Virginia Long-Term Care Clinician Network Monthly Forum

September 20, 2023
The Virginia Long-Term Care Clinician Network (LTC-CN): A partnership between VDH and VCU

The Virginia LTC-CN brings together Medical Directors and advanced practice clinicians working across the state in nursing homes, assisted living facilities and other congregate care settings. It provides a central mode of communication for providers, access to a monthly newsletter and forum, and free LTC resources.

**Recent Forum Topics**
- 2020 AMA CPT coding changes
- Appropriate antipsychotic use in LTC
- Enhanced Barrier precautions
- Antimicrobial stewardship
- Deprescribing and maturation management in LTC
- Properly completing the death certificate

**Growing from the need to problem solve quickly during the COVID-19 pandemic, this peer provider network facilitates communication of vital information and robust discussion on timely topics affecting LTC clinicians throughout the Commonwealth.**

**Network Membership by Region**

**Discussion on Engagement / Success**
- Recruitment
- Clinic time constraints
- Zoom engagement strategies
- Attendance motivation
- Content management
- Demonstrating value

- Beyond 2024 Vision – a real-time learning collaboration connecting health system independent providers in PALTC.

**We would like to thanks:**
- VDH / VCU
- VDH / VCU / LCUs
- Virginia Center on Aging
- VCU Division of Geriatric Medicine
- VCU Department of Gerontology
Introducing the Network - Share w/ Peers

About the Network: The Virginia Long-Term Care Clinician Network (LTC-CN) brings together medical directors and clinicians practicing in nursing homes, assisted living facilities, and other congregate care settings, such as Program of All-inclusive Care for the Elderly (PACE).

Member Benefits:

- Free peer network fostering open discussion and collaboration
- Monthly newsletter
- Monthly forum (third Wednesday of each month from 4:00-5:00 pm)
  - Each registered Network member receives a unique Zoom invite link. Please do not forward your link as this may lead to problems joining the Forum. Encourage your colleagues to register instead!
Where to find us, slides, monthly newsletter?

ltccn.vcu.edu
Who are we?

Staff
- Christian Bergman, MD - Principal Investigator
- Bert Waters, PhD - Project Director
- Laura Finch, MS, GNP, RN - Clinical Coordinator
- Kim Ivey, MS - Communications / Administration
- Jenni Mathews - Survey Data & Evaluations Specialist
- Kristin MacDonald, MS, RD - Newsletter & Content Editor

Steering Committee

Eastern Region: Rob Walters, MD & Mary Mallory, NP
Northwestern Region: Jonathan Winter, MD
Central Region: William Reed, MD & Tangela Crawley-Hardy, NP
Southwest Region: Katherine Coffey-Vega, MD & Jamie Smith, NP
Northern Region: Noelle Pierson, NP
Statewide: Shawlawn Freeman-Hicks, NP

Members: All of you who have registered for the LTC Clinician Network
Monthly Forum - Every 3rd Wednesday, 4-5 PM

Forum topics will be in areas of interest to clinicians working in long term care. We will continue to integrate COVID-19 topics in our discussion. Share the membership QR code with your work colleagues so they can get a unique link.

Upcoming Forums

- October 18  Medical Updates
- November 15  Vaccination Updates
- December 13  **** Change in Date
- January 17, 2024  Trauma Informed Care
Monthly Forum Structure

Introduction - 2 minutes

Open Discussion - 10 minutes

Featured Monthly Topic - 15-20 minutes with discussion

Updates - 3 minutes

Feedback - 3 minutes verbal and evaluation at end of meeting
Pandemic Planning/Preparedness Poll

In preparing for the next pandemic, what is the priority in your experience?

A. Preparedness (PPE, communication networks, emergency preparedness plans, vaccination delivery systems, equipment, cleaning)
B. Addressing challenges and burdens such as regulation, information flow
C. Sustainability (funding, testing, screening, burnout of staff)
D. Collaboration (partnerships, guidance, continuum of care)
E. Staff Education (infection prevention, QAPI)
F. All of above
Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care. During the presentation we can mute ourselves until it is time for more interaction.
Share with your peers on the Virginia LTC-CN

Please use the Chat box to share:

- Name
- Role
- Location in Virginia (city or region)
- Favorite fall activity in Virginia

Thank You for taking care of Virginia's residents of PACE, assisted living and nursing homes!
Diabetes Update

Dr. Christian Bergman
Diabetes Update 2023

Based on American Diabetes Association Standards of Care in Diabetes 2023 Update released Jan 2023

Volume 46 Issue Supplement_1 | Diabetes Care
https://diabetesjournals.org/care/issue/46/Supplement_1
Diabetes Update 2023

Some Figures from American Academy of Clinical Endocrinologists (AACE), May 2023

https://www.endocrinepractice.org/article/S1530-891X(23)00034-4/fulltext
Diabetes Update 2023

What's new?

