Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

January 18, 2018

TODAY'S SPEAKERS

John W. Kennedy, M.D.

President, AMGA Foundation
Chief Medical Officer, AMGA

Andrea L. Cherrington, M.D., M.P.H.

Associate Professor at the Nutrition
Obesity Research Center at
University of Alabama Birmingham

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UPCOMING DATES

- **January 19**: AMGA's Annual Conference early bird registration deadline

  www.amga.org/ac18

- **January 31:** Deadline to apply for the Johnson & Johnson CORE Program
- **February 15:** Monthly campaign webinar on Geisinger's Fresh Food Pharmacy program
- **March 7-10:** AMGA 2018 Annual Conference in Phoenix, AZ

Together2Goal®

TOGETHER 2 GOAL® 2018 WEBINAR SCHEDULE

WEBINARS WILL BE HELD FROM 2-3 P.M. EASTERN

Date	Topic	Presenter(s)
Jan. 18, 2018	**American Diabetes Association (ADA) 2018 Standards of Care**	Andrea L. Cherrington, M.D., M.P.H. (University of Alabama, Birmingham)
Feb. 15, 2018	**An Rx for Good Health: Geisinger's Fresh Food Pharmacy**	Andrea Feinberg, M.D. (Geisinger)
March 15, 2018	**Addressing Health Disparities in Latino Populations with Diabetes**	David Marrero, Ph.D. (University of Arizona)
April 19, 2018	**The Role of the Nurse in Diabetes Care**	Sentara Medical Group
May 17, 2018	**Succeeding in the Together 2 Goal® Bundle**	AMGA Analytics
June 21, 2018	**Blood Pressure Control for Patients with Diabetes**	Robert Matthews (PriMed Physicians)
July 19, 2018	**Shared Medical Appointments for Diabetes Care**	Marianne Sumego, M.D. (Cleveland Clinic)
Aug. 16, 2018	**Diabetes and Obesity**	Timothy Garvey, M.D. (University of Alabama, Birmingham)
Sept. 20, 2018	**Removing Patient Barriers to Medication Adherence**	Molly Ekstrand, RPh, BCACP, AE-C (Park Nicollet HealthPartners Care Group)
Oct. 18, 2018	**Diabetes and Mental Health**	Joanne Rinker, M.S. (American Associate of Diabetes Educators) and Jasmine D. Gonzalvo, PharmD (Purdue University, Eskenazi Health)
Nov. 15, 2018	**How to Succeed in Your Diabetes Prevention Program (DPP)**	Tony Hampton, M.D. (Advocate Medical Group)
Dec. 13, 2018	**The Together 2 Goal® Innovator Track**	Together 2 Goal® Innovator Track Participants

Join AMGA March 7-10 in Phoenix!

Shared Learning

Real-world case studies and insights, led by AMGA member groups

Inspiring Keynotes

Featuring burnout expert Abraham Verghese, disruption guru Jonah Berger, former Congresswoman Gabby Giffords, and astronaut Mark Kelly

Networking

15+ hours of free-flowing conversations and structured networking events

Early bird registration deadline is Jan. 19!

Learn more about our Annual Conference and register at: amga.org/ac18

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National Diabetes Campaign

Monthly Campaign Webinar

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INTRODUCTION

John W. Kennedy, M.D.
Chief Medical Officer, AMGA
President, AMGA Foundation

Together2Goal®

TODAY'S WEBINAR

- Together 2 Goal® Updates
  - Webinar Reminders
  - Together 2 Goal® Campaign Impact
  - Together 2 Goal® January Resource of the Month: CORE Program
- American Diabetes Association 2018 Standards of Care
  - Andrea L. Cherrington, M.D., M.P.H.
- Q&A
  - Use Q&A or chat feature

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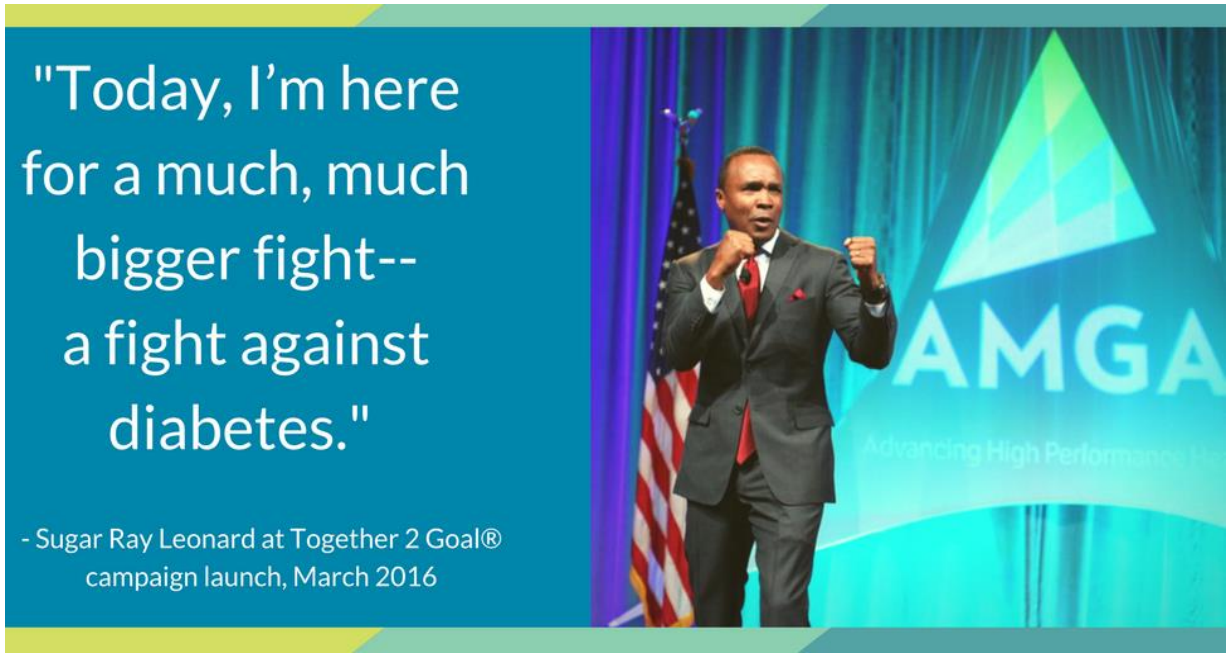
WEBINAR REMINDERS

- Webinar will be recorded today and available the week of January 22nd
  - www.Together2Goal.org
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

Together2Goal®

TOGETHER 2 GOAL®

Our Goal:
Improve care for 1 million people with Type 2 diabetes by 2019



Together 2 Goal®

TOGETHER 2 GOAL® CAMPAIGN IMPACT

- **150** groups in **35** states
- **61,000** FTE physicians
- **2.0 million** patients with Type 2 diabetes
- Over **600,000** lives improved

Together 2 Goal®

NATIONAL DAY OF ACTION RESULTS

Together, we took more than 240,000 actions that reached more than 2 million people!

