Together 2 Goal®

AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar

January 17, 2019

Today's Webinar

- Together 2 Goal® Updates
  - Webinar Reminders
  - National Day of Action Wrap Report
  - AMGA Annual Conference
  - T2G Impact to Date
  - Extension Announcement
  - New Materials & Website
- Diabetes Prevention Program
  - Nisa Maruthur, M.D., M.H.S. of Johns Hopkins University
- Q&A
  - Use Q&A or chat feature

Webinar Reminders

- Webinar will be recorded today and available the week of January 21st
  - www.Together2Goal.org
- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

National Day of Action Wrap Report

- More than **200 healthcare professionals** from nearly **30 groups** came together to take action to improve diabetes care!
- Thanks to everyone who participated. Next year's National Day of Action will take place November 7, 2019. We hope you'll join us!

2019 AMGA Annual Conference

March 27-30, 2019

National Harbor, MD

- New this year: AMGA will offer networking discussion groups by hot topic and by organizational type.
- Registration now open at amga.org/ac2019
- Register by **Friday, February 8** for the lowest early bird rate

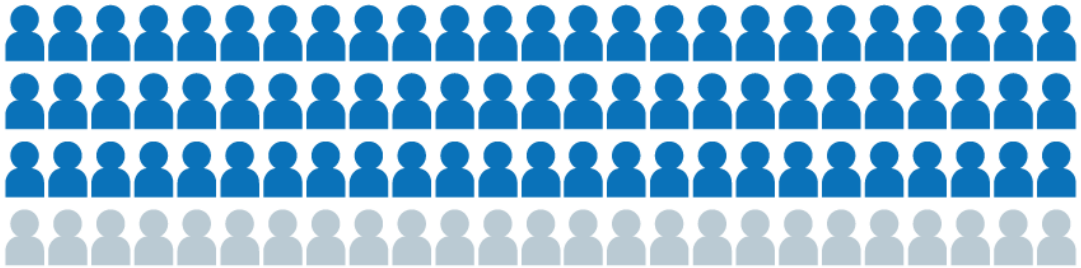
Together 2 Goal® Impact

Together 2 Goal® Impact

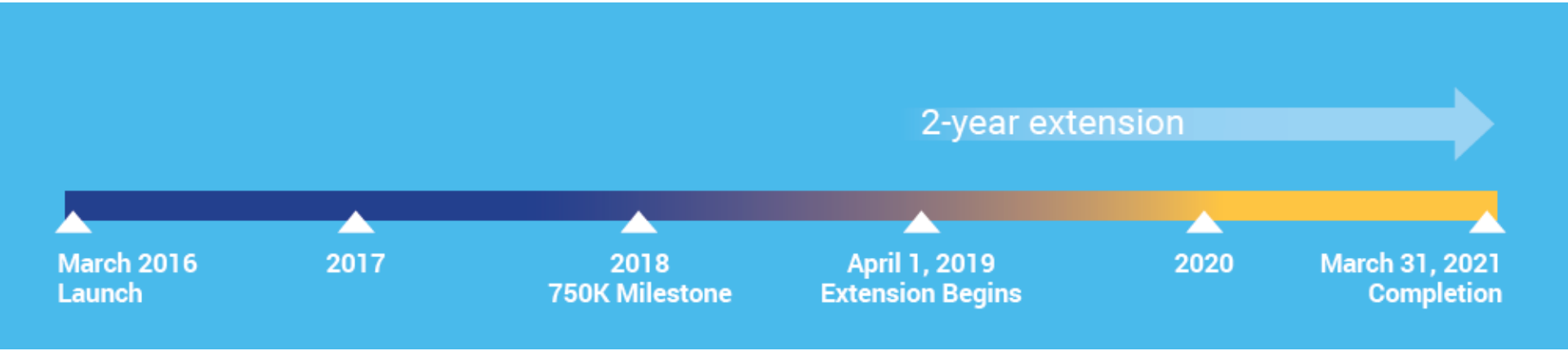
Improved care for more than

750,000 people

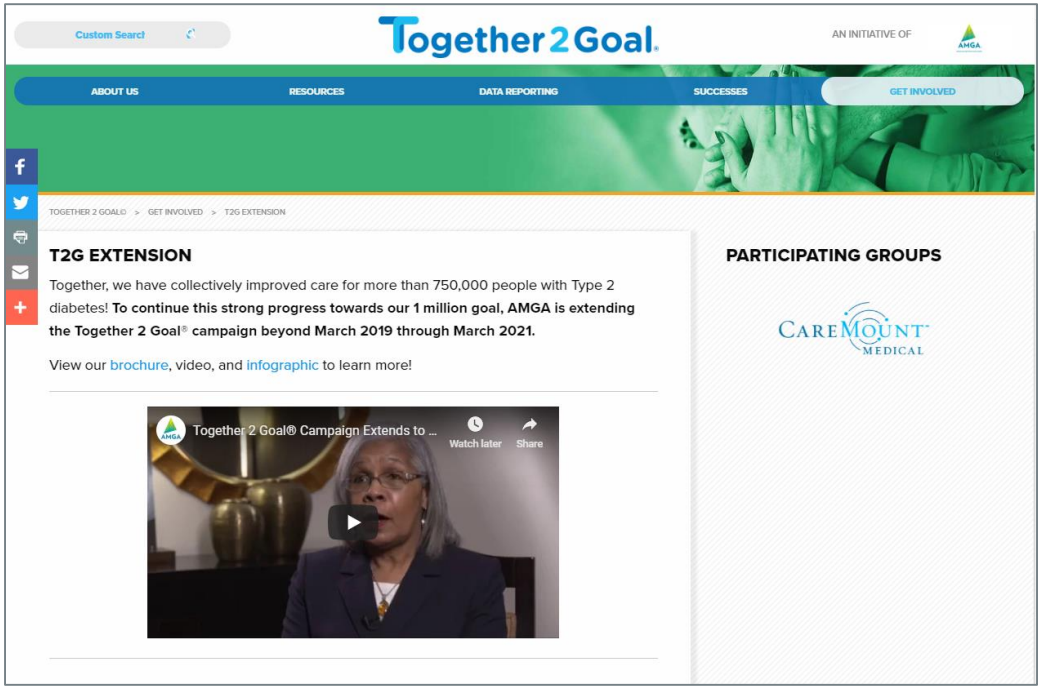
with Type 2 diabetes

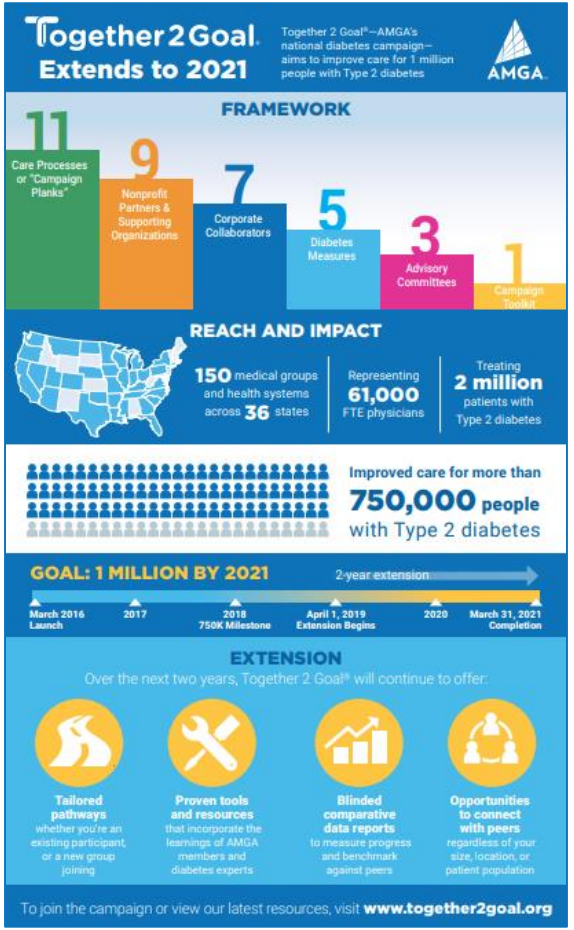


Together 2 Goal® Extends to 2021

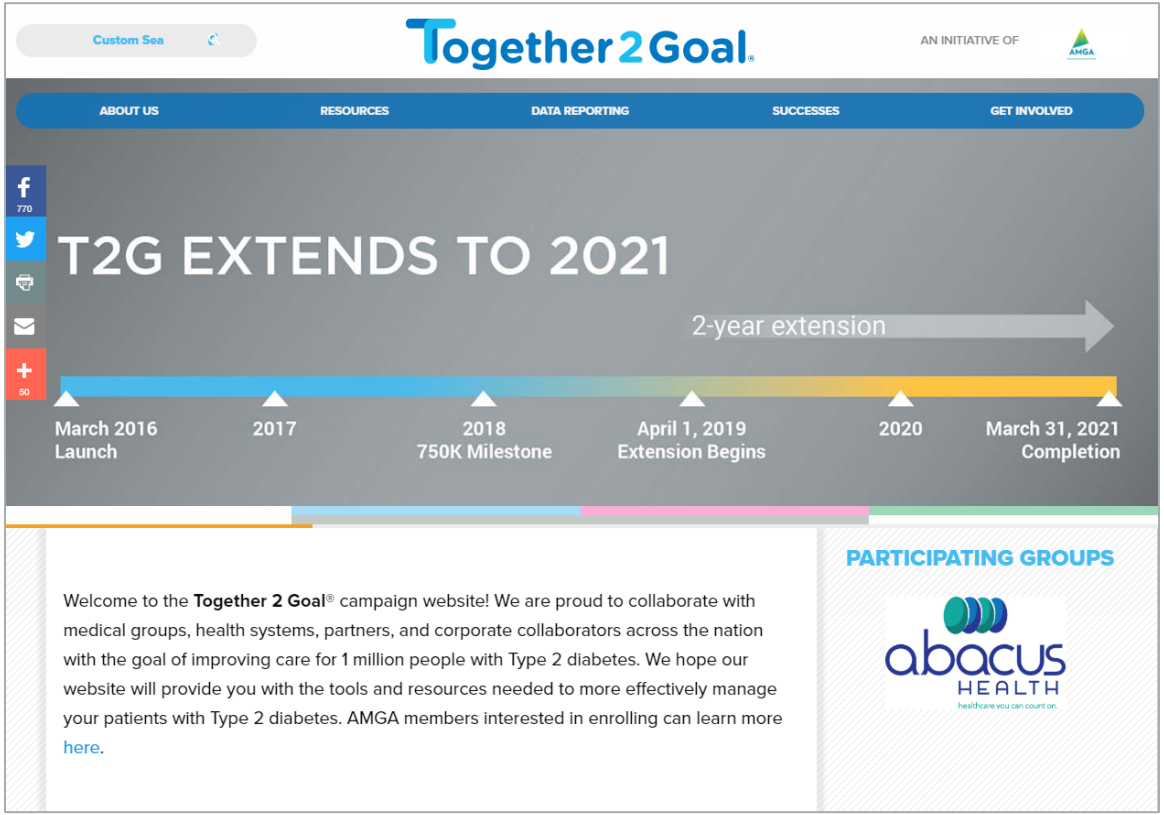


New Materials…





Revamped Website



Today's Featured Presenter

Nisa Maruthur, M.D., M.H.S.

Associate Professor
Johns Hopkins University

Updates on ADA's Standards of Medical Care – 2019

Nisa M. Maruthur, MD, MHS
Associate Professor of Medicine & Epidemiology
Johns Hopkins University
