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Ohio Cardiovascular and Diabetes Health Collaborative

SCHOOL OF MEDICINE
CASE WESTERN RESERVE UNIVERSITY

In partnership with:

THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER

COLLEGE OF MEDICINE AND LIFE SCIENCES THE UNIVERSITY OF TOLEDO

OHIO UNIVERSITY Heritage College of Osteopathic Medicine

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OHIO COLLEGES OF MEDICINE GOVERNMENT RESOURCE CENTER

Ohio Department of Medicaid

Project ECHO®

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Clinic Wrap-Up

Thursday, December 10, 2020

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 Eli Lilly, Novo Nordisk, and Sanofi Aventis, and presentation honoraria from Nova Biomedical, Integritas, and Uptodate.
  - Siran M. Koroukian, PhD receives grant funds for her role as a co-investigator on a study funded by Celgene.
  - 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.
  - Martha Sajatovic, MD receives grant support as PI of studies with Nuromate and Otsuka, study design consulting fees from Alkermes, Otsuka, Neurocrine, and Health, and publication development royalties from Springer Press and Johns Hopkins University.
  - 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.

The Importance of Language in Diabetes

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OHF Ralph S. Licklider, D.O., Research Endowment

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Objectives

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1. Describe type 2 diabetes stigma.

2. List and describe the five ADA and ADCES recommendations for language in diabetes care.

3. List a minimum of three suggestions for recommended terminology in diabetes language.

Diabetes Stigma

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- Considering the role that self-care plays in diabetes management, stigma may be influencing how people view the disease.
- Diabetes stigma refers to negative feelings, such as exclusion, rejection, or blame, associated with having diabetes.
- The most common diabetes stigma, regardless of type of diabetes, was the perception that people with diabetes were responsible for developing their diabetes.

Liu NF, Brown AS, Younge MF, Guzman SJ, Close KL, Wood R, Clinical Diabetes, 2017

Diabetes Stigma

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- A recent study of 5,422 adults found 76% of people with type 1 diabetes and 52% of people with type 2 diabetes experienced stigma.
- Respondents with BMI ≥25 kg/m^2, A1C >7.0%, self-reported blood glucose levels above target, and self-reported depression perceived more stigma.
- The perception of stigma increased with greater insulin therapy intensity.

Liu NF et al., Clinical Diabetes, 2017

Diabetes Stigma

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- 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.

Browne JL et al., BMJ Open, 2013; Tak-Ying SA et al., Clinical Nursing, 2003: Kato A et al., Patient Education and Counseling, 2016; Gredig D & Bartelsen-Raemy A, Health & Social Care, 2017; Dunning T et al., Diabetes Educ, 2017; Beverly EA et al., Clinical Diabetes, 2019; Fisher L et al., Diabetic Medicine, 2009; Lustman PJ et al., Diabetes Care, 2000; Georglades et al., Psychosom Med., 2007; Fisher L et al., Diabetes Care, 2010; Aikens JE, 2012.

Recommended Language

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- 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)

Speight J et al., Diabetes Res Clin Pract, 2012; IDF, Brussels, Belgium, 2014: Dickinson JK et al., Diabetes Care, 2017

Recommended Language

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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…"

Dickinson JK et al., Diabetes Care, 2017

Important Considerations

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- 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

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SKIP	SAY
Diabetic X	Person with diabetes ✓
Test X	Monitor ✓
Control X	Manage ✓
Unrealistic goals X	High expectations for self-management ✓
Suffering from diabetes X	Living with diabetes ✓
Good/bad/poor levels X	Target levels ✓
Compliance or adherence X	Engagement/Taking meds ✓

Takeaways

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

ADA Lipid Guideline Review and Microvascular Complications of Diabetes

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Objectives

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1. List primary prevention indications for statin therapy for patients with diabetes with different degrees of cardiovascular risk.
2. List indications for SGLT inhibitors or GLP1 receptor agonists among patients with diabetic nephropathy.
3. Review the initial approach to identifying and managing microvascular disease.