Together2Goal®

TOGETHER 2 GOAL JANUARY RESOURCE OF THE MONTH: JOHNSON & JOHNSON CORE PROGRAM

- Free all-day diabetes training for up to 40 staff at your organization
- Application is on the T2G website under the "Improve Patient Outcomes" tab and is due January 31, 2018

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TODAY'S FEATURED PRESENTER

Andrea L. Cherrington, M.D., M.P.H.

Associate Professor at the Nutrition
Obesity Research Center at
University of Alabama Birmingham

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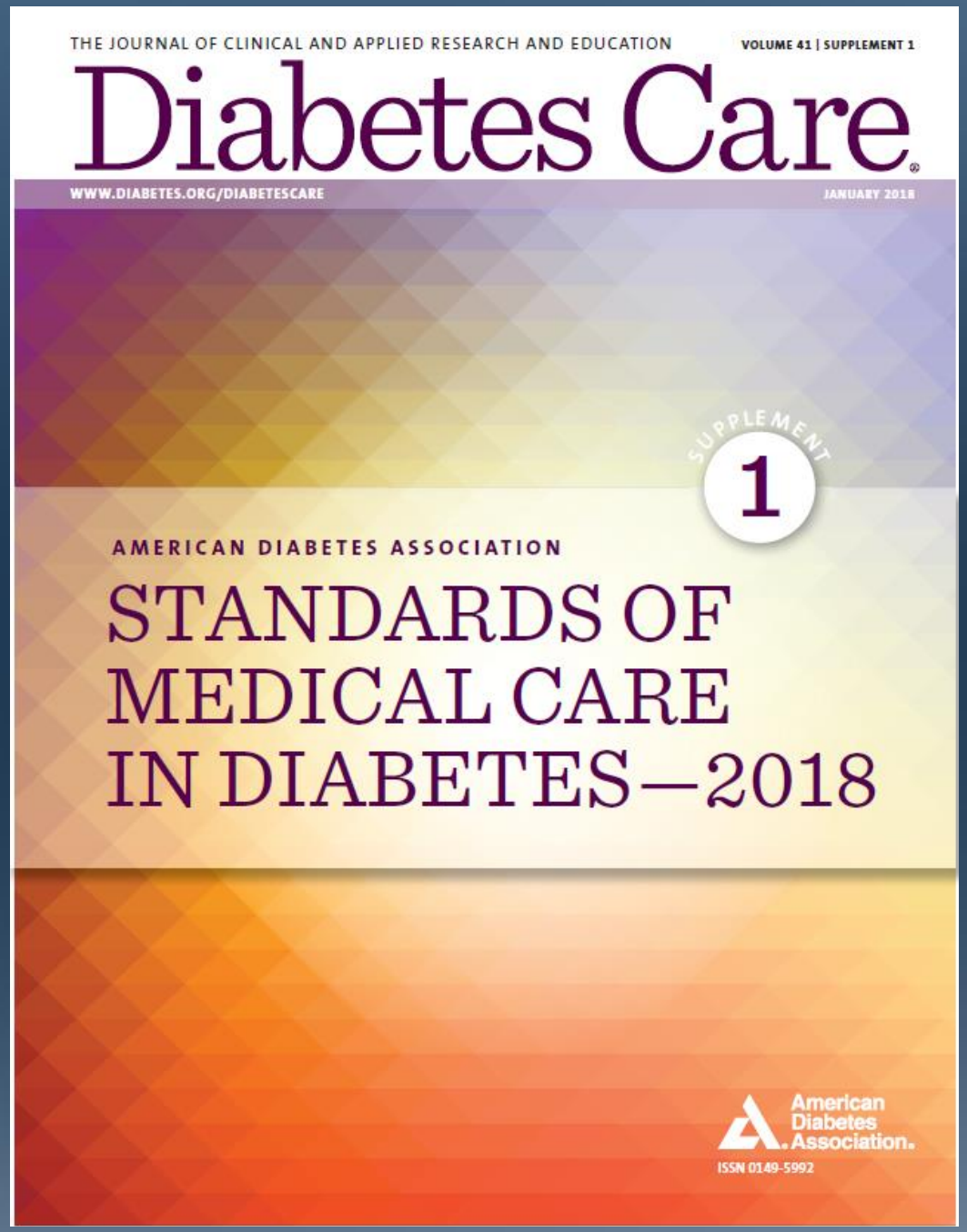


Standards of Medical Care in Diabetes - 2018

Andrea Cherrington, MD MPH
Associate Professor of Medicine
University of Alabama, Birmingham
Behavioral Sub-committee Chair
Professional Practice Committee

American Diabetes Association®

Speaker disclosures

- Astra Zeneca (Advisory board)
- Novo Nordisk (Consultant)
- Boehringer- Ingelheim (Research support)

Standards of Care

- Funded out of the ADA's general revenues and *does not use* industry support.
- Slides correspond with sections within the Standards of Medical Care in Diabetes - 2018.
- Reviewed and approved by the Association's Board of Directors.

Process

- ADA's Professional Practice Committee (PPC) conducts annual review & revision.
- Searched Medline for human studies related to each subsection and published since January 1, 2017.
- Recommendations revised per new evidence, for clarity, or to better match text to strength of evidence.

