



CARDI•OH

Ohio Cardiovascular and Diabetes Health Collaborative



In partnership with:



Cardi-OH ECHO Tackling Type 2 Diabetes

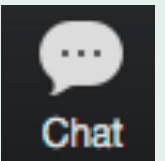
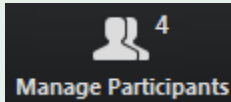
Thursday, January 14, 2021



Welcome



- Please rename yourself with your name and practice location in the “Manage Participants” box.
- Please enter your name and practice location into the “Chat” to record your attendance.
- Use the “Chat” feature to ask questions and receive survey links.
- Please remember to “Mute” your microphone unless speaking.
- Call our Tech Team at 440-796-2221 if you have audio or visual problems.
- If you can’t connect to audio via computer, or you lose computer audio at anytime, you can call in to the clinic; 646-558-8656.





CARDI•OH

Ohio Cardiovascular and Diabetes Health Collaborative

Welcome

Donald Wharton, MD

Assistant Medical Director

Ohio Department of Medicaid

About Cardi-OH

Founded in 2017, the mission of Cardi-OH is to improve cardiovascular and diabetes health outcomes and eliminate disparities in Ohio's Medicaid population.

WHO WE ARE: An initiative of health care professionals across Ohio's seven medical schools.

WHAT WE DO: Identify, produce and disseminate evidence-based cardiovascular and diabetes best practices to primary care teams.

HOW WE DO IT: Utilize monthly newsletters and an online repository of resources at Cardi-OH.org, podcasts available on Cardi-OH Radio, and the Project ECHO® virtual training model.

Learn more at cardi-oh.org



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Ohio Cardiovascular and Diabetes Health Collaborative



*In
partnership
with:*



Cardi-OH ECHO Hub Team



LEAD

Goutham Rao, MD
Case Western Reserve University

FACILITATOR

Kathleen Dungan, MD, MPH
The Ohio State University

DIDACTIC PRESENTERS

Liz Beverly, PhD
Ohio University

Kathleen Dungan, MD, MPH
The Ohio State University

CASE PRESENTER

Goutham Rao, MD
Case Western Reserve University

Spring 2021 Cardi-OH ECHO Participant Sites



1 **MetroHealth Bedford**
Bedford, OH

2 **Neighborhood Family Practice**
Cleveland, OH

3 **Signature Health - Painesville**
Painesville, OH

4 **Signature Health - Ashtabula**
Ashtabula, OH

5 **Chillicothe VA Medical Center -
Athens Community Based
Outpatient Clinic**
The Plains, OH

6 **OhioHealth Physician Group
Heritage College**
Athens, OH

7 **Camden Clark Medical Center**
Parkersburg, WV

8 **Crossroad Health Center**
Cincinnati, OH

9 **Hoxworth General Internal Medicine**
Cincinnati, OH

10 **The Health Care Connection**
Lincoln Heights, OH

11 **Wright State Family Medicine Residency Program**
Dayton, OH

12 **Wright State Geriatrics**
Fairborn, OH

13 **University of Toledo Regency Primary Care**
Toledo, OH

14 **Community Health Services**
Fremont, OH

15 **Ohio State University General Internal Medicine**
Hilliard, OH

Structure of TeleECHO Clinics

Duration	Item
5 minutes	Introductions, roll call, announcements
10 minutes	Didactic presentation, followed by Q&A
20 minutes	Case Study 1 presentation and discussion
20 minutes	Case Study 2 presentation and discussion
5 minutes	Wrap-up/Post-Clinic Survey completion

Disclosure Statements



- The following planners, speakers, moderators, and/or panelists of the CME activity have financial relationships with commercial interests to disclose:
 - Kathleen Dungan, MD, MPH receives consulting fees from Eli Lilly and Tolerion, institutional research fees from Abbott, Novo Nordisk, and Sanofi Aventis, and honoraria from Academy for Continued Healthcare Learning, Cardiometabolic Health Conference, Elsevier, and Uptodate.
 - Adam T. Perzynski, PhD reports being co-owner of Global Health Metrics LLC, a Cleveland-based software company and royalty agreements for book authorship with Springer Nature publishing and Taylor Francis publishing.
 - Christopher A. Taylor, PhD, RDN, LD, FAND reports grant funding for his role as a researcher and presenter for Abbott Nutrition and grant funding for research studies with both the National Cattleman's Beef Association and the American Dairy Association.
 - Jackson T. Wright, Jr., MD, PhD reports research support from the NIH and Ohio Department of Medicaid and consulting with NIH, AHA, and ACC.
 - These financial relationships are outside the presented work.
- All other planners, speakers, moderators, and/or panelists of the CME activity have no financial relationships with commercial interests to disclose.