Different Sections

Standards of Medical Care in Diabetes—2023

S1  Introduction and Methodology
S5  Summary of Revisions
S10  1. Improving Care and Promoting Health in Populations
    Diabetes and Population Health
    Tailoring Treatment for Social Context
S19  2. Classification and Diagnosis of Diabetes
    Classification
    Diagnostic Tests for Diabetes
    Type 1 Diabetes
    Prediabetes and Type 2 Diabetes
    Cystic Fibrosis–Related Diabetes
    Posttransplantation Diabetes Mellitus
    Monogenic Diabetes Syndromes
    Pancreatic Diabetes or Diabetes in the Context of Disease of the Exocrine Pancreas
    Gestational Diabetes Mellitus

S41  3. Prevention or Delay of Type 2 Diabetes and Associated Comorbidities
    Lifestyle Behavior Change for Diabetes Prevention
    Pharmacologic Interventions
    Prevention of Vascular Disease and Mortality
    Person-Centered Care Goals

S140  9. Pharmacologic Approaches to Glycemic Treatment
    Pharmacologic Therapy for Adults With Type 1 Diabetes
    Surgical Treatment for Type 1 Diabetes
    Pharmacologic Therapy for Adults With Type 2 Diabetes

10. Cardiovascular Disease and Risk Management
    The Risk Calculator
    Hypertension/Blood Pressure Control
    Lipid Management
    Statin Treatment
    Antiplatelet Agents
    Cardiovascular Disease

S191  11. Chronic Kidney Disease and Risk Management
    Chronic Kidney Disease
    Epidemiology of Diabetes and Chronic Kidney Disease
    Assessment of Albuminuria and Estimated Glomerular Filtration Rate
    Diagnosis of Diabetic Kidney Disease
    Staging of Chronic Kidney Disease
    Acute Kidney Injury
    Surveillance
    Interventions
    Referral to a Nephrologist
Diabetes Updates 2023

5. Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes
- Diabetes Self-management Education and Support
- Medical Nutrition Therapy
- Physical Activity
- Smoking Cessation: Tobacco and e-Cigarettes
- Supporting Positive Health Behaviors
- Psychosocial Care

6. Glycemic Targets
- Assessment of Glycemic Control
- Glycemic Goals
- Hypoglycemia
- Intercurrent Illness

7. Diabetes Technology
- General Device Principles
- Blood Glucose Monitoring
- Continuous Glucose Monitoring Devices
- Insulin Delivery

14. Children and Adolescents
- Type 1 Diabetes
- Type 2 Diabetes
- Transition From Pediatric to Adult Care

15. Management of Diabetes in Pregnancy
- Diabetes in Pregnancy
- Glycemic Targets in Pregnancy
- Management of Gestational Diabetes Mellitus
- Management of Preexisting Type 1 Diabetes and Type 2 Diabetes in Pregnancy
- Preeclampsia and Aspirin
- Pregnancy and Drug Considerations
Diabetes Update 2023

Sections to Cover Today

6. Glycemic Targets
7. CGM Devices
9. Pharmacological Treatment, type 2 DM
10. Blood Pressure Control
13. Treatment in SNF/LTC

Chat in your questions as we go through the sections so we can pause and discuss.
Glycemic Targets

Table 6.1—Estimated average glucose (eAG)

<table>
<thead>
<tr>
<th>A1C (%)</th>
<th>mg/dL*</th>
<th>mmol/L</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>97 (76–120)</td>
<td>5.4 (4.2–6.7)</td>
</tr>
<tr>
<td>6</td>
<td>126 (100–152)</td>
<td>7.0 (5.5–8.5)</td>
</tr>
<tr>
<td>7</td>
<td>154 (123–185)</td>
<td>8.6 (6.8–10.3)</td>
</tr>
<tr>
<td>8</td>
<td>183 (147–217)</td>
<td>10.2 (8.1–12.1)</td>
</tr>
<tr>
<td>9</td>
<td>212 (170–249)</td>
<td>11.8 (9.4–13.9)</td>
</tr>
<tr>
<td>10</td>
<td>240 (193–282)</td>
<td>13.4 (10.7–15.7)</td>
</tr>
<tr>
<td>11</td>
<td>269 (217–314)</td>
<td>14.9 (12.0–17.5)</td>
</tr>
<tr>
<td>12</td>
<td>298 (240–347)</td>
<td>16.5 (13.3–19.3)</td>
</tr>
</tbody>
</table>

**Recommendations**

6.1 Assess glycemic status (A1C or other glycemic measurement such as time in range or glucose management indicator) *at least* two times a year in patients who are meeting treatment goals (and who have stable glycemic control). E

6.2 Assess glycemic status at least quarterly and as needed in patients whose therapy has recently changed and/or who are not meeting glycemic goals. E
## Glycemic Targets

### Recommendations

6.7 Less stringent A1C goals (such as < 8.0%) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits.

6.8 Reassess glycemic targets based on the individualized criteria.

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### Approach to Individualization of Glycemic Targets

The table shows the approach to individualization of glycemic targets based on various factors such as disease duration, life expectancy, important comorbidities, established vascular complications, patient preference, and resources and support system. The diagram illustrates how these factors influence the selection of A1C targets, with a color-coded key indicating the stringency of the targets.