Professional.diabetes.org/SOC

General Process Changes

- Standards will be ADA's sole source of Clinical Practice Recommendations
- The PPC will continue to update the Standards annually, but has the option to update more frequently online should the PPC determine that new evidence or regulatory changes merit immediate incorporation
- ADA will begin taking proposals from the community for statements, consensus reports, scientific reviews, and clinical/research conferences

Professional.diabetes.org/SOC

Evidence Grading System

A	• Clear evidence from well-conducted, generalizable RCTs, that are adequately powered, including: • Evidence from a well-conducted multicenter trial or meta-analysis that incorporated quality ratings in the analysis; • Compelling nonexperimental evidence; • Supportive evidence from well-conducted RCTs that are adequately powered
B	• Supportive evidence from a well-conducted cohort studies
	• Supportive evidence from a well-conducted case-control study
C	• Supportive evidence from poorly controlled or uncontrolled studies
	• Conflicting evidence with the weight of evidence supporting the recommendation
E	• Expert consensus or clinical experience

Today's Topics

- Lifestyle Management & DM Prevention
- Glycemic Targets
- Pharmacologic Approaches to Glycemic Control
- Cardiovascular Disease & Risk Management

1. Lifestyle Management

Diabetes Self-Management Education & Support

Four critical time points for DSMES delivery:

1. At diagnosis
2. Annually for assessment of education, nutrition, and emotional needs
3. When new complicating factors (health conditions, physical limitations, emotional factors, or basic living needs) arise that influence self-management; and
4. When transitions in care occur

Diabetes.org/FindAProgram

Lifestyle Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S38-S50

Diabetes Distress

- Diabetes distress
  - Very common and distinct from other psychological disorders
  - Negative psychological reactions related to emotional burdens of managing a demanding chronic disease
- Recommendation:
  - Routinely monitor people with diabetes for diabetes distress, particularly when treatment targets are not met and/or at the onset of diabetes complications. B

Referral for Psychosocial Care

Table 4.2—Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment

- If self-care remains impaired in a person with DD after tailored diabetes education
- If a person has a positive screen on a validated screening tool for depressive symptoms
- In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- If intentional omission of insulin or oral medication to cause weight loss is identified
- If a person has a positive screen for anxiety or fear of hypoglycemia
- If a serious mental illness is suspected
- In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- If a person screens positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery if assessment reveals an ongoing need for adjustment support

professional.diabetes.org/MHDirectory

Lifestyle Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S38-S50

2. Prevention or Delay of Type 2 Diabetes

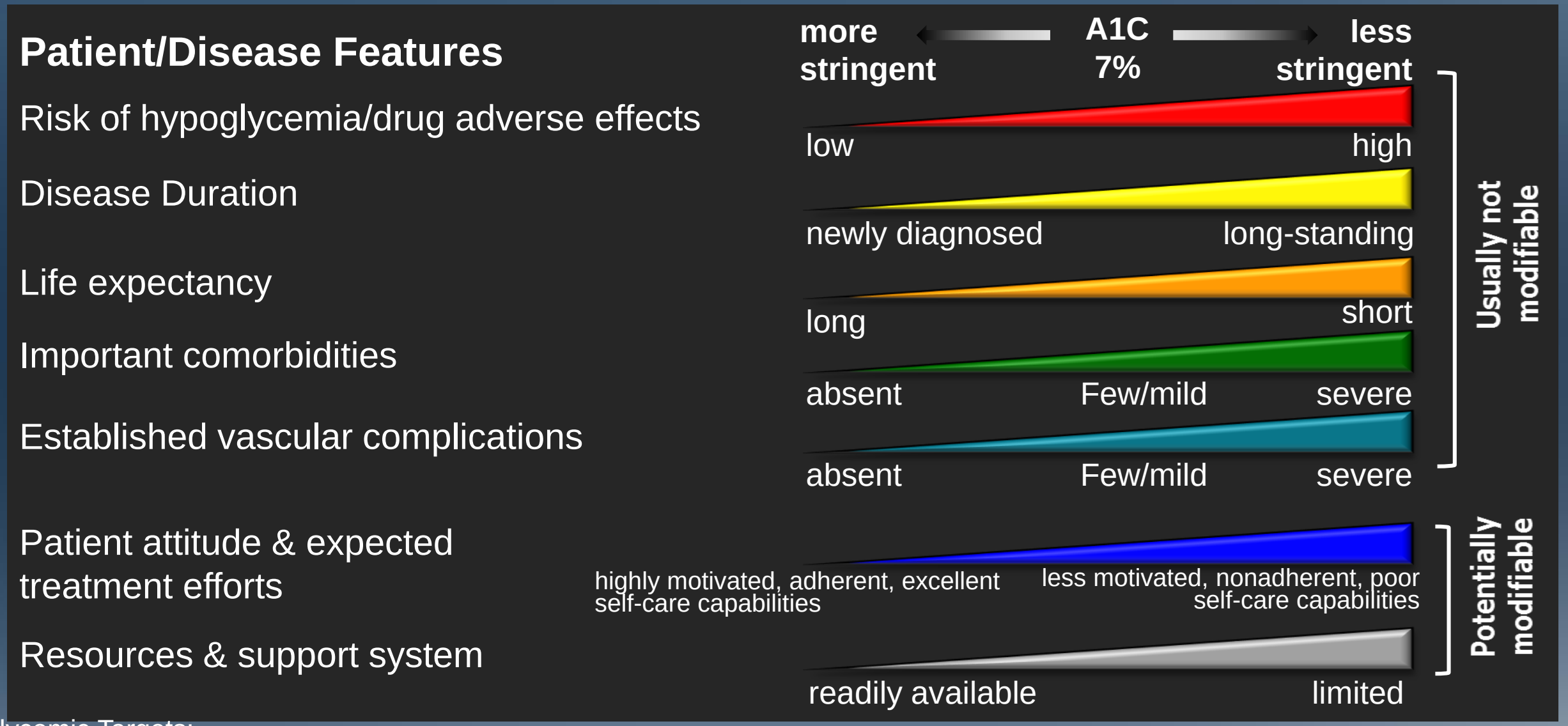
Prevention or Delay of T2DM: Recommendations

- At least annual monitoring for the development of diabetes in those with prediabetes is suggested. E
- Patients with prediabetes should be referred to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week. A

Prevention or Delay of Type 2 Diabetes:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S51-S54

