since mornings may have a stronger routine

For weekly medications: associate with weekly activities (recycle day or religious service)

[a]In response to a questionnaire.

1. Brown MT et al. *Am J Med Sci.* 2016;351(4):387-399. **2.** Michie S et al. *Ann Behav Med.* 2013;46(1):81-95. **3.** Dang DK. *Drug Topics.* July 2015:1-11. **4.** Walker EA et al. *Diabetes Care.* 2006;29(9):1997-2002.

novo nordisk®

Depression

Up to ⅓ of people with diabetes will suffer from major depression at some point[1,a]

What you can ask

"How do you feel about managing your diabetes?"

"How has your diabetes management affected your day-to-day life?"

What you can do

- **Utilize age-appropriate screening measures[2,3]**
  - WHO-5 Well Being Index
  - Problem Areas in Diabetes (PAID) scale
- **Further evaluation will be necessary for individuals who have a positive screen[4]**

[a]In a meta-analysis of 42 studies that had a combined sample size of 21,351 subjects. WHO=World Health Organization. **1.** Anderson RJ et al. *Diabetes Care.* 2001;24(6):1069-1078. **2.** WHO-5 Questionnaire. Accessed March 21, 2023. **3.** Lee EH et al. *Health Qual Life Outcomes.* 2014;12:142. **4.** American Diabetes Association. *Diabetes Care.* 2023;46(suppl 1):S1-S291.

novo nordisk®

Medication side effects

Adverse effects that may contribute to diminished medication-taking behavior[1]:

- Hypoglycemia
- Gastrointestinal (GI) effects
- Weight gain

What you can ask

"Tell me about the last episode of low blood glucose you may have experienced?"

"What concerns do you have about your current diabetes medicines?"

What you can do

- **Consider hypoglycemia risk when selecting medications[2]**
- **Provide guidance on dietary modifications to help mitigate GI side effects[2]**
- **Consider regimen with dual glucose and weight efficacy**

1. Khunti N et al. *Br J Diabetes*. 2019;19(2):99-104. **2.** American Diabetes Association. *Diabetes Care.* 2023;46(suppl 1):S1-S291.

novo nordisk®

Practice process limitations

On average, a physician spends

49 seconds

with a patient

discussing all aspects of a newly prescribed medication[1,a]

Patients forget 40% to 80%

of what they hear in the exam room, and

½ of what they hear is misunderstood[2]

What you can do[3,4]

- **Incorporate team-based care**
- **Provide patient education**
- **Offer plain-language handouts**
- **Utilize the teach-back method**

[a]In a study that reported on patient interactions during primary care visits for 181 patients. **1.** Tarn DM et al. *Patient Ed Counsel.* 2008;72:311-319. **2.** Kessels RPC. *J R Soc Med.* 2003;96:219-222. **3.** American Diabetes Association. *Diabetes Care.* 2023;46(suppl 1):S1-S291. **4.** Capgemini. Accessed March 21, 2023. https://www.capgemini.com/pt-en/wp-content/uploads/sites/20/2017/07/Patient_Adherence__The_Next_Frontier_in_Patient_Care.pdf.

novo nordisk®

Addressing the need for follow-up and support

At diagnosis, HCP explains to the patient that diabetes changes over time and so will the need for medication

Health care provider:
- Assess labs and blood glucose log/app
- Utilize shared decision making
- Write prescription, if necessary (e-prescribe if available)

Staff directed follow up:
- Call to address medication and possible side effects
- Call reminders for next appointment

Health care provider*:
- Assess labs and blood glucose log/app
- Adjust medication, if needed
- Provide resources to address medication-taking behavior

DIAGNOSIS | ONGOING MANAGEMENT | NEXT APPOINTMENT

Staff support:
- Medication information
- Injection techniques
- Appointment details
- Affordability information

Pharmacy support:
- Review important information

Refer support as needed:
- CDCES referral
- MTM
- Care coordinators
- Case managers
- Patient support groups

Staff support:
- Medication reconciliation
- Alert HCP if medication-taking issue

CDCES=Certified Diabetes Care and Education Specialist; **HCP**=health care professional; **MTM**=medication therapy management.
*Depression screening as appropriate. Brown MT, Bussell JK. *Mayo Clin Proc.* 2011;86(4):304-314.

novo nordisk®

Questions

[Diabetes Education & Resource Library | NovoCare® Diabetes Education]

NovoCare® Home Products Help with costs Insurance information Diabetes education Resources | novo nordisk

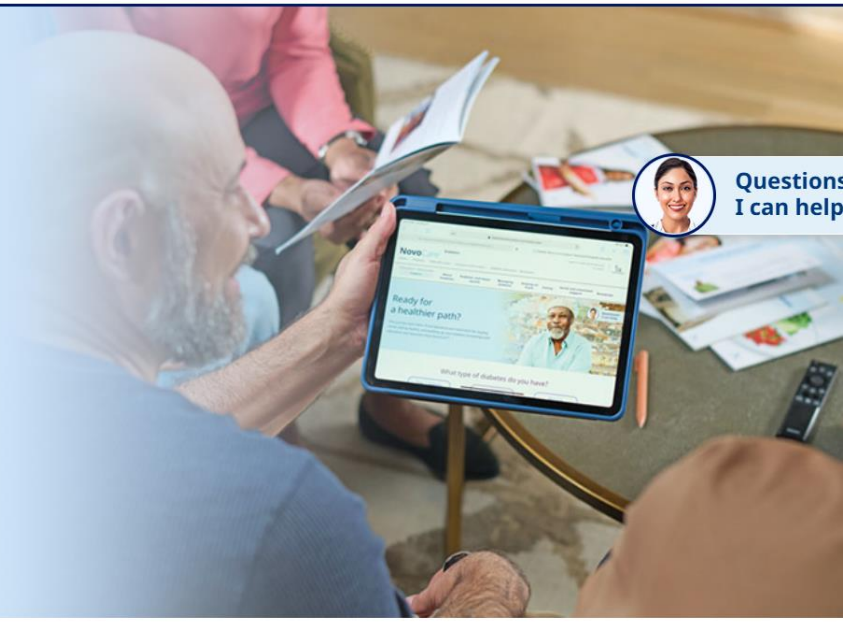
Education + Resources
DIABETES

About Diabetes | Diabetes and Heart Health | Managing diabetes | Staying on track | Eating | Social and emotional support | Resources

RESOURCES

NovoCare® diabetes **education library**

Looking for something specific?
Explore articles about type 1 and type 2 diabetes.



Looking for diabetes resources in other languages? Please use the filter below.

[Airtable - Grid View MCT2D Dot Phrase Library]