Lipids in Persons with DM

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- Use ACC/AHA risk calculator: does not account for DM duration or complications
- Lifestyle
  - Weight loss
  - Mediterranean/DASH diet
  - ↓sat/trans fat
  - ↑fiber, n-3 FA, plant stanol/sterol
  - PA
  - ↑TG: glycemic control also helps
- Monitoring
  - Initial diagnosis or medical evaluation
  - Every 5 years (<age 40)
  - Initiation of statins or other therapy
  - 4-12 weeks after change in therapy
  - Annually for patients on therapy to inform medication taking behavior

Diabetes Care 2020;43(S1):S1-S212

Cholesterol

Age	ASCVD or 10-year ASCVD risk >20%	Recommended statin intensity and combination treatment*
<40 years	No	None**
	Yes	High • If LDL ≥ 70 mg/dL despite maximally tolerated statin, consider adding additional LDL-lowering therapy (ezetimibe or PCSK9i)
≥40 years	No	Moderate***
	Yes	High • If LDL ≥ 70 mg/dL despite maximally tolerated statin, consider adding additional LDL-lowering therapy (ezetimibe or PCSK9i)

*In addition to lifestyle therapy
**Moderate intensity statin may be considered based on risk-benefit profile and CVD risk factors (including LDL cholesterol ≥100 mg/dL (2.6 mmol/L), high blood pressure, smoking, CKD, albuminuria and family history of premature ASCVD)
***High intensity statin may be considered based on CVD risk factors
>75 years: consider statin after shared decision making

Diabetes Care 2020;43(S1):S1-S212

Other Lipids

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- Hypertriglyceridemia
  - If fasting TG >500: evaluate for secondary causes and consider treatment: fibrate, prescription strength fish oil,
  - CVD or multiple risk factors, on statin with controlled LDLc and TG 135-299: consider icosapent ethyl (Vascepa, purified EPA) to reduce CV risk

Diabetes Care 2020;43(S1):S1-S212

	Components of Comprehensive Medical Evaluation	Initial	Follow-up	Annual
PMH/FH	• Diabetes history: duration, prior Rx, hospitalizations	X		
	• Family history: 1st degree relative, AI disease	X		
	• Complications/comorbidities			
	• Microvascular/macrovascular	X		
	• Hypoglycemia: awareness, frequency, cause/timing	X	X	X
	• Obesity, OSA, hypertension, hyperlipidemia	X		X
	• Visits to specialists: eye, dental	X	X	X
Lifestyle	• Eating pattern and weight	X	X	X
	• Physical activity and sleep	X	X	X
	• Tobacco, alcohol, substance use	X		X
Medications	• Current regimen, behavior, side effects	X	X	X
	• Complementary/alternative medicine	X	X	X
	• vaccinations	X		X
Technology	• Use of health apps, patient portal	X		X
	• Glucose monitor: results and use	X	X	X
Behavioral and Self-management	• Psychosocial			
	• Screen for depression, anxiety, disordered eating	X		X
	• Identify social support	X		X
	• Consider assessing cognition	X		X
	• DMSE: prior use, assess skills/barriers	X	X	X
	• Pregnancy planning	X	X	X
Exam	• BMI, BP	X	X	X
	• Skin: acanthosis nigricans, injection sites, lipodystrophy	X	X	X
	• Foot: visual, pulses, either temp/vib/pinprick + 10-g MF	X	*	X
Laboratory	• A1c (every 3 months)	X	X	X
	• Annual: Lipid, LFT, UMCR, Creatinine, vitamin B12 (metformin use), K+	X	#	X^

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*Each visit if neuropathy or prior ulcer/amputation
#more often if medication adjustments
^lipids may be less often if normal, not on therapy

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Neuropathy

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- Assessment annually starting at time of Dx of T2D
- Should include: history +
  - Temperature or pinprick (small fiber)
  - Vibration (125 Hz tuning fork—large fiber)
- 10 gm MF: identifies risk for foot ulcer/amputation
- Up to 50% is asymptomatic
- Diagnosis of exclusion
- Foot care/precautions
- Pain:
  - FDA approval: pregabalin, duloxetine
  - Gabapentin also widely used
  - Tapentadol is FDA approved for PSPN but not recommended first or 2nd line
  - TCA, venlafaxine, carbamazepine, topical capsaicin

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Nephropathy

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- Annual screening: urine albumin:creatine and eGFR
- If UA/cr >30 mg/g or eGFR < 50, perform repeat testing to confirm
- eGFR >30, especially if proteinuria consider
  - SGLT2i (A)
  - GLP1RA (C)
- Optimize BP <140/90, consider 130/80
- ACEI/ARB
- Dietary protein:
  - Not on HD: 0.8 g/kg/day (RDA)
  - On HD: consider higher intake
- Refer to nephrologist if eGFR <30 ml/min/1.73 m^2, rapid progression, or uncertainty in etiology

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Retinopathy

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- Optimize A1c, BP, lipids
- Dilated eye exam
  - At Dx
  - every 1-2 years if no DR
  - annually if +DR
  - Before or in first trimester of pregnancy and every trimester
- PRP: high risk PDR and some severe NPDR
- Intravitreous EGFR: PDR, central macular edema

Diabetes Care 2020;43(S1):S1-S212

Thank you!

Questions/Discussion