3. Glycemic Targets

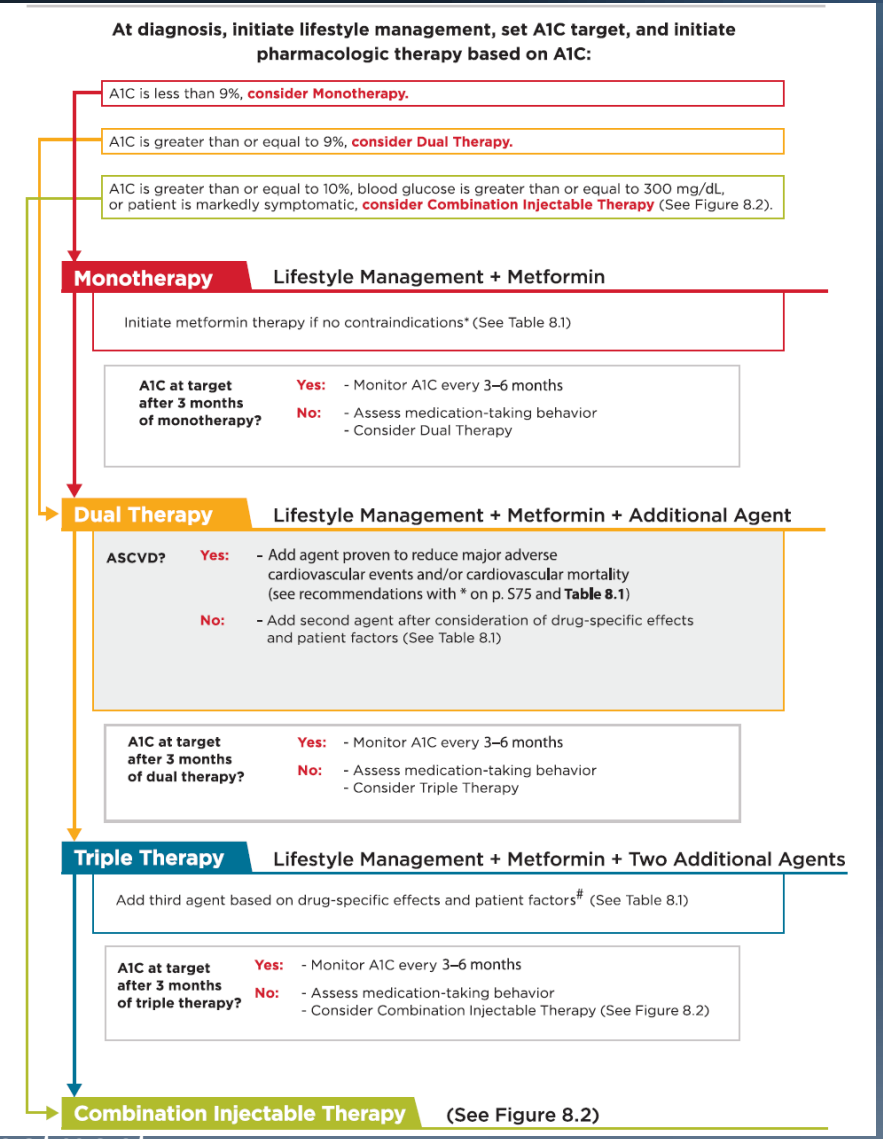
Approach to the Management of Hyperglycemia



Glycemic Targets:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S55-S64

4. Pharmacologic Approaches to Glycemic Treatment

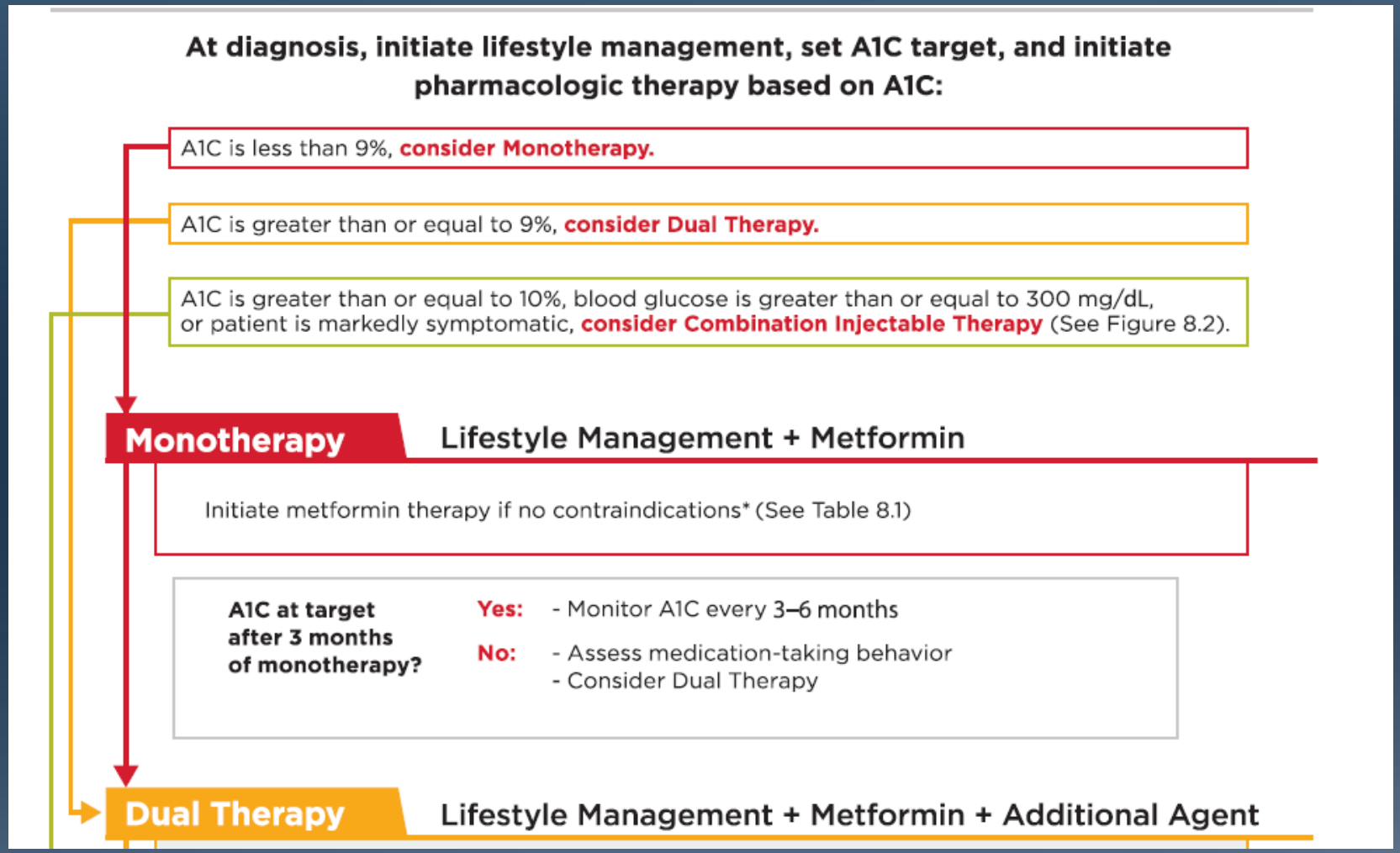
Antihyperglycemic Therapy in Adults with T2DM



Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S73-S85

American Diabetes Association.