Division of General Internal Medicine
Member, ADA Professional Practice Committee

American Diabetes Association.

DISCLOSURES

No financial conflicts of interest.

Slides adapted from American Diabetes Association.

American Diabetes Association.

OBJECTIVES

Describe changes in ADA Standards of Medical Care related to *management* of diabetes.

New content related to prevention, diagnosis, or technology is *not* covered in this presentation.

Standards of Medical Care in Diabetes – 2019

American Diabetes Association®

The Standards.

Intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care.

EVIDENCE

- Search of scientific diabetes literature over past year
- Recommendations revised per new evidence

PROCESS

- Professional Practice Committee
- Reviewed by ADA's Board of Directors
- Living Standards

FUNDING

- Funded out of ADA's general revenues
- Does not use industry support

American Diabetes Association.

Improving Care and Promoting Health in Populations.

New data on the financial costs of diabetes to individuals and society: In 2017, the cost of diagnosed diabetes was **327 billion,** an increase of 26% since 2012.

Because telemedicine is a growing field that may increase access to care for patients with diabetes, discussion was added on its use to facilitate remote delivery of health-related services and clinical information.

Comprehensive Medical Evaluation and Assessment of Comorbidities.

New text was added to guide health care professionals' use of language to communicate with people with diabetes and professional audiences in an informative, empowering, and educational style.

A diabetes care decision cycle figure from the ADA-EASD consensus report was added to emphasize the need for ongoing assessment & shared decision making to achieve health goals and avoid therapeutic inertia.

