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Practical CDE Insights Toward the 2020 ADA Standards of Medical Care in Diabetes for Glycemic Control

Announcer:
Welcome to ReachMD.

This medical industry feature, titled “Practical CDE Insights Toward the 2020 ADA Standards of Care for Glycemic Control” is sponsored by Novo Nordisk. This program is intended for healthcare professionals.

Here’s your host Dr. Jennifer Caudle.

Dr. Caudle:
Coming to you from the ReachMD studios, this is ReachMD, and I’m your host, Dr. Jennifer Caudle. Joining me to share practical insights on the 2020 ADA Standards of Medical Care in Glycemic Control are Nurse Practitioners Lisa Coco, Debbie Hinnen, and Davida Kruger.

Lisa Coco is a Family Nurse Practitioner and Certified Diabetes Educator on staff in the Department of Endocrinology, Diabetes and Metabolic Diseases at the Thomas Jefferson University Hospitals in Philadelphia, Pennsylvania. Welcome to you, Lisa.

Lisa:
Thank you, Dr. Caudle.

Dr. Caudle:
Debbie Hinnen is an Advanced Practice Nurse and Certified Diabetes Educator on staff at Memorial Hospital and the University of Colorado Health in Colorado Springs. She is the past president of the American Association of Diabetes Educators and has served on the National Board of Directors for the American Diabetes Association. It’s great to have you with us, Debbie.

Debbie:
Greetings from Colorado.

Dr. Caudle:
And Davida Kruger is a Certified Nurse Practitioner in Diabetes at the Henry Ford Health System in Detroit, Michigan. She is the past chair of the American Diabetes Association Research Foundation and has served on the ADA’s Research Policy Committee. Davida, welcome.

Davida:
Thank you. It’s a pleasure to be here.

Dr. Caudle:
So, let’s start with a refresher on the 2020 ADA Standards of Care for Glycemic Control. Lisa, can you share with us a brief overview of the major changes here?

Lisa:
Sure, I’d be happy to. So, the 2020 ADA Standards of Care for Glycemic Control recommend that along with the initiation of lifestyle intervention and metformin at diagnosis, indicators of high risk or established atherosclerotic cardiovascular disease, chronic kidney disease, or heart failure is assessed in initial combination with a GLP-1 RA or SGLT2 with a proven cardiovascular benefit, meaning a label indicating for reducing cardiovascular events can be considered, and this recommendation should be considered independently of

the baseline A1C or individualized A1C target.

Dr. Caudle:
Thank you for that. Now, Debbie, I understand that there are some important points of difference in these recommendations from the previous standards of care. So, what are those updates?

Debbie:
Well, it's really quite an impressive change. The previous recommendations stated that the GLP RAs and SGLT2 inhibitors with proven cardiovascular benefit, and, again, that's defined as having a label indication for reducing cardiovascular events, these were recommended after lifestyle and metformin for patients with type 2 diabetes and established cardiovascular disease, but to reiterate what Lisa just mentioned – it's so important – the updated 2020 ADA Standards of Care for Glycemic Control now include patients with type 2 diabetes and high-risk indicators for atherosclerotic cardiovascular disease without established disease itself, and that's a huge change since we have a large population of at-risk patients with type 2 diabetes. The other change for the 2020 ADA Standards of Care for Glycemic Control includes recommendations around CV risk status being independent of baseline A1C or A1C targets. Uh, recommendations should be considered for our high-risk or established ASCVD, CKD, or heart failure patients independent of baseline A1C or individualized A1C targets, so those two changes are having us consider various patient factors with emphasis on evaluating CV risk when we're selecting therapy for our patients with type 2 diabetes and high-risk or established CVD.

Dr. Caudle:
Davida, what are some of these other patient clinical characteristics that we should factor in when considering initiating therapies for patients with individualized, uh, A1C targets?

Davida:
Well, I think with the Medical Standards of Care, we're looking at patient and drug characteristics beyond A1C lowering to find the most appropriate therapeutic options for our patients. We're taking into account that our patients have cardiovascular disease or have high-risk indicators, and this puts them at greater risk for morbidity and mortality, so now we really are taking more than just glucose into consideration. The Medical Standards for Care continue to provide recommendations based on patient factors, such as minimizing risk of hypoglycemia, compelling need to minimize weight gain or promote weight reduction, and cost of medication, which are issues I come across all the time in my practice.

Dr. Caudle:
Thank you for that. For those of you who are just joining us, this is ReachMD, and I'm your host, Dr. Jennifer Caudle, and with me to share practical insights on the new 2020 ADA Standards of Care for Glycemic Control are Nurse Practitioners Lisa Coco, Debbie Hinnen, and Davida Kruger.