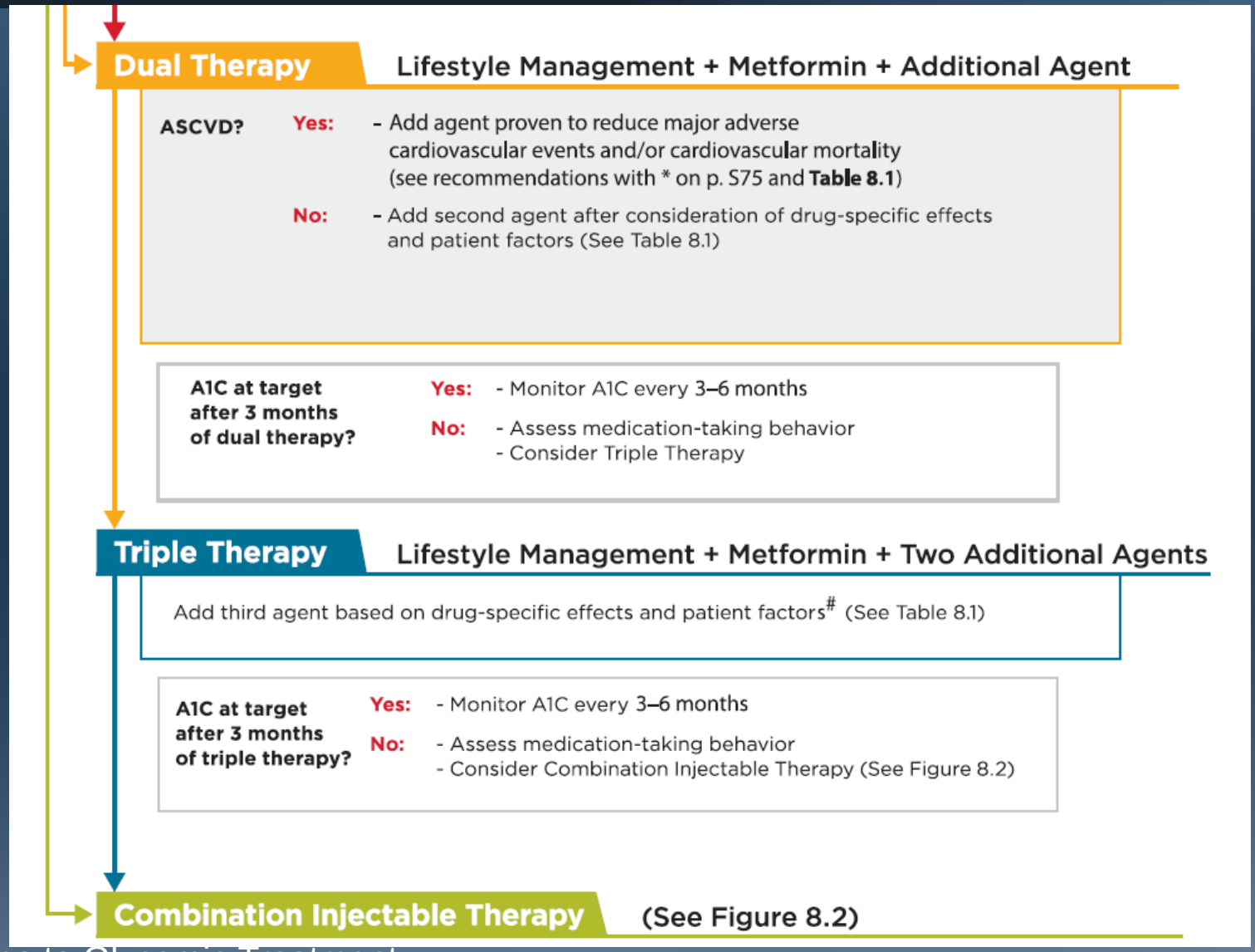
Antihyperglycemic Therapy in Adults with T2DM



Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S73-S85

American Diabetes Association.

Antihyperglycemic Therapy in Adults with T2DM



Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S73-S85

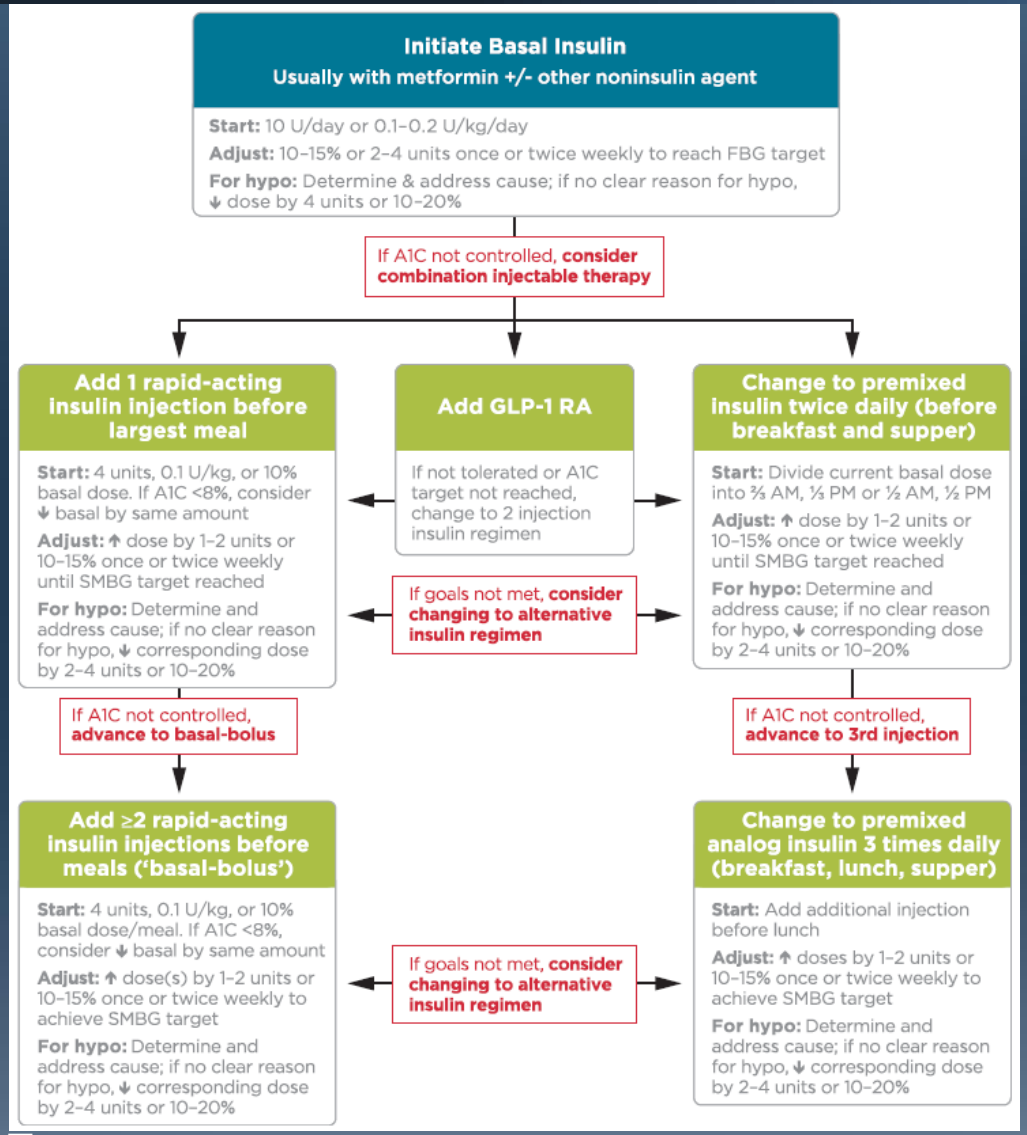
American Diabetes Association.