A new recommendation was added to explicitly call out the importance of the diabetes care team and to list the professionals that make up the team.

American Diabetes Association.

Comprehensive Medical Evaluation and Assessment of Comorbidities (continued).

The table listing the components of a comprehensive medical evaluation was revised, and the section on assessment and planning was used to create a new table (Table 4.2).

A new table was added listing factors that increase risk of treatment-associated hypoglycemia (Table 4.3).

A recommendation was added to include the 10-year atherosclerotic cardiovascular disease (ASCVD) risk as part of overall risk assessment.

The fatty liver disease section was revised to include updated text and a new recommendation regarding when to test for liver disease.

Decision Cycle for Patient-centered Glycemic Management in Type 2 Diabetes

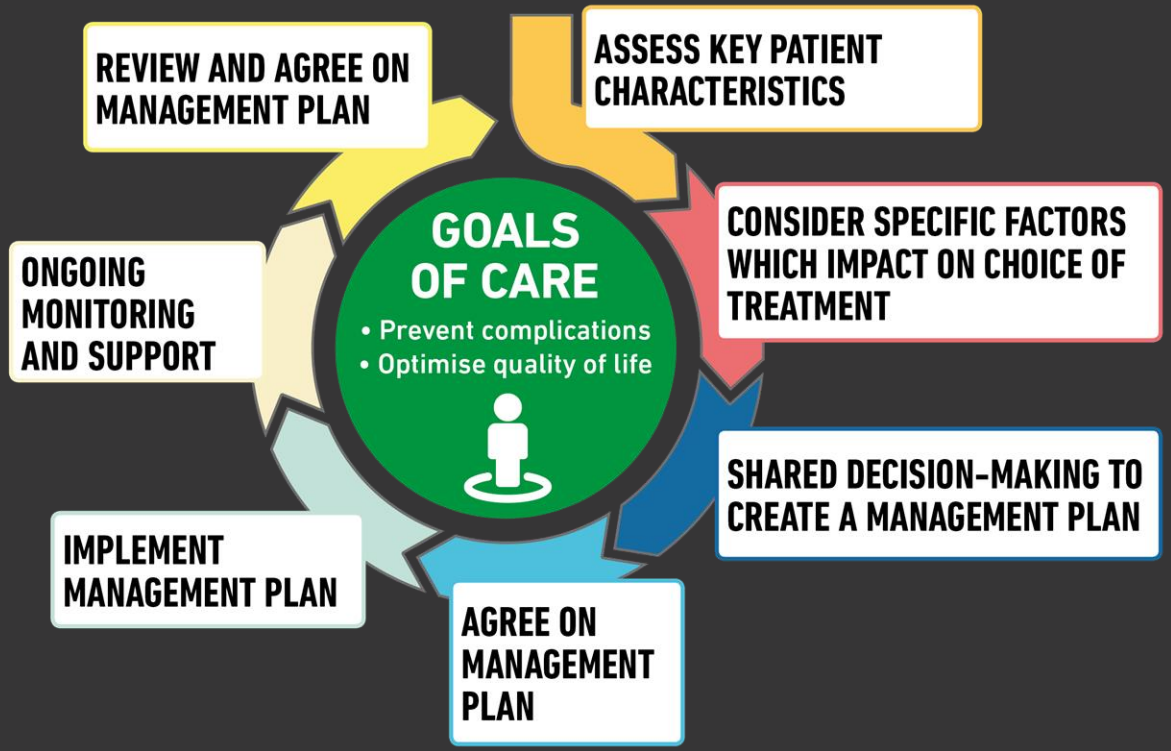


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Table 4.2—Assessment and treatment plan*

Assess risk of diabetes complications

- ASCVD and heart failure history
- ASCVD risk factors (see **Table 10.2**) and 10-year ASCVD risk assessment
- Staging of chronic kidney disease (see **Table 11.1**)
- Hypoglycemia risk (**Table 4.3**)

Goal setting

- Set A1C/blood glucose target
- If hypertension present, establish blood pressure target
- Diabetes self-management goals (e.g., monitoring frequency)

Therapeutic treatment plan

- Lifestyle management
- Pharmacologic therapy (glucose lowering)
- Pharmacologic therapy (cardiovascular disease risk factors and renal)
- Use of glucose monitoring and insulin delivery devices
- Referral to diabetes education and medical specialists (as needed)

ASCVD, atherosclerotic cardiovascular disease. *Assessment and treatment planning is an essential component of initial and all follow-up visits.

Table 4.3—Assessment of hypoglycemia risk

Factors that increase risk of treatment-associated hypoglycemia

- Use of insulin or insulin secretagogues (i.e., sulfonylureas, meglitinides)
- Impaired kidney or hepatic function
- Longer duration of diabetes
- Frailty and older age
- Cognitive impairment
- Impaired counterregulatory response, hypoglycemia unawareness
- Physical or intellectual disability that may impair behavioral response to hypoglycemia
- Alcohol use
- Polypharmacy (especially ACE inhibitors, angiotensin receptor blockers, nonselective β-blockers)

Lifestyle Management.

More discussion was added about the importance of macronutrient distribution based on an individualized assessment of current eating patterns, preferences, and metabolic goals. There is not a one-size-fits-all eating pattern for individuals with diabetes, and meal planning should be individualized.

A recommendation was modified to encourage people with diabetes to decrease consumption of both sugar sweetened and nonnutritive-sweetened beverages and use other alternatives, with an emphasis on water intake.

The sodium consumption recommendation was modified to eliminate the further restriction that was potentially indicated for those with both diabetes and hypertension.

Lifestyle Management (continued).

Additional discussion was added to the physical activity section to include the benefit of a variety of leisure-time physical activities and flexibility and balance exercises.

The discussion about e-cigarettes was expanded to include more on public perception and how their use to aide smoking cessation was not more effective than “usual care.”

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Glycemic Targets.