**Figure 6.2**—Patient and disease factors used to determine optimal glycemic targets. Characteristics and predilections toward the left justify more stringent efforts to lower A1C; those toward the right suggest less stringent efforts. A1C 7% = 53 mmol/mol. Adapted with permission from Inzucchi et al. (71).
7.11 - **Real-time continuous glucose monitoring A** or **intermittently scanned continuous glucose monitoring B** should be offered for diabetes management in adults with diabetes on multiple daily injections or continuous subcutaneous insulin infusion who are capable of using the devices safely (either by themselves or with a caregiver). The choice of device should be made based on the individual’s circumstances, preferences, and needs.

**Table 7.3—Continuous glucose monitoring devices**

<table>
<thead>
<tr>
<th>Type of CGM</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>rtCGM</td>
<td>CGM systems that measure and display glucose levels continuously</td>
</tr>
<tr>
<td>isCGM with and without alarms</td>
<td>CGM systems that measure glucose levels continuously but require scanning for visualization and storage of glucose values</td>
</tr>
<tr>
<td>Professional CGM</td>
<td>CGM devices that are placed on the person with diabetes in the health care professional’s office (or with remote instruction) and worn for a discrete period of time (generally 7–14 days). Data may be blinded or visible to the person wearing the device. The data are used to assess glycemic patterns and trends. Unlike rtCGM and isCGM devices, these devices are clinic-based and not owned by the person with diabetes.</td>
</tr>
</tbody>
</table>

CGM, continuous glucose monitoring; isCGM, intermittently scanned CGM; rtCGM, real-time CGM.

**Real-time CGMs**

These systems are made up of three components: the sensor (a small wire catheter that is inserted under the skin on your arm or abdomen), a transmitter that attaches to the sensor, and a handheld receiver and/or smartphone that displays your glucose data in real time.

**Intermittently scanned CGMs**

This system requires you to scan the device to get your glucose data. It uses two components: a combined glucose sensor/transmitter (inserted in your upper arm) and a separate touchscreen reader device. The sensor continuously samples and measures glucose levels, generates a new glucose value every minute, and records the reading every 15 minutes for 10 to 14 days of sensor wear time, depending on the model.
Continuous Glucose Monitoring

Real-time CGMs
These systems are made up of three components: the sensor (a small wire catheter that is inserted under the skin on your arm or abdomen), a transmitter that attaches to the sensor, and a handheld receiver and/or smartphone that displays your glucose data in real time.

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>SYSTEM COMPONENTS</th>
<th>SENSOR</th>
<th>APPLICATOR</th>
<th>GLUCOSE READINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>FreeStyle Libre 3</td>
<td></td>
<td>112</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensor + App</td>
<td>Size: 15 x 2.9 mm</td>
<td>One-piece applicator</td>
<td>Real-time glucose reading sent every minute to smartphone</td>
</tr>
</tbody>
</table>

Medtronic Guardian CGM

Intermittently scanned CGMs
This system requires you to scan the device to get your glucose data. It uses two components: a combined glucose sensor/transmitter (inserted in your upper arm) and a separate touchscreen reader device. The sensor continuously samples and measures glucose levels, generates a new glucose value every minute, and records the reading every 15 minutes for 10 to 14 days of sensor wear time, depending on the model.
The investigators propose to conduct a randomized controlled trial to determine whether the use of Dexcom CGM with Glucose Telemetry System (CGM-GTS) with hypoglycemia alarm compared to standard of care using capillary POC testing, will facilitate diabetes treatment and reduce the risk of hypoglycemia in patients with T2D in LTC facilities. Participants in the standard of care group will also wear a CGM (blinded one).
Repeated performance of finger-stick blood glucose tests to maintain standing orders for insulin injection or oral hypoglycemic agents does not meet the criteria for Part B payment in a SNF. Payment for nursing care glucose monitoring is encompassed under Medicare Part A and other payment methods. If the patient is in a skilled nursing facility, routine glucose monitoring (including any tests which are not promptly reported) is a part of routine personal care and is not a separately billed procedure (PM AB-00-108, December 2000).