Overview of 2020 Standard of Medical Care & the Importance of Language in Diabetes



Elizabeth Beverly, PhD

Associate Professor

Heritage Faculty Endowed Fellowship in Behavioral Diabetes

OHF Ralph S. Licklider, DO, Research Endowment

Department of Primary Care

Ohio University Heritage College of Osteopathic Medicine

Kathleen Dungan, MD, MPH

Professor, Associate Director Clinical Services

Division of Endocrinology, Diabetes & Metabolism

The Ohio State University

Objectives

1. List and describe the five ADA and ADCES recommendations for language in diabetes care.
2. List criteria for screening and diagnosis of type 2 diabetes in adults.
3. Describe a step-wise progression in management of new onset type 2 diabetes.

The Importance of Language in Diabetes



Elizabeth Beverly, PhD

Associate Professor

Heritage Faculty Endowed Fellowship in Behavioral Diabetes

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Diabetes & Language



- Research documented negative attributions providers, friends, and family members that include the following: “weak,” “lazy,” “gluttons,” “disgusting,” “poor,” “bad,” and “not terribly intelligent.”
- People with diabetes who perceive more stigma report higher levels of psychological distress, more depressive symptoms, less social support, and lower quality of life.
 - Associated with fewer self-care behaviors, higher A1C levels, and increased complications.

Recommended Language



- Upon identification that language in diabetes can be stigmatizing and harmful, the following organizations have published position statements:
 - Diabetes Australia (2010)
 - International Diabetes Federation (2014)
 - American Diabetes Association (2017)
 - American Association of Diabetes Educators (2017)

Recommended Language



Recommendations from ADA and AADE Consensus Report (Diabetes Care, 2017)	Examples	Suggestions
1. Use language that is neutral, nonjudgmental, and based on facts, actions, or physiology/biology.	Control Good/bad/poor Glycemic control	Manage Numbers/choices Blood glucose levels/A1C
2. Use language that is free from stigma.	Noncompliant Lifestyle disease	Engagement/Involvement Diabetes
3. Use language that is strengths-based, respectful, inclusive, and imparts hope.	Prevent Refused	Reduce risk Declined
4. Use language that fosters collaboration between patients and providers.	Regimen You can/can't	Plan/Choices “Would you like to consider”
5. Use language that is person-centered.	Diabetic “What did you do?”	Person who has diabetes “Tell me about...”

Important Considerations



- People with diabetes are diverse.
- What applies to one person will not apply to another.
- It is impossible to predict what any single individual might prefer or not prefer.

Summary

SKIP

Diabetic **X**

Test **X**

Control **X**

Unrealistic goals **X**

Suffering from diabetes **X**

Good/bad/poor levels **X**

Compliance or adherence **X**

SAY

Person with diabetes ✓

Monitor ✓

Manage ✓

High expectations for self-management ✓

Living with diabetes ✓

Target levels ✓

Engagement/taking meds ✓

Takeaways



- Ask the person you are interacting with what they prefer.
- Play it safe and choose person-first language.

Overview of 2020 Standard of Medical Care in Diabetes

Kathleen Dungan, MD, MPH

Professor, Associate Director Clinical Services

Division of Endocrinology, Diabetes & Metabolism

The Ohio State University



Who to screen?