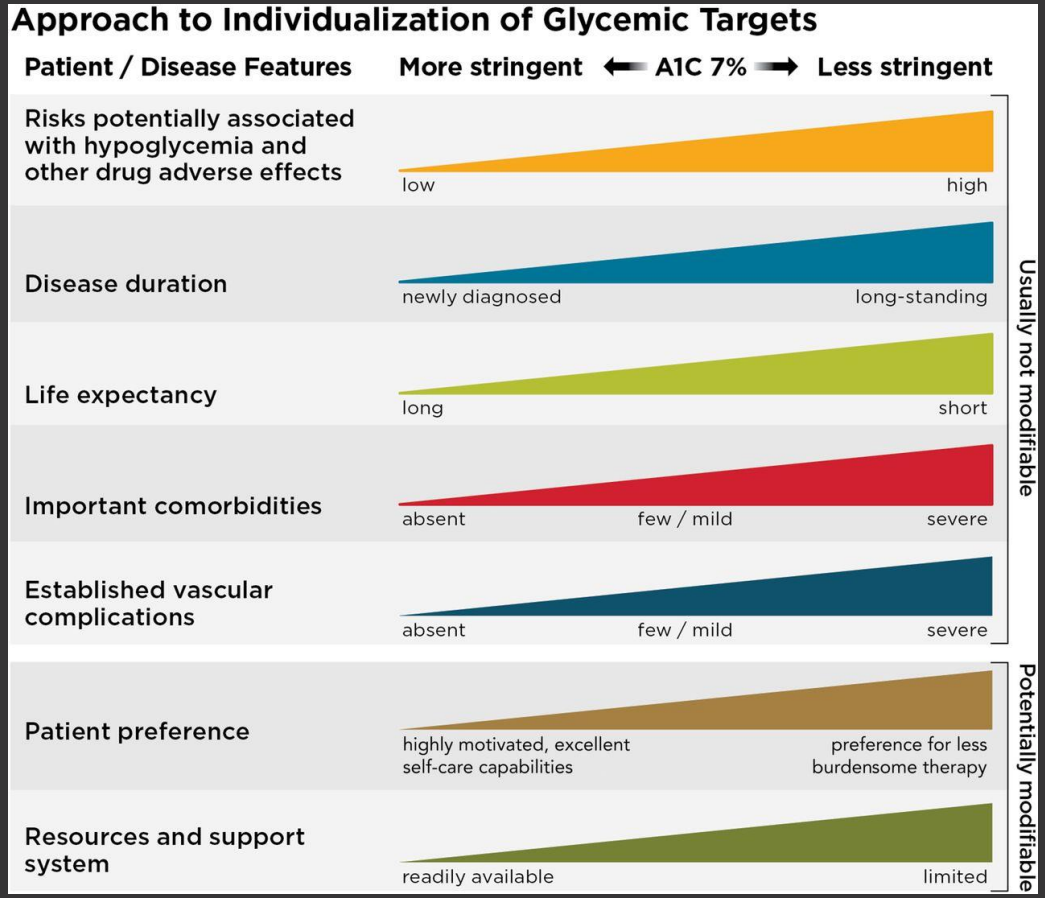
This section now begins with a discussion of A1C tests to highlight the centrality of A1C testing in glycemic management.

The self-monitoring of blood glucose and continuous glucose monitoring text and recommendations were moved to the new Diabetes Technology section.

To emphasize that the risks and benefits of glycemic targets can change as diabetes progresses and patients age, a recommendation was added to reevaluate glycemic targets over time.

The section was modified to align with the living Standards updates made in April 2018 regarding the consensus definition of hypoglycemia.

Patient and Disease Factors Used to Determine A1C Targets.



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Obesity Management for the Treatment of Type 2 Diabetes.

A recommendation was modified to acknowledge the benefits of tracking weight, activity, etc., in the context of achieving and maintaining a healthy weight.

A brief section was added on medical devices for weight loss, which are not currently recommended due to limited data in people with diabetes.

The recommendations for metabolic surgery were modified to align with recent guidelines, citing the importance of considering comorbidities beyond diabetes when contemplating the appropriateness of metabolic surgery for a given patient.

Pharmacologic Approaches to Glycemic Treatment.

The section on the pharmacologic treatment of type 2 diabetes was significantly changed to align, as per the living Standards update in October 2018, with the ADA-EASD consensus report on this topic, summarized in the new Figs. 9.1 and 9.2. This includes consideration of key patient factors: a) important comorbidities such as ASCVD, chronic kidney disease, and heart failure, b) hypoglycemia risk, c) effects on body weight, d) side effects, e) costs, and f) patient preferences.

To align with the ADA-EASD consensus report, the approach to injectable medication therapy was revised (Fig. 9.2). A recommendation that, for most patients who need the greater efficacy of an injectable medication, a glucagon-like peptide 1 receptor agonist should be the first choice, ahead of insulin.

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Figure 2

GLUCOSE-LOWERING MEDICATION IN TYPE 2 DIABETES: OVERALL APPROACH

FIRST-LINE THERAPY IS METFORMIN AND COMPREHENSIVE LIFESTYLE (INCLUDING WEIGHT MANAGEMENT AND PHYSICAL ACTIVITY)
IF HbA_{1c} ABOVE TARGET PROCEED AS BELOW

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

ESTABLISHED ASCVD OR CKD

ASCVD PREDOMINATES

EITHER/OR

- GLP-1 RA with proven CVD benefit[1]
- SGLT2i with proven CVD benefit[1], if eGFR adequate[2]

If HbA_{1c} above target

If further intensification is required or patient is now unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:

- Consider adding the other class (GLP-1 RA or SGLT2i) with proven CVD benefit
- DPP-4i if not on GLP-1 RA
- Basal insulin[4]
- TZD[5]
- SU[6]

HF OR CKD PREDOMINATES

PREFERABLY
SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs if eGFR adequate[3]

OR

If SGLT2i not tolerated or contraindicated or if eGFR less than adequate[2] add GLP-1 RA with proven CVD benefit[1]

If HbA_{1c} above target

- Avoid TZD in the setting of HF

Choose agents demonstrating CV safety:

- Consider adding the other class with proven CVD benefit[1]
- DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
- Basal insulin[4]
- SU[6]

NO

WITHOUT ESTABLISHED ASCVD OR CKD

COMPELLING NEED TO MINIMISE HYPOGLYCAEMIA

DPP-4i	GLP-1 RA	$SGLT2i^2$	TZD
If HbA_{1c} above target			
$SGLT2i^2$ **OR** TZD	$SGLT2i^2$ **OR** TZD	GLP-1 RA **OR** DPP-4i **OR** TZD	$SGLT2i^2$ **OR** DPP-4i **OR** GLP-1 RA

If HbA_{1c} above target

Continue with addition of other agents as outlined above

If HbA_{1c} above target

Consider the addition of SU[6] **OR** basal insulin:

- Choose later generation SU with lower risk of risk of hypoglycaemia
- Consider basal insulin with lower risk of hypoglycaemia[7]

COMPELLING NEED TO MINIMISE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

EITHER/OR

- GLP-1 RA with good efficacy for weight loss[8]
- $SGLT2i^2$

If HbA_{1c} above target

- $SGLT2i^2$
- GLP-1 RA with good efficacy for weight loss[8]