Table 8.1—Drug-specific and patient factors to consider when selecting antihyperglycemic treatment in adults with type 2 diabetes

	Efficacy*	Hypoglycemia	Weight Change	CV Effects		Cost	Oral/SQ	Renal Effects		Additional Considerations
				ASCVD	CHF			Progression of DKD	Dosing/Use considerations	
Metformin	High	No	Neutral (Potential for Modest Loss)	Potential Benefit	Neutral	Low	Oral	Neutral	▪ Contraindicated with eGFR <30	▪ Gastrointestinal side effects common (diarrhea, nausea) ▪ Potential for B12 deficiency
SGLT-2 Inhibitors	Intermediate	No	Loss	Benefit: canagliflozin, empagliflozin†	Benefit: canagliflozin, empagliflozin	High	Oral	Benefit: canagliflozin, empagliflozin	▪ Canagliflozin: not recommended with eGFR <45 ▪ Dapagliflozin: not recommended with eGFR <60; contraindicated with eGFR <30 ▪ Empagliflozin: contraindicated with eGFR <30	▪ **FDA Black Box:** Risk of amputation (**canagliflozin**) ▪ Risk of bone fractures (canagliflozin) ▪ DKA risk (all agents, rare in T2DM) ▪ Genitourinary infections ▪ Risk of volume depletion, hypotension ▪ ↑LDL cholesterol
GLP-1 RAs	High	No	Loss	Neutral: lixisenatide, exenatide extended release Benefit: liraglutide†	Neutral	High	SQ	Benefit: liraglutide	▪ Exenatide: not indicated with eGFR <30 ▪ Lixisenatide: caution with eGFR <30 ▪ Increased risk of side effects in patients with renal impairment	▪ **FDA Black Box:** Risk of thyroid C-cell tumors (**liraglutide, albiglutide, dulaglutide, exenatide extended release**) ▪ Gastrointestinal side effects common (nausea, vomiting, diarrhea) ▪ Injection site reactions ▪ ?Acute pancreatitis risk
DPP-4 Inhibitors	Intermediate	No	Neutral	Neutral	Potential Risk: saxagliptin, alogliptin	High	Oral	Neutral	▪ Renal dose adjustment required; can be used in renal impairment	▪ Potential risk of acute pancreatitis ▪ Joint pain
Thiazolidinediones	High	No	Gain	Potential Benefit: pioglitazone	Increased Risk	Low	Oral	Neutral	▪ No dose adjustment required ▪ Generally not recommended in renal impairment due to potential for fluid retention	▪ **FDA Black Box:** Congestive heart failure (**pioglitazone, rosiglitazone**) ▪ Fluid retention (edema; heart failure) ▪ Benefit in NASH ▪ Risk of bone fractures ▪ Bladder cancer (pioglitazone) ▪ ↑LDL cholesterol (rosiglitazone)
Sulfonylureas (2nd Generation)	High	Yes	Gain	Neutral	Neutral	Low	Oral	Neutral	▪ Glyburide: not recommended ▪ Glipizide & glimepiride: initiate conservatively to avoid hypoglycemia	▪ FDA Special Warning on increased risk of cardiovascular mortality based on studies of an older sulfonylurea (tolbutamide)
Insulin — **Human Insulin**	Highest	Yes	Gain	Neutral	Neutral	Low	SQ	Neutral	▪ Lower insulin doses required with a decrease in eGFR; titrate per clinical response	▪ Injection site reactions ▪ Higher risk of hypoglycemia with human insulin (NPH or premixed formulations) vs. analogs
Insulin — **Analogs**						High	SQ			

*See ref. 31 for description of efficacy. †FDA approved for CVD benefit. CVD, cardiovascular disease; DKA, diabetic ketoacidosis; DKD, diabetic kidney disease; NASH, nonalcoholic steatohepatitis; RAs, receptor agonists; SQ, subcutaneous; T2DM, type 2 diabetes.

Combination Injectable Therapy in T2DM



Pharmacologic Approaches to Glycemic Treatment:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S73-S85

American Diabetes Association.

5. Cardiovascular Disease and Risk Management

Cardiovascular Disease

- ASCVD is the leading cause of morbidity & mortality for those with diabetes.
- Largest contributor to direct/indirect costs
- Common conditions coexisting with type 2 diabetes (e.g., hypertension, dyslipidemia) are clear risk factors for ASCVD.
- Diabetes itself confers independent risk
- Control individual cardiovascular risk factors to prevent/slow CVD in people with diabetes.
- Systematically assess all patients with diabetes for cardiovascular risk factors.

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Table 9.1—Randomized controlled trials of intensive versus standard hypertension treatment strategies