The home glucose monitoring device is on the list of instruments that can be administered by providers registered under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), including providers registered with only a certificate of waiver. However, Medicare Part B may only pay for a glucose monitoring device and related disposable supplies under the durable medical equipment benefit if the equipment is used in the home or in an institution that is used as a home. A hospital or SNF is not considered a home under the SSA, Sect. 1861 (h)

Pharmacological Treatment in T2DM

**LIFESTYLE THERAPY**

- **Entry HbA1c < 7.5%**
  - MONOTHERAPY
    - Metformin
    - SGLT2i
    - GLP-1 RA
  - DUAL THERAPY
    - Metformin + SGLT2i
    - Metformin + GLP-1 RA
  - TRIPLE THERAPY
    - Metformin + SGLT2i + GLP-1 RA

- **Entry HbA1c ≥ 7.5%**
  - MONOTHERAPY
    - insulin or other insulin secretagogues
  - DUAL THERAPY
    - Metformin + insulin or other insulin secretagogues
  - TRIPLE THERAPY
    - Metformin + insulin or other insulin secretagogues + GLP-1 RA

**ADD OR INTENSIFY INSULIN**

- For patients without HbA1c goal, consider adding insulin with or without oral agents.
- For patients with HbA1c ≥ 7.8% or treatment intolerance, consider adding a DPP-4i or GLP-1 RA to existing therapy.

**PROGRESSION OF DISEASE**

- **HbA1c goal 3 months**
  - Entry HbA1c < 7.5%
  - Entry HbA1c ≥ 7.5%

**SYMPTOMS**

- NO
  - No symptoms present
- YES
  - Symptoms present

**LEGEND**

- Green boxes indicate medications that are recommended for treatment.
- Orange boxes indicate medications that are optional for treatment.
- Red boxes indicate medications that are not recommended for treatment.

**USE OF GLUCOSE-LOWERING MEDICATIONS IN THE MANAGEMENT OF TYPE 2 DIABETES**

- Multiagent pharmacotherapy is recommended for patients with type 2 diabetes.
- The specific combination of medications should be tailored to the individual patient's needs.
- Options include: metformin + GLP-1 RA, SGLT2i, DPP-4i, or insulin.

**2017 AACE**

**2023 ADA**

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<table>
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<td>Biguanides</td>
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<td>850 mg (IR)</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>1,000 mg (ER)</td>
</tr>
<tr>
<td>Sulfonylureas (2nd generation)</td>
<td>Glimepiride</td>
<td>4 mg</td>
</tr>
<tr>
<td></td>
<td>Glipizide</td>
<td>10 mg (IR)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10 mg (X/ER)</td>
</tr>
<tr>
<td></td>
<td>Glyburide</td>
<td>6 mg (micronized)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 mg</td>
</tr>
<tr>
<td>Thiazolidinedione</td>
<td>Poglitazone</td>
<td>45 mg</td>
</tr>
<tr>
<td>α-Glucosidase inhibitors</td>
<td>Acarbose</td>
<td>100 mg</td>
</tr>
<tr>
<td></td>
<td>Miglitol</td>
<td>100 mg</td>
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<tr>
<td>Meglitinides</td>
<td>Nateglinide</td>
<td>120 mg</td>
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<tr>
<td></td>
<td>Repaglinide</td>
<td>2 mg</td>
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<tr>
<td>DPP-4 inhibitors</td>
<td>Alogliptin</td>
<td>25 mg</td>
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<td></td>
<td>Saxagliptin</td>
<td>5 mg</td>
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<td></td>
<td>Linagliptin</td>
<td>5 mg</td>
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<td></td>
<td>Sitagliptin</td>
<td>100 mg</td>
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<tr>
<td>SGLT2 inhibitors</td>
<td>Ertugliflozin</td>
<td>15 mg</td>
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<td></td>
<td>Dapagliflozin</td>
<td>10 mg</td>
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<td></td>
<td>Canagliflozin</td>
<td>300 mg</td>
</tr>
<tr>
<td></td>
<td>Empagliflozin</td>
<td>25 mg</td>
</tr>
<tr>
<td>GLP-1 RAs</td>
<td>Exenatide (extended release)</td>
<td>2 mg powder for suspension or pen</td>
</tr>
<tr>
<td></td>
<td>Exenatide</td>
<td>10 μg pen</td>
</tr>
<tr>
<td></td>
<td>Dulaglutide</td>
<td>4.5 mg mL pen</td>
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<tr>
<td></td>
<td>Semaglutide</td>
<td>1 mg pen</td>
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<tr>
<td></td>
<td></td>
<td>14 mg (tablet)</td>
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<tr>
<td></td>
<td>Liaglutide</td>
<td>1.8 mg pen</td>
</tr>
<tr>
<td></td>
<td>Lisixenatide</td>
<td>20 μg pen</td>
</tr>
<tr>
<td>GLP-1/GIP dual agonist</td>
<td>Tirzepatide</td>
<td>15 mg pen</td>
</tr>
<tr>
<td>Bile acid sequestrant</td>
<td>Colesevelam</td>
<td>625 mg tabs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.75 g suspension</td>
</tr>
<tr>
<td>Dopamine-2 agonist</td>
<td>Bromocriptine</td>
<td>0.3 mg</td>
</tr>
<tr>
<td>Amylin mimetic</td>
<td>Pramlintide</td>
<td>120 μg pen</td>
</tr>
</tbody>
</table>
Figure 3.3 — Use of glucose-lowering medications in the management of type 2 diabetes. ACE, angiotensin-converting enzyme inhibitor; ACR, albumin-to-creatinine ratio; ARB, angiotensin receptor blocker; ASCVD, atherosclerotic cardiovascular disease; CGM, continuous glucose monitoring; CKD, chronic kidney disease; CV, cardiovascular; DPP-4, dipeptidyl peptidase-4 inhibitor; eGFR, estimated glomerular filtration rate; GLP-1, glucagon-like peptide 1 receptor agonist; HbA1c, hemoglobin A1c; HF, heart failure; IV-MACE, hospitalization for heart failure; KDIGO, kidney disease outcomes initiative; MACE, major adverse cardiovascular events; MI, myocardial infarction; SDOH, social determinants of health; SGLT2, sodium-glucose cotransporter 2 inhibitor; T2D, type 2 diabetes; T2D, thiazolidinedione. Adapted from Davies et al. (85).
Let's look at a different way to display this
- Complication-Centric Algorithm for Glycemic Control
- Glucose-Centric Algorithm for Glycemic Control
- Algorithm for Adding/Intensifying Insulin