If HbA_{1c} above target

If triple therapy required or SGLT2i and/or GLP-1 RA not tolerated or contraindicated use regimen with lowest risk of weight gain

PREFERABLY

DPP-4i (if not on GLP-1 RA) based on weight neutrality

If DPP-4i not tolerated or contraindicated or patient already on GLP-1 RA, cautious addition of:

- SU[6]
- TZD[5]
- Basal insulin

COST IS A MAJOR ISSUE[9–10]

- SU[6]
- TZD[10]

If HbA_{1c} above target

- TZD[10]
- SU[6]

If HbA_{1c} above target

- **Insulin therapy** basal insulin with lowest acquisition cost

OR

- Consider DPP-4i **OR** SGLT2i with lowest acquisition cost[10]

1. Proven CVD benefit means it has label indication of reducing CVD events. For GLP-1 RA strongest evidence of tiraglutide > semaglutide > exenatide. For SGLT2i evidence modestly stronger for empagliflozin > canagliflozin.
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Both empagliflozin and canagliflozin have shown reduction in HF and reduction in CKD progression in CVOTs
4. Degludec or U100 glargine have demonstrated CVD safety
5. Low dose may be better tolerated though less well studied for CVD effects
6. Choose later generation SU with lower risk of hypoglycaemia
7. Degludec / glargine U300 < glargine U100 / detemir < NPH insulin
8. Semaglutide > tiraglutide > dulaglutide > exenatide > lixisenatide
9. If no specific comorbidities (i.e. no established CVD, low risk of hypoglycaemia and lower priority to avoid weight gain or no weight related comorbidities)
10. Consider country- and region-specific cost of drugs. In some countries TZDs relatively more expensive and DPP-4i relatively cheaper

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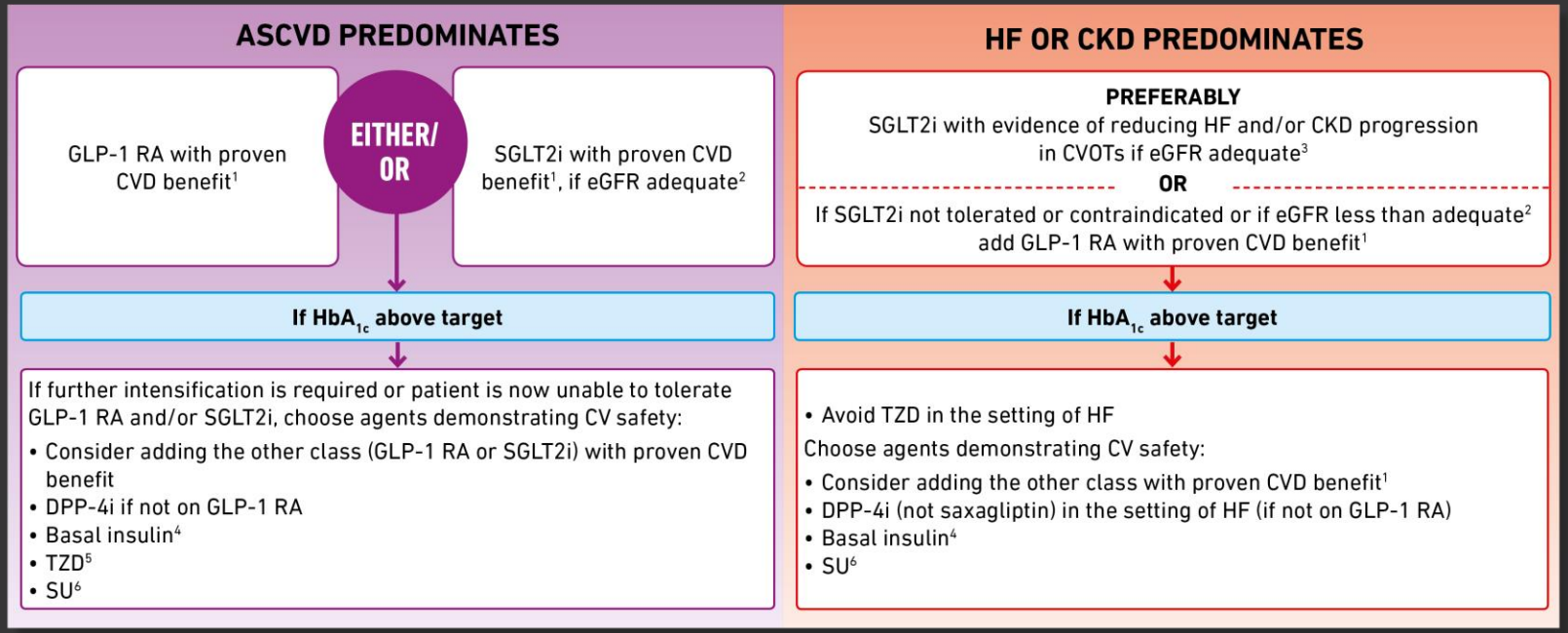

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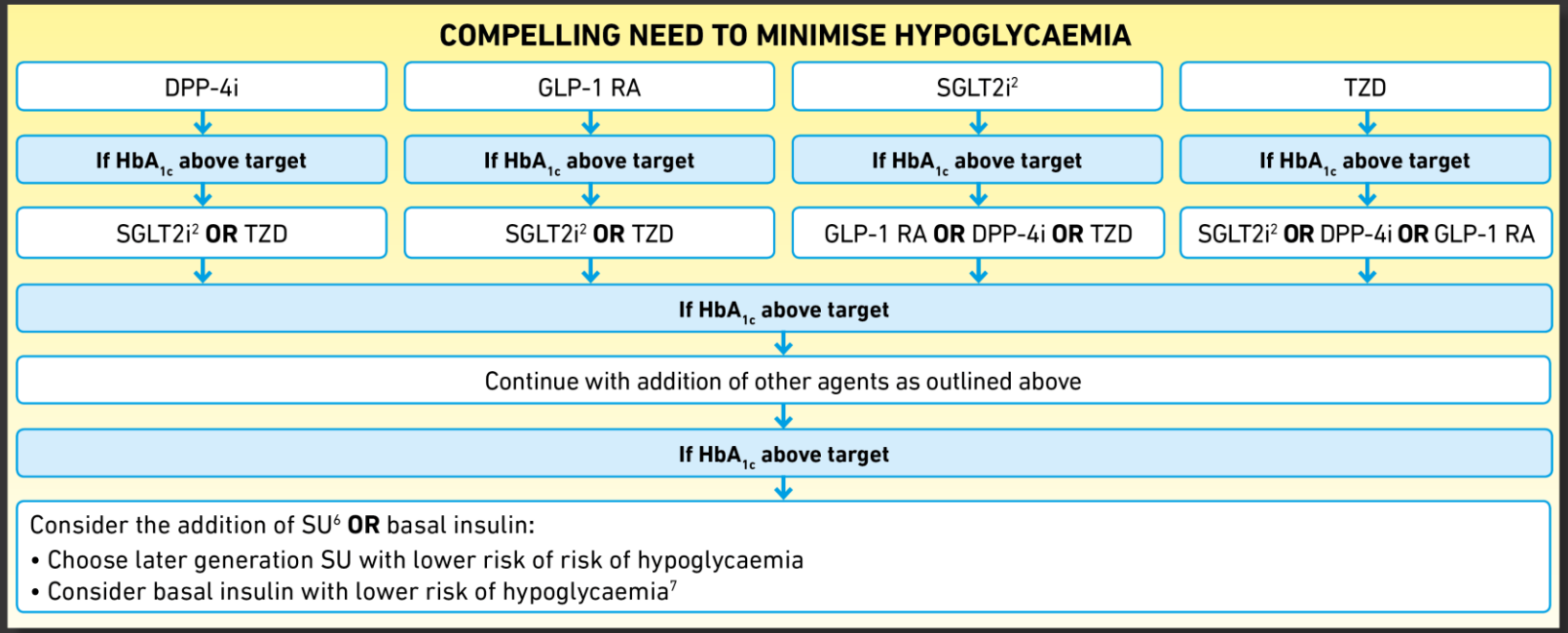