Clinical trial	Population	Intensive	Standard	Outcomes
ACCORD BP (16)	4,733 participants with T2D aged 40–79 years with prior evidence of CVD or multiple cardiovascular risk factors	Systolic blood pressure target: <120 mmHg Achieved (mean) systolic/diastolic: 119.3/64.4 mmHg	Systolic blood pressure target: 130–140 mmHg Achieved (mean) systolic/diastolic: 133.5/70.5 mmHg	• No benefit in primary end point: composite of nonfatal MI, nonfatal stroke, and CVD death • Stroke risk reduced 41% with intensive control, not sustained through follow-up beyond the period of active treatment • Adverse events more common in intensive group, particularly elevated serum creatinine and electrolyte abnormalities
ADVANCE BP (17)	11,140 participants with T2D aged 55 years and older with prior evidence of CVD or multiple cardiovascular risk factors	Intervention: a single-pill, fixed-dose combination of perindopril and indapamide Achieved (mean) systolic/diastolic: 136/73 mmHg	Control: placebo Achieved (mean) systolic/diastolic: 141.6/75.2 mmHg	• Intervention reduced risk of primary composite end point of major macrovascular and microvascular events (9%), death from any cause (14%), and death from CVD (18%) • 6-year observational follow-up found reduction in risk of death in intervention group attenuated but still significant (142)
HOT (143)	18,790 participants, including 1,501 with diabetes	Diastolic blood pressure target: ≤80 mmHg	Diastolic blood pressure target: ≤90 mmHg	• In the overall trial, there was no cardiovascular benefit with more intensive targets • In the subpopulation with diabetes, an intensive diastolic target was associated with a significantly reduced risk (51%) of CVD events
SPRINT (144)	9,361 participants without diabetes	Systolic blood pressure target: <120 mmHg Achieved (mean): 121.4 mmHg	Systolic blood pressure target: <140 mmHg Achieved (mean): 136.2 mmHg	• Intensive systolic blood pressure target lowered risk of the primary composite outcome 25% (MI, ACS, stroke, heart failure, and death due to CVD) • Intensive target reduced risk of death 27% • Intensive therapy increased risks of electrolyte abnormalities and AKI

CVD, cardiovascular disease; T2D, type 2 diabetes. Data from this table can also be found in the ADA position statement "Diabetes and Hypertension" (5).

Hypertension/BP Control: Recommendations

Screening and Diagnosis:

- Blood pressure (BP) should be measured at every routine clinical visit. Patients found to have elevated BP(≥140/90) should have BP confirmed using multiple readings, including measurements on a separate day, to diagnose hypertension. B
- All hypertensive patients with diabetes should monitor their BP at home. B

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Hypertension/BP Control: Recommendations (2)

Treatment Goals

- Most people with diabetes and hypertension should be treated to a systolic BP goal of <140 mmHg and a diastolic BP goal of <90 mmHg. A
- Lower systolic and diastolic BP targets, such as 130/80 mmHg, may be appropriate for individuals at high risk of CVD, if they can be achieved without undue treatment burden. C
- In pregnant patients with diabetes and preexisting hypertension who are treated with antihypertensive therapy, BP targets of 120-160/80-105 mmHg are suggested in the interest of optimizing long-term maternal health and minimizing impaired fetal growth. E

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Recommendations for the Treatment of Confirmed Hypertension in People With Diabetes

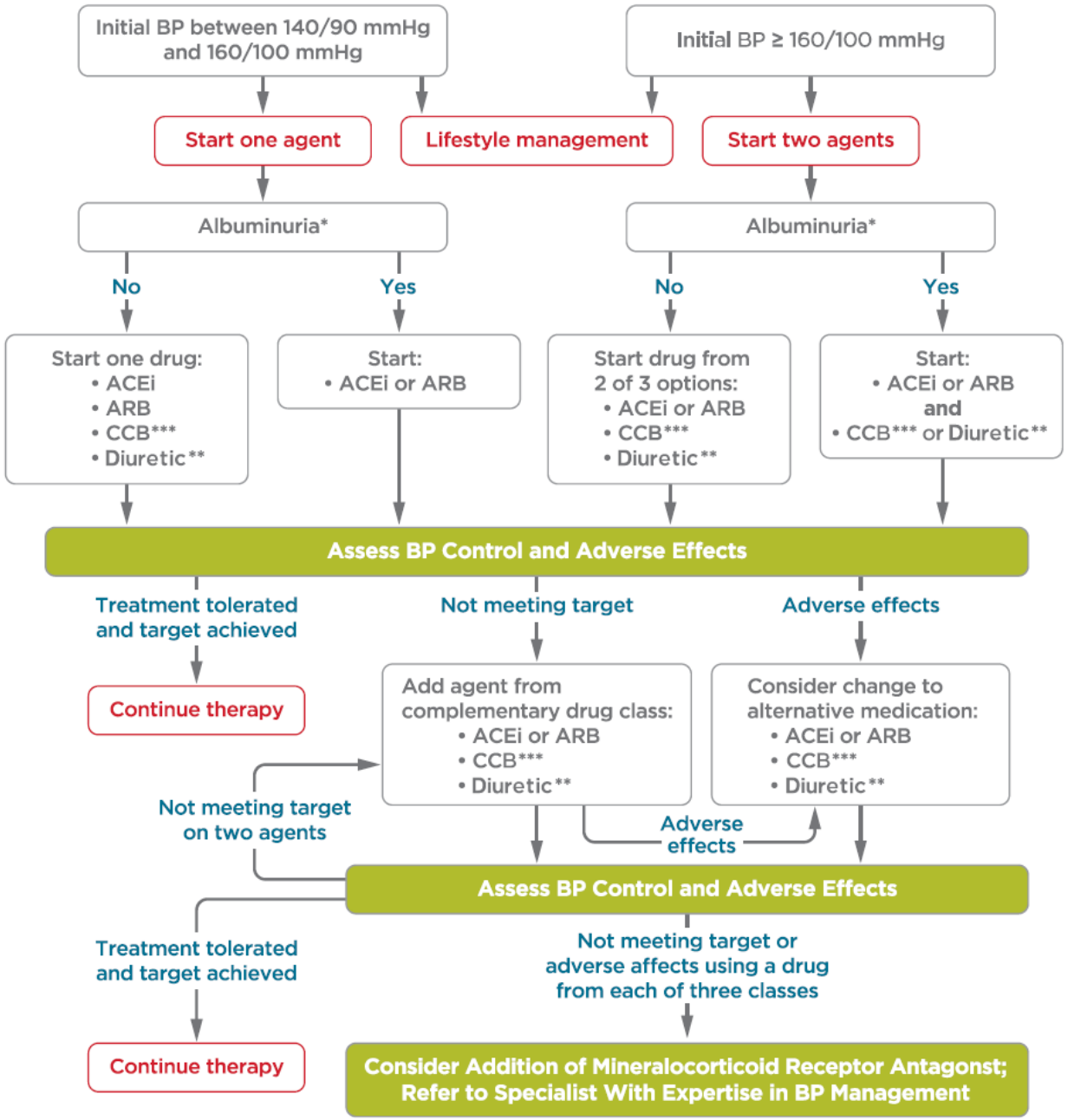


Table 9.2—Recommendations for statin and combination treatment in adults with diabetes

Age	ASCVD	Recommended statin intensity^ and combination treatment*
<40 years	No	None†
	Yes	High • If LDL cholesterol ≥70 mg/dL despite maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor)#
≥40 years	No	Moderate‡
	Yes	High • If LDL cholesterol ≥70 mg/dL despite maximally tolerated statin dose, consider adding additional LDL-lowering therapy (such as ezetimibe or PCSK9 inhibitor)

*In addition to lifestyle therapy. ^For patients who do not tolerate the intended intensity of statin, the maximally tolerated statin dose should be used. †Moderate-intensity statin may be considered based on risk-benefit profile and presence of ASCVD risk factors. ASCVD risk factors include LDL cholesterol ≥100 mg/dL (2.6 mmol/L), high blood pressure, smoking, chronic kidney disease, albuminuria, and family history of premature ASCVD. ‡High-intensity statin may be considered based on risk-benefit profile and presence of ASCVD risk factors. #Adults aged <40 years with prevalent ASCVD were not well represented in clinical trials of non-statin–based LDL reduction. Before initiating combination lipid-lowering therapy, consider the potential for further ASCVD risk reduction, drug-specific adverse effects, and patient preferences.