Lipid and HTN management
### Complications-Centric Algorithm for Glycemic Control

#### Lifestyle Intervention

- ASCVD or High Risk for ASCVD
- Heart Failure
- Stroke/TIA
- CKD
- NONE

#### Independent of Glycemic Target and Other T2D Therapies

- GLP-1 RA or SGLT2
- SGLT2
- GLP-1 RA or Pioglitazone
- SGLT2 or GLP-1 RA

#### Individualize Glycemic Target

- A1C ≤8.5% for most patients or 7%-8% if high risk for adverse consequences from hypoglycemia and/or limited life expectancy

#### Continue or Start Metformin if Appropriate

- If not at glycemic target at <3 months, titrate to maximum tolerated dose or add agent not in use

#### If Not at Goal: Continue to Glucose-Centric Algorithm for Glycemic Control or Algorithm for Adding/Intensifying Insulin

<table>
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GLUCOSE-CENTRIC ALGORITHM FOR GLYCEMIC CONTROL

LIFESTYLE INTERVENTION

Start or continue metformin if appropriate1

INDIVIDUALIZE GLYCEMIC TARGET

A1C ≤6.5% for most persons or 7%-8% if high risk for adverse consequences from hypoglycemia and/or limited life expectancy

- Overweight or Obesity2
- Hypoglycemia Risk2
- Access / Cost
- Severe Hyperglycemia4

Patients may present with >1 scenario

Order of medications suggests hierarchy for selection7

Basal Insulin6
- Prandial Insulin or GLP-1RA or GIP/GLP-1RA6

Examples of Basal Insulin with Glucose-Sensitive Dual Acting Insulin
- A1C >7.5% start 2 agents, A1C >8.0% or >15% above goal start 2-3 agents

GLP-1 RA or GIP/GLP-1 RA or SGLT2
GLP-1 RA or GIP/GLP-1 RA or SGLT2
TZD or SU/GLN
GLP-1 RA | GIP/GLP-1 RA | SGLT2 | COLSVL | BRC-QR

IF NOT AT GOAL: CONTINUE TO ALGORITHM FOR ADDING/INTENSIFYING INSULIN

- Titrator to maximum tolerated dose. If not at glycemic target at ≤3 months, add best available agent not in use7
- GLP-1 RA | GIP/GLP-1 RA | SGLT2 | TZD | DPP-4 | SU/GLN | COLSVL | BRC-QR | PRAML11

CONCERNS OR NOT PREFERRED

- Avoid SU/GLN
- Avoid SU/GLN
- GLP-1 RA | GIP/GLP-1 RA | SGLT2 | COLSVL | BRC-QR
- Other agents likely ineffective in the setting of glucotoxicity8

Class | Compound(s) | Dosage strength/ product (if applicable)
--- | --- | ---
Biguanides | Metformin | 850 mg (IR)
Sulfonyleureas (2nd generation) | Glimepiride | 4 mg
| Glipizide | 10 mg (IR)
| Glyburide | 10 mg (XL/ER)
| | 6 mg (micronized)
Thiazolidinediones | Pioglitazone | 45 mg
| | 10 mg
- α-Glucosidase inhibitors | Acarbose | 100 mg
| | 100 mg
Meglitinides | Nateglinide | 120 mg
| | 2 mg
DPP-4 inhibitors | Alogliptin | 25 mg
| | 5 mg
| Saxagliptin | 5 mg
| | 5 mg
| Linagliptin | 5 mg
| | 100 mg
SGLT2 inhibitors | Eruditugliflozin | 15 mg
| | 10 mg
| Dasagliflozin | 10 mg
| | 300 mg
| Canagliflozin | 100 mg
| | 25 mg
GLP-1 RAs | Exenatide (extended release) | 2 mg powder for suspension or pen
| | 10 μg pen
| Dulaglutide | 4.5 mg/mL pen
| | 1 mg pen
| | 14 mg (tablet)
| Liraglutide | 1.8 mg pen
| | 20 μg pen
GLP-1/GIP dual agonist | Tirzepatide | 15 mg pen
Bile acid sequestrant | Colesevelam | 625 mg tabs
| | 3.75 g suspension
Dopamine-2 agonist | Bromocriptine | 0.8 mg
Amylin mimetic | Pramlintide | 120 μg pen