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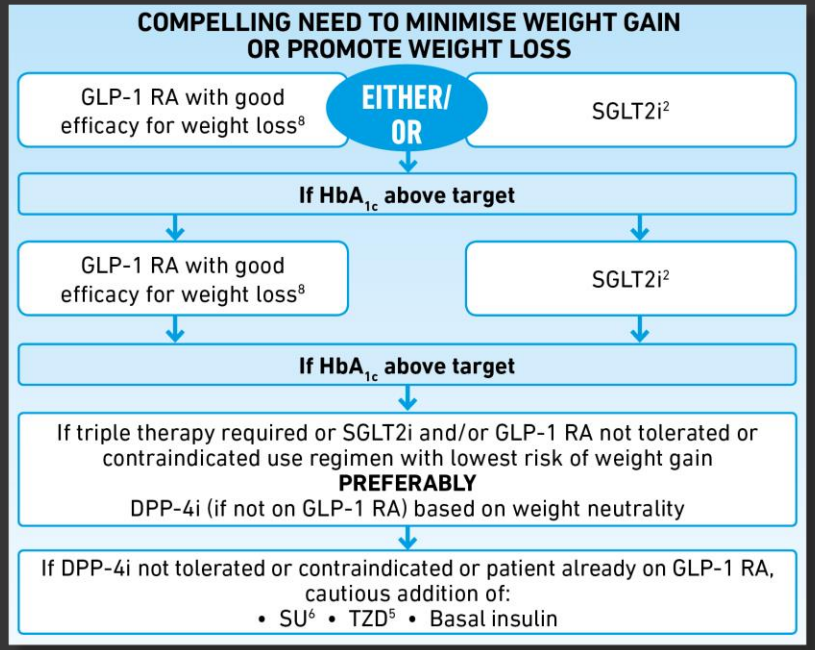

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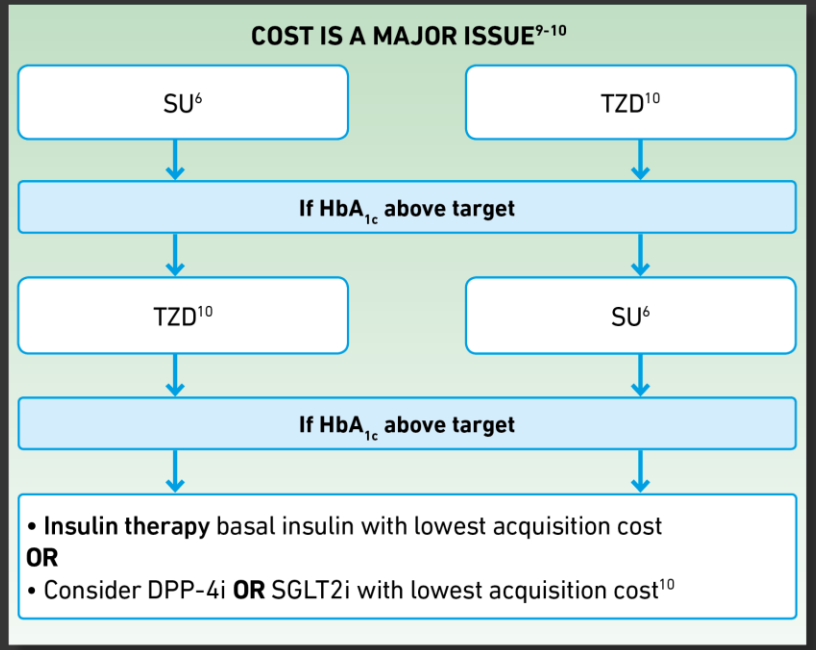


American Diabetes Association.

Pharmacologic Approaches to Glycemic Treatment (continued).

A new section was added on insulin injection technique, emphasizing the importance of technique for appropriate insulin dosing and the avoidance of complications (lipodystrophy, etc.).

The section on noninsulin pharmacologic treatments for type 1 diabetes was abbreviated, as these are not generally recommended.

Cardiovascular Disease and Risk Management.

For the first time, this section is endorsed by the American College of Cardiology. Additional text was added to acknowledge heart failure as an important type of CVD in people with diabetes for consideration when determining optimal diabetes care.

Blood pressure recommendations were modified:

- For individuals with diabetes and hypertension at higher cardiovascular risk (existing ASCVD or 10-year ASCVD >15%), a blood pressure target of <130/80 mmHg may be appropriate, if it can be safely attained.
- For individuals with diabetes and hypertension at lower risk for CVD (10-year ASCVD risk <15%), treat to a blood pressure target of <140/90 mmHg.

A discussion of the appropriate use of the ASCVD risk calculator was included, and recommendations were modified to include assessment of 10-year ASCVD risk as part of overall risk assessment and in determining optimal treatment approaches.

AMERICAN COLLEGE of CARDIOLOGY

ASCVD Risk Estimator Plus

Estimate Risk | Therapy Impact | Advice

Unit of Measure US SI

Reset All

App is intended for primary prevention patients (without ASCVD).