So, coming back to these clinical characteristics, let's consider some methods to help patients address them more effectively and maintain adherence to treatment along the way. So, what are some counseling tips you've learned to improve the course of care for patients with type 2 diabetes? Uh, Lisa, let's start with you.

Lisa:
Sure. Education, both for me and my colleagues in clinical practice, is key, and initially, this often translates to explaining to the patient, while you're prescribing the medication, how it works in the body, what it's indicated for, the benefits that they may experience important safety information, and any helpful tips to accessing the medication. This all can be addressed at the appointment, whether that's in person or through telehealth methods. Doing this remotely is more challenging, but it can be done. As long as it's done slowly and the patients are made to feel confident in our recommended approach, I find them to be quite happy to start a new regimen.

Dr. Caudle:
Excellent. Davida, what's your perspective here?

Davida:
Well, I totally agree with Lisa on the education front. For example, if I can provide a medication to address my patient's need to minimize the risk of hypoglycemia and minimize weight gain or help promote weight reduction, then that is the education that I think is really important to share with our patients, and there's no reason I can't teach a patient how to take a medication or an injection through telehealth. I have them pick up their prescription and then schedule the appointment, and we all, we can easily do the training and the education in person or via telehealth, and I also think our patients should talk to someone who's going to follow diet and exercise plans with them as well.

Dr. Caudle:
Anything else you'd like to add, Debbie?

Debbie:
When it comes to choosing a medication to help address CV risk, I don't think patients with type 2 diabetes generally have much awareness that they're at a higher risk for cardiovascular disease versus those without type 2 diabetes, so we have some groundwork to lay down to make sure patients are aware of that risk and the complications associated with diabetes. For example, family history of cardiovascular disease increases your risk. So, if you draw that out, I think you can help them understand their own risk in turn, and when you're ready to take the next step, we need to dive into how these medications work.

Dr. Caudle:
And let's stay on that theme of laying out the groundwork with patients, as you mentioned, Debbie. Clearly, doing this effectively requires a fair amount of coordination with other members of the care team to minimize loss of follow-ups, compliance issues, and hand-off errors between specialties. So, how do you keep this team connected?

Debbie:
I make a lot of telephone calls, to start, especially if I'm concerned that there's going to be any confusion or disagreement on the care plan. So, I'll call the cardiologist, I'll call the nephrologist, and I'll ask for the nurse or the provider. I try to summarize in just a couple of sentences the evidence-based important in-service information, but I think it's very challenging to coordinate because not everybody's in my building. We have a nurse-run clinic, and we do the diabetes management, but these are very complex patients, and so keeping up by phone or email or sharing our notes, those are, are some of the most important things we can do. Now, I would add that keeping our patients on boarded with their medication also requires regular telephone follow-ups and other touchpoints. I ask patients to send me their blood sugars and call within a week, the most two weeks, because I want to be sure they got the right medication, I want to be sure they started it, and I want to be sure that if it's an injectable that they can do it safely and effectively at home.

Dr. Caudle:
That certainly makes a lot of sense. You know, and, Lisa, what is your take on this?

Lisa:
Well, I always say the best patient is the informed patient. In our department alone, we have two RD/CDEs that teach several different classes. We have beginner, intermediate, and advanced classes, and the CDEs also provide one-on-one counseling and training and do all of our pump trainings, so I'm very fortunate to have that in my healthcare system. Explaining to a patient what diabetes is, what the A1C means, and the possible complications that can develop when it's uncontrolled, helps immensely with compliance, especially when you point out the dangers of cardiovascular disease, whether they're at risk or already have established disease, and like Debbie said earlier, it's very common for our diabetic patient to have a cardiologist, nephrologist, primary care physician, and RD/CDEs, so having a coordinated system in place helps keep everyone on the same page.

Dr. Caudle:
Davida, how about from your perspective?

Davida:
I think our colleagues in general and specialty practices are getting much better at understanding the complexity of type 2 diabetes. Diabetes is associated with various comorbidities, and we're trying to match our treatment with the active or potential problems of each patient, so we're trying to make sure that we address our individual patient needs when selecting a treatment option. We have to match them up to the risks and needs of each patient.

Dr. Caudle:
Well, that's a great comment for us to think on as we come to the end of today's program. I'd like to thank my guests for helping us better understand their unique perspectives on the new 2020 ADA Standards of Care. Lisa Coco, Debbie Hinnen, and Davida Kruger, it was wonderful speaking with you all today.

Lisa:
Thank you very much.

Debbie:
Thanks for having us.

Announcer:

You've been listening to this Medical Industry Feature, sponsored by Novo Nordisk. If you missed any part of this discussion visit reachmd.com/heartoft2d. And to access the full 2020 ADA Standards of Care, go to diabetes.org and select Resources for Medical Practitioners. This is ReachMD. Be part of the knowledge.