1 Take with food with dose titration for enhanced tolerance. 2 See also COMPLICATIONS-CENTRIC MODEL FOR THE CARE OF PERSONS WITH OVERWEIGHT/OBESITY and PROFILES OF WEIGHT-LOSS MEDICATIONS table. 3 Evaluate for issues leading to hyperglycemia or hypoglycemia unawareness and manage with patient-centered strategies. 4 A1C >10% and/or BG ≥300 with symptomatic hyperglycemia, reduce glucose/A1C as promptly and safely as possible. 5 See also ALGORITHM FOR ADDING/INTENSIFYING INSULIN. 6 GLP-1 RA requires titration phase which can delay glycemic control. After glucose toxicity is resolved, consider adding other agents. 7 See also PROFILES OF ANTIMYOGLYCEMIC MEDICATIONS table. 8 GLP-1 RA and DPP-4 should not be combined. 9 TZD can cause fluid retention but have benefit for NAFDL, CVD prevention, dyslipidemia. 10 Access/Cost are dependent on location of the market. Insulin costs vary widely with devices (e.g., pens versus vials) and formulations (e.g., analogues versus combinations such as 70/30). 11 PRAML is used as an adjunct with prandial insulin.

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Algorithm Figure 7-Glucose-Centric Glycemic Control
ASCVD RISK REDUCTION ALGORITHM: DYSLIPIDEMIA

ASSESS LIPID PANEL (LDL-C, HDL-C, Non-HDL-C, TG, Apo B)\(^1\)

LIFESTYLE INTERVENTION: increase ↑ dietary fiber | ↑ healthy fat | ↓ saturated fat | ↓ simple carbs | ↓ added sugars | ↑ physical activity | weight management

PREDIABETES OR T2D + RISK FACTORS: USE ASCVD 10-YEAR RISK CALCULATOR
Major ASCVD Risk Factors: Age > 40 | HTN | CKD > 3a | Smoking | Family History of Premature ASCVD | Low HDL-C | High Non-HDL-C

INITIATE STATIN THERAPY

HIGH RISK <10%
T2D <10 years <2 other risk factors
No target organ damage

Moderate-intensity statin
Goal

<table>
<thead>
<tr>
<th>LDL-C (mg/dL)</th>
<th>Non-HDL-C (mg/dL)</th>
<th>TG (mg/dL)</th>
<th>Apo B (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;100</td>
<td>&lt;130</td>
<td>&lt;150</td>
<td>&lt;80</td>
</tr>
</tbody>
</table>

High-intensity statin

<table>
<thead>
<tr>
<th>LDL-C (mg/dL)</th>
<th>Non-HDL-C (mg/dL)</th>
<th>TG (mg/dL)</th>
<th>Apo B (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;55</td>
<td>&lt;80</td>
<td>&lt;150</td>
<td>&lt;70</td>
</tr>
</tbody>
</table>

EXTREME RISK >20%
T2D & ASCVD
Severe target organ damage: eGFR <45 mL/min/1.73 m\(^2\), UACR > 300, ABI < 0.9, LV systolic or diastolic dysfunction

HYPERTRIGLYCERIDEMIA MANAGEMENT:

TG <150
TG 150–199
TG 200–499\(^3\)
TG ≥500
TG >1000\(^4\)

- Intensify Lifestyle & Achieve Glycemic Targets
- Fibrates or/and Rx Grade Omega-3

If TG >135: Consider addition of icosapent ethyl to statin if DM and CVD or ≥2 risk factors

- TG target achieved: Continue lifestyle therapy, maximally tolerated statin and achieve glucose targets

- Niacin\(^5\)

\(^1\) Baseline LDL-C >190 mg/dL, consider familial hypercholesterolemia. \(^2\) Statin intolerance: Use alternative statin with lower incidence of myopathy (ple_tuplesatin, extended-release fluvastatin) or decrease dose/frequency, use non-statin Rx, check for Rx interactions, consider CoQ10. \(^3\) TG >200 and HDL <40, add fibrates/Omega-2 to achieve apo B and non-HDL goals. \(^4\) Elevated triglycerides >500 mg/dL to >1000 mg/dL can cause acute pancreatitis. Urgent intervention with dietary management and fibrates/Omega-3 therapy is needed. Suspect familial chylomicronemia syndrome or lipodystrophy, refer to lipid specialist. \(^5\) For severe hypertriglyceridemia >1000 refractory to previous interventions, consider niacin to reduce the risk of pancreatitis. Niacin may lower TG and Lp(a) but does not reduce ASCVD and can promote hyperglycemia.
# Treatment in SNF/LTC: Gluc/BP/Lipids