- >45 years old

Or

Overweight or obese adults with 1 or more risk factors:

- High risk ethnicity
- 1st degree relative with DM
- CVD
- GDM or baby > 9#
- HTN
- HDL <35 mg/dl
- TG >250 mg/dl
- PCOS
- Physical inactivity
- Condition associated with insulin resistance (acanthosis nigricans)
- Gestational Diabetes

- *Repeat screen*
 - *every 3 years if normal*
 - *annually if prediabetes*

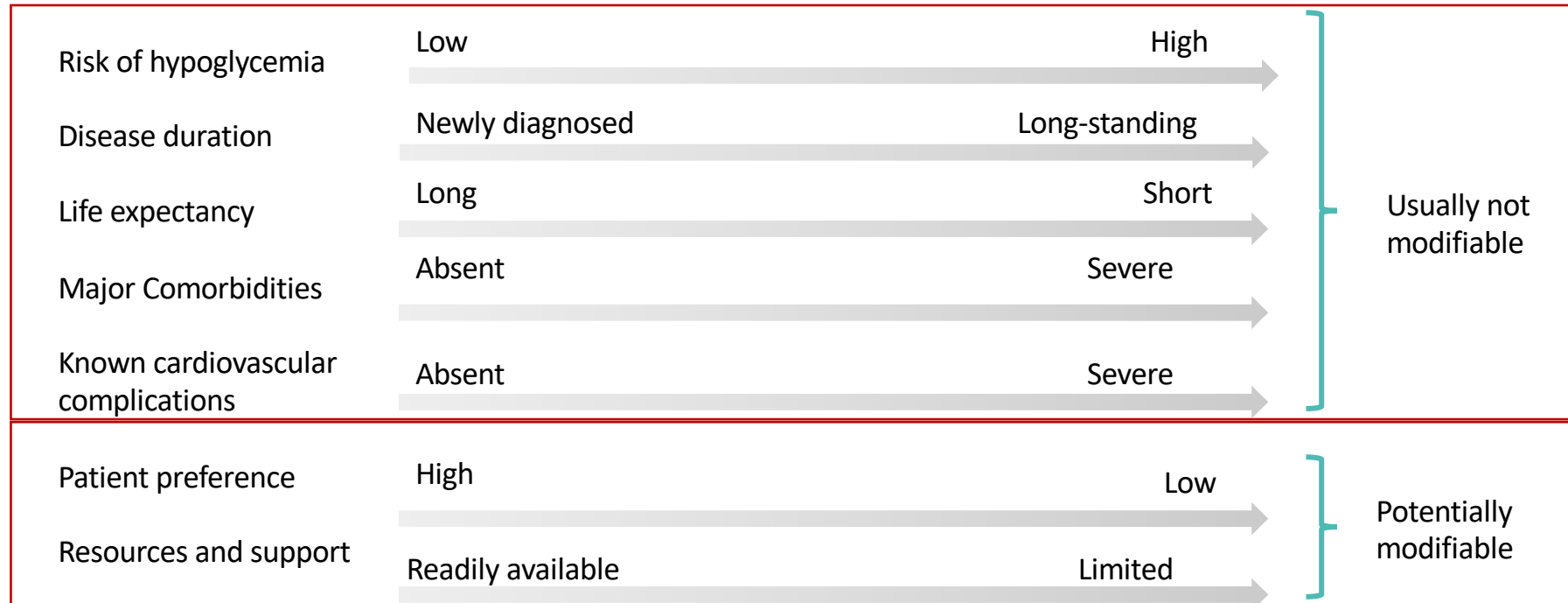
How Should we Screen?

Method	Normal	Prediabetes	Diabetes
Fasting BG*	<100 mg/dl	100-125 mg/dl	≥126 mg/dl
2 hr OGTT (75 gm)#	<140 mg/dl	140-199 mg/dl	≥200 mg/dl
HbA1c	<5.7%	5.7-6.4%	≥6.5%
Random BG	-	-	Symptoms of DM & random serum BG ≥ 200 mg/dl

*In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results (e.g. fasting glucose + HbA1c) from the same sample or in two separate test samples.

Refer people with prediabetes and overweight/obesity to an intensive lifestyle intervention program such as the Diabetes Prevention Program (DPP) and/or to individualized MNT.