Current Age *

Age must be between 20-79

Sex *

Male | Female

Race *

White | African American | Other

Systolic Blood Pressure (mm Hg) *

Value must be between 90-200

Diastolic Blood Pressure (mm Hg)

Value must be between 60-130

Total Cholesterol (mg/dL) *

Value must be between 130 - 320

HDL Cholesterol (mg/dL) *

Value must be between 20 - 100

LDL Cholesterol (mg/dL)

Value must be between 30-300

History of Diabetes? *

Yes | No

Smoker: *

Yes | Former | No

On Hypertension Treatment? *

Yes | No

On a Statin?

Yes | No

On Aspirin Therapy?

Yes | No

Do you want to refine current risk estimation using data from a previous visit?

Yes | No

Determine Therapy Impact

View Advice

Cardiovascular Disease and Risk Management (continued).

The recommendation and text regarding the use of aspirin in primary prevention was updated with new data:

- Aspirin therapy (75-162 mg/day) may be considered as a primary prevention strategy in those who are at increased CV risk, after a discussion with the patient on the benefits versus increased risk of bleeding.

For alignment with the ADA-EASD consensus report, two recommendations were added for the use of medications that have proven cardiovascular benefit in people with ASCVD, with and without heart failure.

Microvascular Complications and Foot Care.

The recommendation on the use of telemedicine in retinal screening was modified:

- Telemedicine programs that use validated retinal photography with remote reading by an ophthalmologist or optometrist and timely referral for a comprehensive eye examination when indicated can be an appropriate screening strategy for diabetic retinopathy.

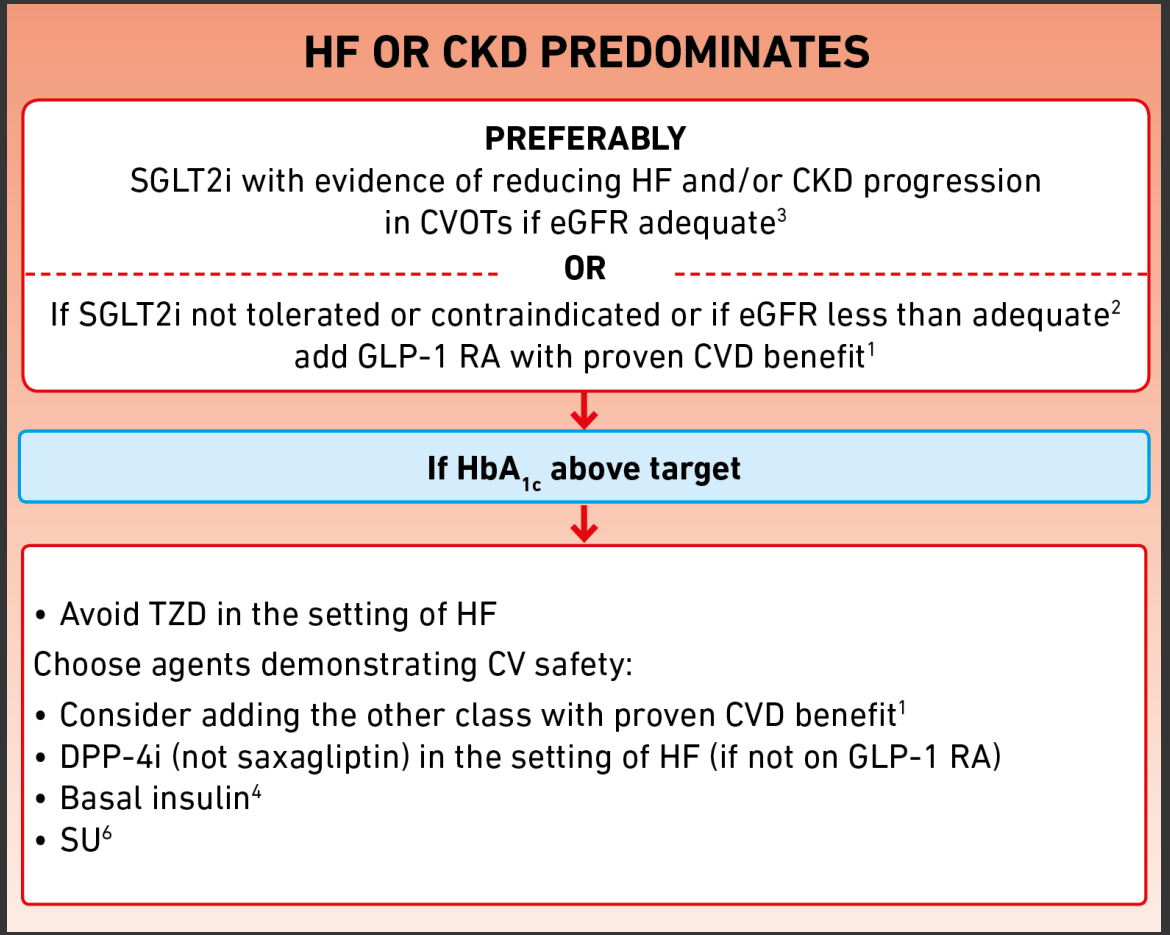
Gabapentin was added to the list of agents to be considered for the treatment of neuropathic pain in people with diabetes based on data on efficacy and the potential for cost savings.

Microvascular Complications and Foot Care (continued).

The gastroparesis section includes a discussion of a few additional treatment modalities.

The recommendation for patients with diabetes to have their feet inspected at every visit was modified to only include those at high risk for ulceration. Annual examinations remain recommended for everyone.

To align with the ADA-EASD consensus report, a recommendation was added for people with type 2 diabetes and chronic kidney disease to consider agents with proven benefit with regard to renal outcomes.