## Table 13.1—Framework for considering treatment goals for glycemia, blood pressure, and dyslipidemia in older adults with diabetes

<table>
<thead>
<tr>
<th>Patient characteristics/health status</th>
<th>Rationale</th>
<th>Reasonable A1C goal‡</th>
<th>Fasting or preprandial glucose</th>
<th>Bedtime glucose</th>
<th>Blood pressure</th>
<th>Lipids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy (few coexisting chronic illnesses, intact cognitive and functional status)</td>
<td>Longer remaining life expectancy</td>
<td>&lt;7.0–7.5% (53–58 mmol/mol)</td>
<td>80–130 mg/dL (4.4–7.2 mmol/L)</td>
<td>80–180 mg/dL (4.4–10.0 mmol/L)</td>
<td>&lt;130/80 mmHg</td>
<td>Statin, unless contraindicated or not tolerated</td>
</tr>
<tr>
<td>Complex/intermediate (multiple coexisting chronic illnesses* or two or more instrumental ADL impairments or mild-to-moderate cognitive impairment)</td>
<td>Intermediate remaining life expectancy, high treatment burden, hypoglycemia vulnerability, fall risk</td>
<td>&lt;8.0% (64 mmol/mol)</td>
<td>90–150 mg/dL (5.0–8.3 mmol/L)</td>
<td>100–180 mg/dL (5.6–10.0 mmol/L)</td>
<td>&lt;130/80 mmHg</td>
<td>Statin, unless contraindicated or not tolerated</td>
</tr>
<tr>
<td>Very complex/poor health (LTC or end-stage chronic illnesses** or moderate-to-severe cognitive impairment or two or more ADL impairments)</td>
<td>Limited remaining life expectancy makes benefit uncertain</td>
<td>Avoid reliance on A1C; glucose control decisions should be based on avoiding hypoglycemia and symptomatic hyperglycemia</td>
<td>100–180 mg/dL (5.6–10.0 mmol/L)</td>
<td>110–200 mg/dL (6.1–11.1 mmol/L)</td>
<td>&lt;140/90 mmHg</td>
<td>Consider likelihood of benefit with statin</td>
</tr>
</tbody>
</table>
Treatment in SNF/LTC

Recommendations (E expert consensus or clinical experience)

13.20 Consider diabetes education for the staff of long-term care (LTC) and rehabilitation facilities to improve the management of older adults with diabetes. E

13.21 People with diabetes residing in LTC facilities need careful assessment to establish individualized glycemic goals and to make appropriate choices of glucose-lowering agents based on their clinical and functional status. E

13.22 Consider use of CGM to assess risk for hypoglycemia in older adults treated with sulfonylureas or insulin. E

Older adults in LTC may have irregular and unpredictable meal consumption, undernutrition, anorexia, or impaired swallowing. Meals tailored to patients’ culture, preferences, and personal goals may increase QoL, satisfaction with meals, and nutrition status. It may be helpful to give insulin after meals to ensure that the dose is appropriate for the amount of carbohydrate consumed in the meal.

## Virginia Medicaid Formulary

### Diabetes: Injectable Hypoglycemics
- **GLP-1**
  - Byetta®
  - Humalog Cartridge & Vial & Pen
  - Humalog Kwipen 100 unit/ml
  - Humalog Junior Kwipen
  - Humalog Mix 50/50 vial & Humalog Mix 75/25 vial
  - Humulin S00 U/M pen/vial
  - Humulin® 70/30 pen/vial (OTC)
  - Humulin® N pen/vial (OTC)
  - Humulin® R pen/vial
  - Insulin lispro vial
  - Insulin lispro protamine mix kwipen
  - Insulin lispro Jr. Kwipen
  - Insulin lispro Pen
  - Insulin aspart cartridge pen/vial
  - Insulin aspart/insulin aspart protamine insulin pen
  - Insulin aspart/insulin aspart protamine vial
  - Lantus® Solostar® and vial
  - Levemir® pen/vial
  - Novolog® cartridge
  - Novolog® Flexpen/vial
  - Trulicity™
  - Victoza®

### Diabetes: Oral Hypoglycemics
- **SGLT2**
  - acarbose
  - Farxiga™
  - glimepiride
  - glipizide IR & ER
  - glyburide & micronized
  - glyburide/metformin
  - Invokamet
  - Invokamet XR
  - Invokana™
  - Janumet® & Janumet XR®
  - Januvia®
  - Jardiance®
  - Jentaduetos®
  - metformin & metformin ER
  - nateglinide
  - pioglitazone
  - repaglinide
  - Synjardy®
  - Tradjenta™
  - Xigduo™ XR

### Weight Management Agents
- **Contrave** - naltrexone/bupropion
- **Orlistat** / Xenical - lipase inhibitor
- Qsymia - phentermine/topiramate
- Saxenda SQ - Victoza, liraglutide, GLP1
- Wegovy SQ - Ozempic, semaglutide, GLP1

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[https://www.virginiamedicaidpharmacieservices.com/provider/external/medicaid/vamps/doc/en-us/VAm
d-PDLquick-20230101.pdf](https://www.virginiamedicaidpharmacieservices.com/provider/external/medicaid/vamps/doc/en-us/VAm
d-PDLquick-20230101.pdf) Jan 1 2023
Bergman Panel Review

What does your panel look like?

