

Together2Goal[®]

AMGA Foundation
National Diabetes Campaign

June 2020 Webinar at Work

"Putting T2G webinars into practice"

Webinar: ["Cardiovascular Benefit of New Diabetes Medications"](#)

Speakers: Gretchen Shull, M.D.,
Vice President of Diabetes Care at Mercy Clinic - Joplin

Webinar Date: June 18, 2020

Summary:

In the course of this webinar, Dr. Gretchen Shull 1) explores the connection between cardiovascular disease (CVD) and diabetes, 2) reviews the evolution of treating diabetes and CVD, 3) highlights the current guidelines and medications, and 4) provides strategies to implement current and relevant medications.

1. CVD and Diabetes

In the growing population of patients with diabetes, CVD is the number one cause of morbidity and mortality. Complications attributed to CVD increase the financial and physical burden on patients and caregivers as well as the health system.

2. Evolution of Treating Diabetes and CVD

In older studies (e.g., UKPDS (2000), ACCORD (2008), ADVANCE (2008), and VADT (2009)), the interventions resulted in reduced microvascular complications, but with no to low impact on cardiovascular mortality and major adverse cardiovascular events (MACE). The results of these studies demonstrated that individual glycemic controls are essential, but intensive glycemic control is not enough to improve cardiovascular outcomes. Additionally, these studies were beginning to suggest that statins were more important than glucose medications.

The evidence promoted not just a focus on glucose control, but the use of multifactorial interventions to treat diabetes. The target areas for improvement are: hyperglycemia, hypertension, dyslipidemia, and obesity. The traditional order for interventions is to start with lifestyle modifications and then introduce medications (i.e., prescriptions to control hbA1c, blood pressure, LDL cholesterol, and weight) with an emphasis on doing no harm. Lifestyle management remains the foundation of treatment beyond glycemic control and should be used alongside new agents (e.g., SGLT-2 inhibitor and GLP-1 agonist).

3. **Current Guidelines and Medications**

In a change from the 2019 ADA Standards of Care, the 2020 Standards of Care recommends considering medications for CVD protection for all patients with a high risk for or established ASCVD, CKD, or HF regardless of A1c control. The ADA previously only recommended adding CVD medications if a high-risk patient's A1c was not in control. Other guidelines (AACE/ACE) also recommend the use of SGLT-2 inhibitors and GLP-1 agonists if there is an established or high ASCVD risk independent of glycemic control.

4. **Strategies for Implementing Current and Relevant Medications**

Incorporating clinical decision-making tools helps clinicians stay current with the latest recommendations in diabetic management. The tools only display appropriate medications based on the unique parameters of each patient and reduce errors by pre-filtering based on glomerular filtration rate (GFR) and common contraindications. Mercy has worked to ensure their decision-making tools are fluid to allow for updates based on changing guidelines. However, it's important to include patient preferences (e.g., cost, dosing schedule, etc.) to guide treatment choice. Additionally, examining the time-in-range for glucose control with patients shows a bigger picture of patient data. Ambulatory Glucose Profile (AGP) reports help inform treatment choices and allow patients to have a better understanding of their glucose patterns and trends.

Implementation Tips:

When considering the different options of diabetes medications for patients:

- Examine time-in-range for glucose control with patients.
 - An AGP Report is a helpful tool for shared-decision making discussions.
- Consider cost barriers for patients when prescribing medications.
- Address patient adherence for more successful glucose control.
 - Do not choose medications that the patient will not take.
- Favor step-wise addition of glucose lowering medications over initial combination therapy.
 - There remains insufficient evidence to suggest first-line combination therapy is superior.
 - However, patients needing greater than 1.5% A1c reduction will likely need combination therapy.
- Approach diabetes care as a team.
 - Primary care, specialty departments, pharmacy, nursing, and nutrition all play important roles for comprehensive care.

Team Discussion:

1. How do we identify patients with diabetes at risk of vascular complications? (e.g., ASCVD Risk Calculator, EMR tools/reports)

2. How do we leverage current guidelines to inform treatment plans?

3. How can we help clinicians stay current with the latest recommendations in diabetes management?

4. How do we balance unique patient glycemic goals (e.g. shared-decision making) with our efforts to improve overall population health metrics?

5. Within our health system, what role do specialty departments have in the overall treatment plan for patients with diabetes and CVD? How can we promote or improve cross-department collaboration?

Additional Notes:

Next Steps:

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- _____
- _____
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Resources:

- The American Diabetes Association [Standards of Medical Care in Diabetes \(2020\)](#)
- American Association of Clinical Endocrinologists (AACE) and American College of Endocrinology (ACE) [Comprehensive Type 2 Diabetes Management Algorithm \(2020\)](#)
- [Ambulatory Glucose Profile Reports \(AGP\)](#)