ADA Approach to A1C Targets

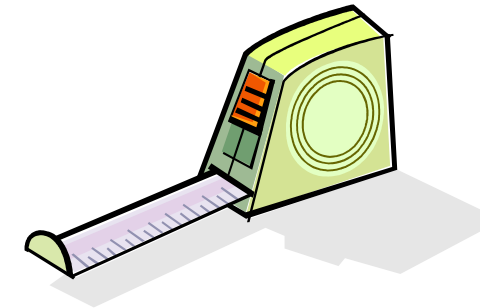


Glucose Target



Measuring Success

Health status	A1c (%)	Fasting/premeal (mg/dl)	Peak Postprandial (mg/dl)	Bedtime (mg/dl)
General Population				
Healthy*	7.0	80-130	180	*
Older Adults				
Healthy	7.5	90-130	*	90-150
Intermediate	8.0	90-150	*	100-180
Poor	8.5	100-180	*	110--200



***Goals should be individualized.** Healthy refers to few comorbidities, intact cognition and activities of daily living while poor indicates end-stage comorbidities, moderate-severe cognitive impairment, or requiring long-term care or dependency in 2 or more activities of daily living.

Glucose Monitoring

	SMBG	CGM
Non-insulin therapy	Structured (varied times of day) as needed to <ul style="list-style-type: none"> • Inform or monitor treatment adjustment • Inform lifestyle choices • During illness • Monitoring hypoglycemia (SU or glinide) 	Consider short-term/professional CGM if not meeting goals
Basal insulin	1-3+ times/day (especially FBG)	Consider if cost is not a barrier
MDI	3+ times per day <ul style="list-style-type: none"> • Meals • Exercise • Driving • Hypoglycemia • Occ. Postprandial (dose titration) 	<ul style="list-style-type: none"> • If not meeting A1c goals • Real-time alert preferred for people with frequent hypoglycemia, severe events, or hypoglycemia unawareness

ADA Standards of Care 2021



If A1c >1.5% above target consider early combination

Metformin + Lifestyle
↓
Established ASCVD or CKD[^]

All patients
Lifestyle advice
Caloric restriction
Evidence-based weight loss programs
Weight loss surgery
Weight loss medication

Treatment regardless of baseline A1c, glucose target or metformin

ASCVD

GLP-1RA or SGLT2i* with proven CV benefit

HFrEF (LVEF <45)

SGLT2i* with proven HF benefit[^]

CKD + albuminuria

SGLT2i* with proven CKD benefit[#]

CKD, no albuminuria

GLP-1RA or SGLT2i* with proven CV benefit

Other agent demonstrating CV safety:

- DPP4i (Sitagliptin, Linagliptin) if not on GLP-1RA
- Low dose TZD
- Degludec or Glargine U100
- Glimepiride

Yes

No

If A1c above goal, consider compelling indications for treatment

Hypoglycemia

SGLT2i*
GLP-1RA
DPP-4i
TZD

Other agent

- Colesevalam
- Bromocriptine QR
- AGI
- *later generation SFU OR degludec/ glargine U300*

Weight Gain

GLP-1RA⁺
SGLT2i*

Other agent

- Colesevalam
- Bromocriptine QR
- AGI
- *Minimize SFU, insulin, TZD*

Cost

SFU
TZD

Other agent

- AGI
- Glinides
- NPH insulin

If A1c above goal, add agent based upon compelling indications above

*if adequate eGFR, [^]Empagliflozin and dapagliflozin have shown benefit in dedicated HF studies. Canagliflozin has demonstrated reduction in hospitalization for HF in CV outcomes trials.
[#]Dapagliflozin and canagliflozin have demonstrated benefit in dedicated renal outcomes studies. Empagliflozin has demonstrated reduction in CKD progression in CV outcomes trials.
⁺Weight loss is greatest with semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide

Therapeutic Considerations in T2DM

In addition to lifestyle changes



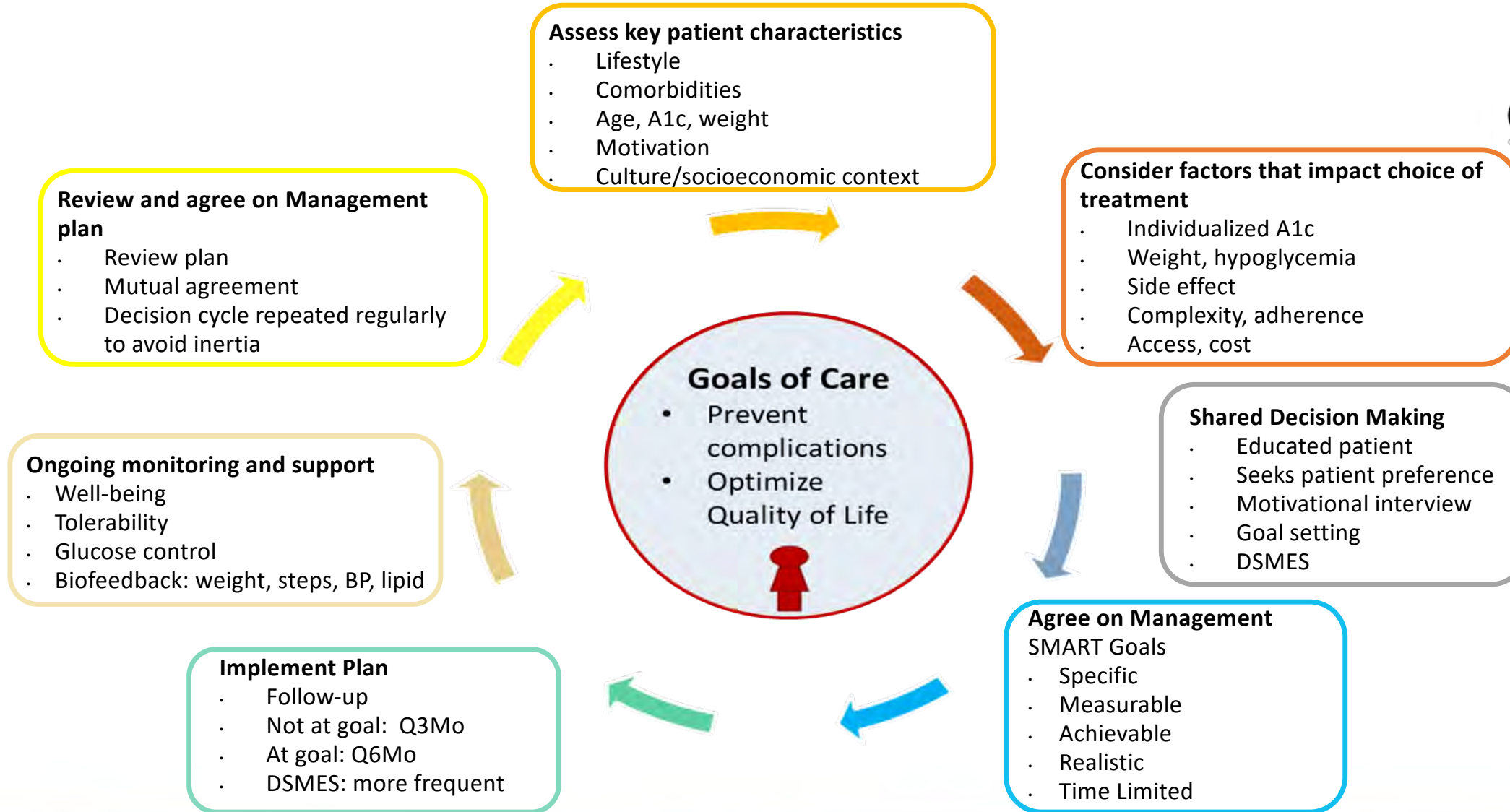
	Metformin	SFU	TZD	DPP4i	SGLT2i	GLP-1RA ⁺	Insulin
Efficacy*	++	++	++	+	++	+++	+++
Hypoglycemia	-	+	-	-	-	-	+
Weight	-	↑	↑	-	↓	↓↓	↑
Side Effect	GI, lactic acidosis	Hypoglycemia	Edema, HF, Frx	Rare	GU mycotic infection, dehydration, DKA, frx	GI	hypoglycemia
CV benefit	?	-	?	-	+	+	-
Cost	↓	↓	↓	↑	↑	↑	↑

**The magnitude of A1c reduction is dependent on baseline A1c*

⁺Weight loss is greatest with semaglutide > liraglutide > dulaglutide > exenatide > lixisenatide

Glucose lowering is greatest with semaglutide > liraglutide/dulaglutide > exenatide QW > exenatide BID / ?lixisenatide

Patient-Centered Glycemic Management





Thank you!