Shouldn’t I update my treatment approach?

Insulin only seems out of date, right?

What are YOU doing?
Open Forum

Share an idea. Anything you need help with?
What’s new in your Virginia Health District?
Any announcements?
1. Vaccination Resources
   https://www.ahcancal.org/Quality/Pages/GetVaccinated.aspx

2. How was VAMDA?

3. Any conferences people have anything to share about?
COVID-19:
Data, Treatment, Vaccines

No new therapeutics. New vaccines are approved and out. Any news on your local vaccines? Please speak up or add to chat.

As announced September 12 the new COVID vaccines (Moderna and Pfizer) are recommended for those over 6 months of age. They may be given with RSV and Flu vaccines in separate doses separated by an inch or more. Don’t forget the pneumococcal vaccine also!
Hospital Beds In Use

This measure looks at the average number of inpatient beds in use for COVID-19 for a given week. This can help determine how COVID-19 is impacting total hospital capacity.

2.21% percent of inpatient beds in use for COVID-19 for the week ending 09/16/2023

11.1% points higher than the previous week ending 09/09/2023

4 week trend in percent of total inpatient beds used by COVID-19 patients

% Beds Occupied by Patients with COVID-19 is Low
Virginia COVID-19 Outbreaks in a Long-term Care Setting
(n=172)

May 2023: 7 outbreaks in Assisted Living, 17 in Nursing Home, and 5 in Multicare.
June 2023: 5 outbreaks in Assisted Living, 12 in Nursing Home, and 6 in Multicare.
July 2023: 12 outbreaks in Assisted Living, 11 in Nursing Home, and 6 in Multicare.
August 2023: 28 outbreaks in Assisted Living, 43 in Nursing Home, and 20 in Multicare.
In the month of August, there were 105 COVID-19 outbreaks reported from Virginia long-term care facilities:

- 28 from assisted living facilities
- 43 from nursing homes
- 20 from multicare facilities

Virginia Department of Health (VDH) COVID-19 Dashboards updated September 16

Vaccines are still free of charge to recipients (no charge or copay), but can seek reimbursement from private insurance, Medicare or Medicaid. *** check with facility pharmacy for details

Vaccination Program Provider Agreement

Share with colleagues in chat: Have you started your vaccination clinics for flu, RSV and COVID?
Accreditation

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</tr>
</thead>
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</tr>
<tr>
<td></td>
<td>VCU Health Continuing Education designates this activity for a maximum of <strong>1.00 ANCC contact hours</strong>. Nurses should claim only the credit commensurate with the extent of their participation in the activity.</td>
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<td></td>
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   a. Go to [vcu.cloud-cme.com](http://vcu.cloud-cme.com) to create an account – make sure to add your cell phone number

2. Once you have registered or if you **have participated before**:
   a. Text the course code to (804) 625-4041.
   b. The course code for today’s event is: ###### (please note this is only active for 5 days)

Complete Evaluation & Claim Credit, **within 60 days of the event**

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2. Sign in using email address used above
3. Click “My CE”
   - Click the name of the activity to Click “Evaluations and Certificates” complete evaluation

Need help? [ceinfo@vcuhealth.org](mailto:ceinfo@vcuhealth.org)
Thank you for joining! Evaluation will pop up up-

Next Newsletter - coming to you October 11.

Next Monthly Forum - October 18 at 4pm. Scroll down in the Zoom registration confirmation email you received for a calendar link you can use to update your calendar automatically with the Zoom link for future meetings.

On your way out of Zoom, kindly answer a 3-question feedback survey.

Stay in touch! Email us at ltccn@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu
Disclosures

The speakers and presenters for today have no relevant financial conflicts of interest.

Funding Disclosure: This work is supported by the Virginia Department of Health, Office of Epidemiology, Division of Healthcare-Associated Infections (HAI) and Antimicrobial Resistance (AR) Program and the Centers for Disease Control and Prevention, Epidemiology and Laboratory Capacity (ELC) Program under federal award number NU50CK000555 and state subrecipient number VCULTC603-GY23 in the amount of $820,002. The content presented is solely the responsibility of the authors and does not necessarily represent the official views of the Centers for Disease Control, the Virginia Department of Health, or Virginia Commonwealth University.

Virginia Long-Term Care Infrastructure Pilot Project (VLIPP) funding will be utilized in nursing homes and long-term care facilities to assist with the ongoing COVID-19 response and to bolster preparedness for emerging infections. The projects are based on identified needs that align with funding objectives.