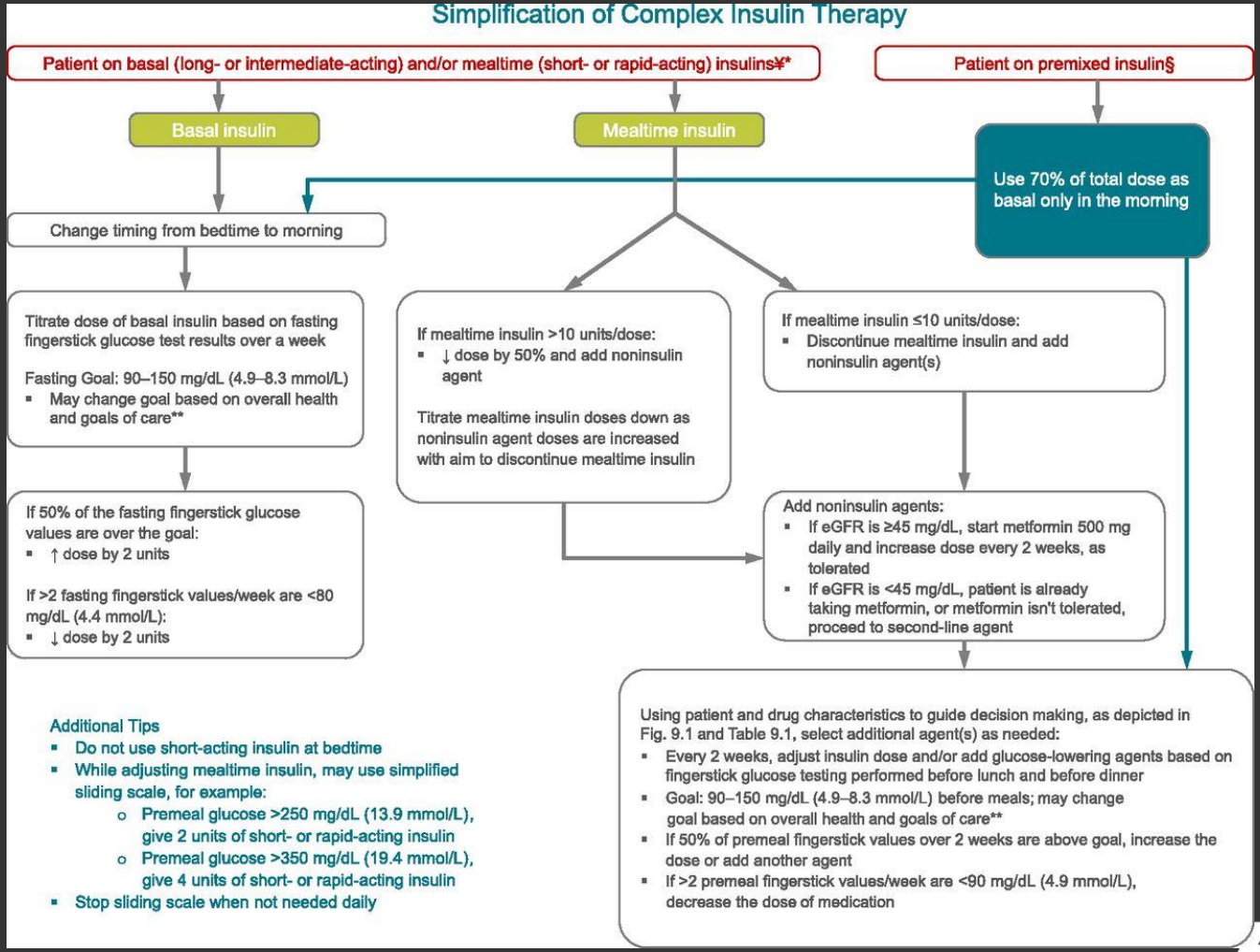


Older Adults.

A new section and recommendation on lifestyle management was added to address the unique nutritional and physical activity needs and considerations for older adults.

Within the pharmacologic therapy discussion, deintensification of insulin regimes was introduced to help simplify insulin regimen to match individual's self-management abilities. A new figure was added (Fig. 12.1) that provides a path for simplification. A new table was also added (Table 12.2) to help guide providers considering medication regimen simplification and deintensification/deprescribing in older adults with diabetes.

Simplification of Complex Insulin Therapy



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Management of Diabetes in Pregnancy.

Women with preexisting diabetes are now recommended to have their care managed in a multidisciplinary clinic to improve diabetes and pregnancy outcomes.

Greater emphasis has been placed on the use of insulin as the preferred medication for treating hyperglycemia in gestational diabetes mellitus as it does not cross the placenta to a measurable extent and how metformin and glyburide should not be used as first-line agents as both cross the placenta to the fetus.

Diabetes Care in the Hospital.

Because of their ability to improve hospital readmission rates and cost of care, a new recommendation was added calling for providers to consider consulting with a specialized diabetes or glucose management team where possible when caring for hospitalized patients with diabetes.

American Diabetes Association.

- Full version available
- Abridged version for PCPs
- Free app, with interactive tools
- Pocket cards with key figures
- Free webcast for continuing education credit

Professional.Diabetes.org/SOC

American Diabetes Association.

Thank you!

February Webinar

- **Date/Time**: February 21, 2019 from 2-3pm Eastern
- **Topic**: Clinical Inertia and Diabetes Care
- **Presenter**: Daniel McCall, M.D. (Hattiesburg Clinic)

TOGETHER 2 GOAL® 2019 WEBINAR SCHEDULE

WEBINARS WILL BE HELD FROM 2-3PM EASTERN

Date	Topic	Presenter(s)
Jan. 17, 2019	**American Diabetes Association (ADA) 2019 Standards of Care**	Nisa Maruthur, M.D., M.H.S. (Johns Hopkins University)
Feb. 21, 2019	**Clinical Inertia and Diabetes Care**	Daniel McCall, M.D. (Hattiesburg Clinic)
March 21, 2019	**Overcoming Barriers to Diabetes Self-Management Education (DSME) Referrals**	Jodi Lavin-Tompkins, M.S.N., R.N., CDE, BC-ADM (American Association of Diabetes Educators) and Valerie Spier, M.P.H., R.D., CDE (Sutter Health)
April 18, 2019	**T2G Campaign Extension**	AMGA
May 16, 2019	**Mental Health Integration and Diabetes Management**	Brenda Reiss-Brennan, Ph.D., APRN and Mark Greenwood, M.D. (Intermountain Healthcare)
June 20, 2019	**T.B.D.**	T.B.D.
July 18, 2019	**Innovator Track Cardiovascular Disease Cohort Results**	Innovator Track Cardiovascular Disease Cohort Participants
Aug. 15, 2019	**Embedded Pharmacists in Primary Care**	Diane L. George, D.O. (Henry Ford Medical Group)
Sept. 19, 2019	**Innovator Track Eye Care Cohort Results**	Innovator Track Eye Care Cohort Participants
Oct. 17, 2019	**Billing and Coding for Diabetes Care**	Debra Barnhart (Mercy Health)
Nov. 21, 2019	**Culinary Medicine as an Emerging Population Health Intervention**	Timothy Harlan, M.D., FACP, CCMS and Leah Sarris, R.D., LDN, CCMS (Tulane University School of Medicine)
Dec. 19, 2019	**T2G Diabetes Bundle Collaborative Results**	T2G Diabetes Bundle Collaborative Participants

Questions