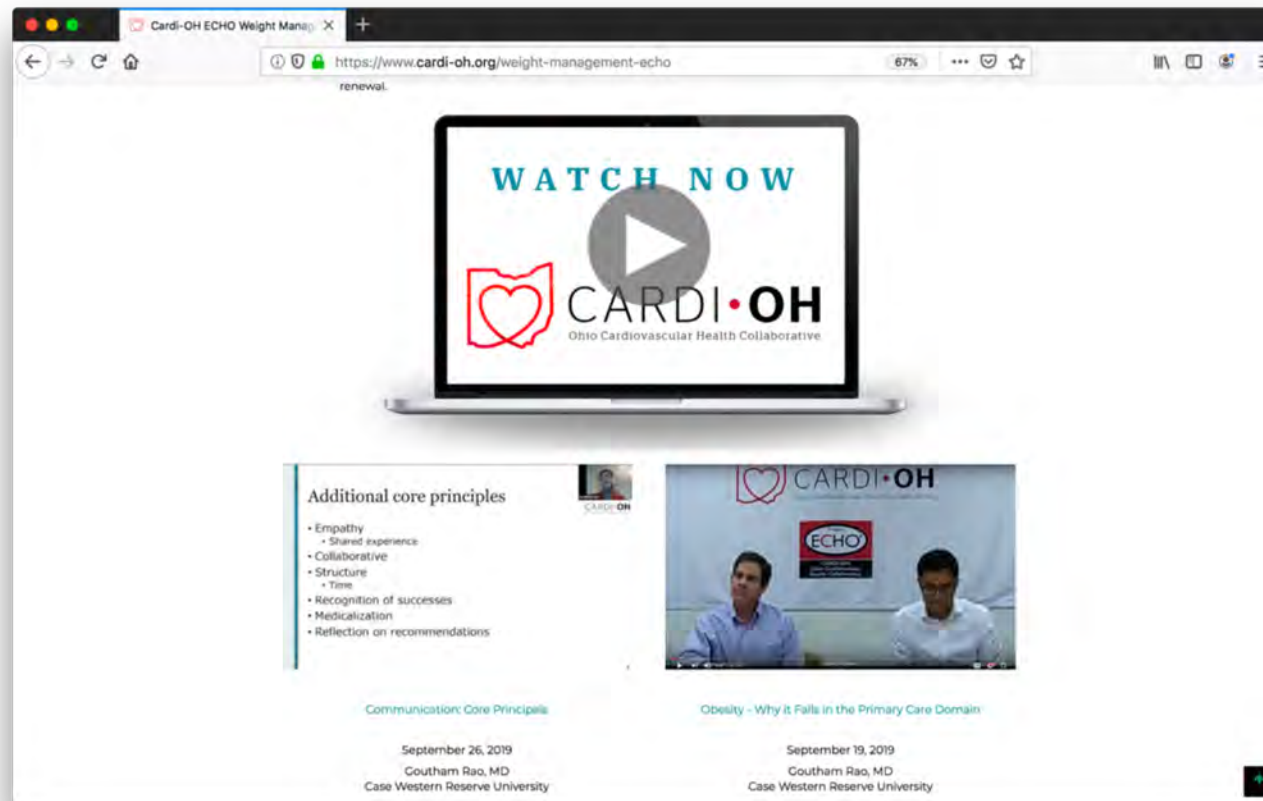
Questions/Discussion

Watch Previous Cardi-OH TeleECHO Clinics



Register on [Cardi-OH.org](https://www.cardi-oh.org) to watch all Tackling Type 2 Diabetes TeleECHO Clinics:

- <https://www.cardi-oh.org/user/register>
- <https://www.cardi-oh.org/echo/diabetes-spring-2021>





Reminders



- A Post-Clinic Survey has been emailed to you. Please complete this survey as soon as possible.
- *The MetroHealth System is accredited by the Ohio State Medical Association to provide continuing medical education for physicians.*
- *The MetroHealth System designates this educational activity for a maximum of 1 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.*

February 2021 Webinar

Registration Now Open!

Integrating Behavioral Health and Primary Care Services: Lessons Learned From Three Ohio Practices

Wednesday, February 10, 2021

12:00 – 1:00 PM EST

No cost to attend

Free CME credits available

Register online:

<https://www.cardi-oh.org/>