Antiplatelet Agents: Recommendations

- Use aspirin therapy (75-162 mg/day) as a secondary prevention strategy in those with diabetes and a history of ASCVD. A
- For patients with ASCVD and documented aspirin allergy, clopidogrel (75 mg/day) should be used. B
- Dual antiplatelet therapy (with low-dose aspirin and a P2Y12 inhibitor) is reasonable for a year after an acute coronary syndrome A and may have benefits beyond this period. B

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Coronary Heart Disease: Recommendations

Treatment

- In patients with known ASCVD, consider ACE inhibitor or ARB therapy to reduce the risk of CV events. A
- In patients with prior myocardial infarction, β-blockers should be continued for at least 2 years after the event. B
- In patients with T2DM with stable congestive heart failure, metformin may be used if estimated glomerular filtration rate remains >30 mL/min but should be avoided in unstable or hospitalized patients with congestive heart failure. B

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Coronary Heart Disease: Recommendations

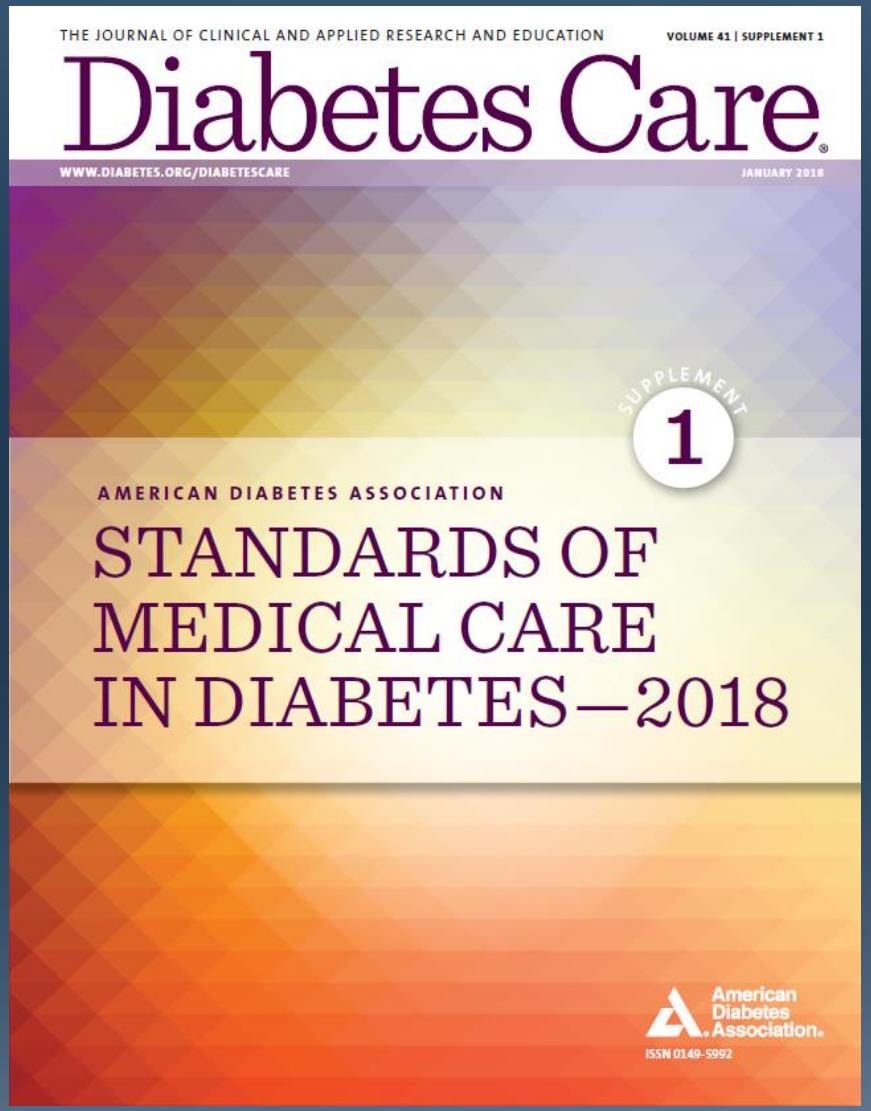
Treatment

- In patients with T2DM and established ASCVD, antihyperglycemic therapy should begin with lifestyle management and metformin and subsequently incorporate an agent proven to reduce major adverse CV events and CV mortality (currently empagliflozin and liraglutide), after considering drug-specific and patient factors. A
- In patients with T2DM and established ASCVD, after lifestyle management and metformin, the antihyperglycemic agent canagliflozin may be considered to reduce major adverse CV events, based on drug-specific and patient factors. C

Cardiovascular Disease and Risk Management:
Standards of Medical Care in Diabetes - 2018. *Diabetes Care* 2018; 41 (Suppl. 1): S86-S104

Helpful Resources

2018 Standards of Care - Resources



- Full version available
- Abridged version for PCPs
- Free app (February 2018)
- Pocket cards with key figures
- Free webcast for continuing education credit

Professional.Diabetes.org/SOC

Professional Education

- Live programs
- Online self-assessment programs
- Online webcasts

Professional.Diabetes.org/CE

Professional Membership

- Journals
- Meeting, book and journal discounts
- Career center
- Quarterly member newsletter

Professional.Diabetes.org/membership

Thank you

American Diabetes Association®

FEBRUARY 2018 MONTHLY WEBINAR

- **Date/Time:** Thursday, February 15, 2-3pm Eastern
- **Topic:**
- Rx for Good Health: Geisinger's Fresh Food Pharmacy
- **Presenter:** Andrea Feinberg, M.D. of Geisinger

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