KNOW DIABETES BY HEART

Clinical Practice and Health System Change Guide:

Principles of Diabetes and Cardiovascular Management for Ambulatory Care Settings

Know Diabetes by Heart™
KnowDiabetesbyHeart.org
INTRODUCTION

Cardiovascular disease (CVD) is the leading cause of death and a major cause of heart attacks, strokes, heart failure and disability for people with type 2 diabetes—yet only about half of the patients recognize their risk.1,2,3 According to the Centers for Disease Control and Prevention, among U.S. adults age 21 years or older with diabetes (of whom 95% have type 2 diabetes),4

- **15.6%** have an A1C value higher than 9%.
- **73.6%** had systolic blood pressure of 140 mm Hg or higher or diastolic blood pressure of 90 mm Hg or higher, or they were on a prescription medication for high blood pressure.
- **58.2%** with no self-reported CVD who were eligible for statin therapy were on a lipid-lowering medication.
- **66.9%** with self-reported CVD who were eligible for statin therapy were on a lipid-lowering medication.

To comprehensively and systematically address and reduce the national public health impact of type 2 diabetes and CVD, the American Heart Association and the American Diabetes Association launched Know Diabetes by Heart™. The collaborative initiative focuses on CVD risk reduction in clinical care systems and practices by supporting patients and clinical care providers with ways to better manage type 2 diabetes patients and prevent CVD.
This guide provides principles and best practices to achieve optimal cardiometabolic health management for people with type 2 diabetes. It focuses on three core areas, specifically for ambulatory care settings:

- Principles for providers, health systems and care teams
- Population health best practices through quality improvement
- Best practices in supporting patients in care plan management

This guide is based on the science and clinical practice guidelines of the American Heart Association and American Diabetes Association. The core principles of diabetes management and CVD prevention remain focused on the following (consistent with AHAs Life’s Simple 7).

1. Measure and monitor height and weight (waist circumference should be considered).
2. Measure and track blood pressure accurately.
3. Measure and track A1C at intervals.
4. Measure and track lipid levels (total cholesterol, HDL) and assess ASCVD risk.
5. Assess tobacco use during every patient visit and counsel accordingly.
6. Assess physical activity level during every visit.
7. Assess dietary pattern during every visit.

A comprehensive patient-centered approach to a patient’s lifestyle habits, blood pressure, blood glucose and estimated 10-year risk of a future ASCVD event is the first step to management. Prevention and treatment strategies must include a strong focus on lifestyle optimization (tobacco cessation and reduced exposure to secondhand smoke; improvement in diet; and increased physical activity) to reduce the risk of CVD and future ASCVD events.

For additional guidance on care for people with type 2 diabetes, please go to the AHA/ACC’s 2019 of CVD and future ASCVD events.

Principles for Health Care Systems, Providers and Care Teams

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<th>Principle</th>
<th>Outpatient Strategy</th>
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<td>Establishing Foundational Concepts for Teams</td>
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<td>- Designs a diabetes and cardiovascular disease (or diabetes) in your practice.</td>
<td>Identify your practice’s referral plan. Consistent referrals to specialists, neurologists, endocrinologists, cardiologists, etc.</td>
<td>AHA’s Life’s Simple 7, <a href="https://www.lifesimples7.org/practice-guidelines/resources">https://www.lifesimples7.org/practice-guidelines/resources</a></td>
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<td>- Focus the members of the care team (PCP, PA, NP, nurse, pharmacist, nutritionist, dietitian, etc.) on their delineated roles and responsibilities for intake, screening of risk factors, diagnosis and treatment plan, education, counseling and follow-up.</td>
<td>Assess risk factors, ASCVD, staging of chronic kidney disease, heart failure history and hypoglycemic attack. Consider barriers to care (socioeconomic, transportation, etc.).</td>
<td>ADA’s Life’s Simple 7, <a href="https://www.lifesimples7.org/practice-guidelines/resources">https://www.lifesimples7.org/practice-guidelines/resources</a></td>
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<td>- Make diabetes management and reduction of CVD risk a priority for the health system.</td>
<td>Assess for ASCVD risk factors, ASCVD, staging of chronic kidney disease, heart failure history and hypoglycemic attack. Consider barriers to care (socioeconomic, transportation, etc.).</td>
<td>ADA’s Life’s Simple 7, <a href="https://www.lifesimples7.org/practice-guidelines/resources">https://www.lifesimples7.org/practice-guidelines/resources</a></td>
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Identifying and Assessing Processes

Develop a policy and process to address cardiometabolic health for every patient.

- Develop protocols, workflows, for how patients with diabetes and CVD should be identified, organized and tracked.
- Use a local patient-centered medical home (PCMH) model or identify referral protocols as needed.
- Identify follow-up protocols.

- Assess for diabetes and cardiovascular disease. Identify patients at increased risk of diabetes or cardiovascular disease. Use Framingham risk assessment.

Prepare patients and care team for effective diabetes and CVD management during office visits.

- Establish a protocol for patient management. Contact patients to confirm appointments; instruct them to bring medications and a medication list; and be prepared to discuss potential or real problems with medications or medication adherence.
- Use the patient to identify own gaps.
- Design workflows and use tools to ensure order/actions.
- Establish a blood glucose and/or blood pressure monitoring program for patient at home.

Identifying Clinical Processes

Systematically leverage evidence-based guidelines and treatment protocols for diabetes and CVD.

- Effectively implement new diabetes science, specifically AHAs and ADA guidelines.
- Develop and deploy diabetes, hypertension, weight, lipid, and heart guidelines appropriate to practice.
- Overcome treatment inertia, implement follow-up protocols to close a treatment plan.
- Develop and implement pattern-sensitive plan that includes shared decision-making of patient and provider. Focus on lifestyle modification (ALAs Simple 7) and medication management.
- Identify and implement a patient-centered plan that includes shared decision-making of patient and provider. Focus on lifestyle modification (ALAs Simple 7) and medication management.
- Establish a blood glucose and/or blood pressure monitoring program for patient at home (as appropriate).
- Establish follow-up protocol.

Assessing Impact

Conduct a periodic assessment of the organizational effectiveness in policies and protocols. Actions that are lacking should be focused on patient outcomes.

- Establish routine processes to understand the effect of changes and shifts in practice. Identify needed changes. Complete the Diabetes Outcomes (DOQs) tool to document changes and shifts in practice.

AHA/ACC, American Heart Association/American College of Cardiology; AHA, American Heart Association; ADA, American Diabetes Association; ASCVD, atherosclerotic cardiovascular disease; CVD, cardiovascular disease; DOQs, Diabetes Outcomes Questionnaire; PCMH, patient-centered medical home.
COMPREHENSIVE PATIENT-CENTERED APPROACH FOR THE MANAGEMENT OF TYPE 2 DIABETES AND CARDIOVASCULAR DISEASE

Population Health: Quality Improvement through Health Systems

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Best Practices for Supporting Patients in Managing their Care Plan

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