



1

KHC Office Hours:
**The AHA's Target: Type 2 Diabetes Initiative &
Related Resources**
January 22, 2025

**Tim Nikolai, Sr. Rural Health Director
American Heart Association**

The bottom section of the slide contains three logos. On the left is the Kansas Medical Society logo, which features a stylized caduceus and the text 'KANSAS MEDICAL SOCIETY Established 1859'. In the center is the KHC logo, with 'KHC' in a stylized font above 'Kansas Healthcare' and 'COLLABORATIVE' below it. On the right is the Kansas Hospital Association logo, which features the letters 'KHA' in a yellow box above 'Kansas Hospital ASSOCIATION'.

2

DISCLAIMER

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3

Today’s Webinar Agenda

- Welcome – 5 mins
- Content Presentation 45 mins
- Q&A 5 Mins
- Closing Comments 2 mins



4

Target: Type 2 DiabetesSM & Related Resources From the American Heart Association

Tim Nikolai,
Sr. Rural Health Director, Midwest
American Heart Association



5

Disclosures

I am not a clinician or health care professional. I will provide the information I know and attempt to answer questions to the best of my ability. Of course, I am happy to help direct you to further resources.

Objectives

To provide an overview of American Heart Association tools and efforts focused on the evidence-based management of Type 2 Diabetes and overall cardiovascular health improvement.



6



American Heart Association.

Our Mission: To be a relentless force for a world of longer, healthier lives.

Our Vision: Advancing health and hope for everyone, everywhere.

Our Guiding Values:


- Improving & extending people's lives
- Speaking with a trustworthy voice
- Inspiring passionate commitment
- Ensuring equitable health for all
- Bringing science to life
- Making extraordinary impact
- Meeting people where they are
- Building powerful partnerships



American Heart Association.

7

Diabetes in Kansas



Demographic	KS (%)	U.S. (%)
Diabetes - American Indian/Alaska Native	19.0%	17.9%
Diabetes - Asian	13.0%	10.0%
Diabetes - Black	13.8%	15.9%
Diabetes - Hawaiian/Pacific Islander	Data unavailable	U.S.: 15.0%
Diabetes - Hispanic	10.7%	12.8%
Diabetes - Multiracial	8.2%	11.2%
Diabetes - White	11.3%	11.2%
Diabetes - Less Than High School	17.3%	21.7%
Diabetes - High School/GED	15.1%	15.1%
Diabetes - Some Post-High School	13.5%	13.8%
Diabetes - College Grad	9.4%	9.0%
Diabetes - Metro	11.0%	11.7%
Diabetes - Non-Metro	12.3%	13.8%


Diabetes in Shawnee, KS

Shawnee has an estimated 28% of adults report having diabetes in 2023, compared to an average of 15% across the United States.

Diabetes in Wichita, KS

Wichita has an estimated 14% of adults report having diabetes in 2023, compared to an average of 15% across the United States.

Other metrics available at [America's Health Rankings](#) & [City Health Dashboard](#)



American Heart Association.

8

Multiple Chronic Conditions (MCC)

- More than 1 in 4 Americans have 2+ concurrent chronic conditions including hypertension, diabetes, and heart disease.
- Prevalence of multiple chronic conditions among individuals increases with age.
- As the number of chronic conditions ↑, the risks of the following outcomes also ↑:
 - Mortality,
 - Poor functional status; unnecessary hospitalizations
 - Adverse drug events; duplicative tests; conflicting medical advice.
- 66% of total health care spending is directed toward care for the approximately 27% of Americans with MCC.
- Only about a third of people 45 and older with type 2 diabetes have discussed their risk with their health care provider for developing heart attacks, stroke or cardiovascular disease, according to a 2021 national survey.

U.S. Department of Health and Human Services. Multiple Chronic Conditions—A Strategic Framework: Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions. Washington, DC. December 2010.

9

CVD Risk Targets & Event Risks

Percent *CVD risk reduction* for being at target level among 2018 persons with diabetes for each of the measures:

Blood pressure	LDL-C	HBA1c
17%	33%	37%

Percent lower adjusted risk of CVD events with one, two, or three risk factors at target level:

Any 1 of 3	Any 2 of 3	3 of 3
36%	52%	62%

Wong, et al. Diabetes Care 2016 May; 39(5) 668-676. Incident of CVD was defined as MI, CHD death, cardiac procedure (PCI, CABG, or coronary revascularization), stroke, or HF.

10

Our Work in Outpatient/Ambulatory Quality

TARGET:BP™ |  

MIPS #236, eCQM CMS#165v11, PQRS #236 or ACO #28



American Heart Association.
Check. Change. Control.
Cholesterol™

MIPS #438 or eCQM CMS347v6



American Heart Association.
Target: Type 2 Diabetes™

NQF 0059, eCQM CMS#122v11 or MIPS #001

- Provide clinical guidelines and protocols.
- Offer free resources directed towards both providers and patients.
- Connect clinical partners to others around the country engaged in the same work.
- Offer recognition opportunities for any health care organization that demonstrates a commitment to, and/or achieves, clinical excellence.

Registration for program(s) can be completed at heart.org/registermyoutpatientorg



American Heart Association.
Outpace CVD

11



Our Clinical Systems Change Work



Engage

Build relationships with health care organizations.



Affirm

Documenting, recognizing, and celebrating improvement – and looking to next steps

Engage



Equip



Equip

Sharing evidence-based tools and resources




Transform

Integrating systems changes into workflows, policies, and procedures


Transform




12



Standards of Care in Diabetes 2025





Standards of Care in Diabetes 2025

WEBINAR
Standards of Care in Diabetes 2025 Update for Early Career Professionals

OVERVIEW

The 2025 Standards of Care in Diabetes includes the American Diabetes Association's (ADA) current clinical practice recommendations and is intended to provide clinicians, patients, researchers, payers, and others with the components of diabetes care, general treatment goals, and tools to evaluate the quality of care. The recommendations are based on an extensive review of the clinical diabetes literature, supplemented with input from the ADA staff and medical community at large. The Standards of Care in Diabetes is updated annually, or more frequently, when new evidence or regulatory changes merit immediate incorporation and is published in Diabetes Care. Join this session to hear first-hand updates to the 2025 Standards of Care guidelines from Dr. Nura El Sayed.

LEARNING OBJECTIVES

At the end of this activity, the attendees should be able to identify the 2025 ADA Standards of Care for classifying, diagnosing, preventing and treating prediabetes and diabetes.

BENEFITS

1 FREE CE (CME, ABIM/MOC, ACPE, ANCC, AAPA, CDR, COP)

EVENT DETAILS


January 29, 2025 at 12pm ET

[Free CE - Register Now](#)


The [Standards of Care in Diabetes—2025](#) was released in December 2024.

Notable updates to the Standards of Care in Diabetes—2025 include:

1. Continuous Glucose Monitoring (CGM): Recommended for More Patients
2. Early and Tailored Device Selection.
3. Comprehensive Education and Ongoing Support
4. Access Across All Ages and A1C Levels
5. Standardized Reporting for Better Decision-Making



13



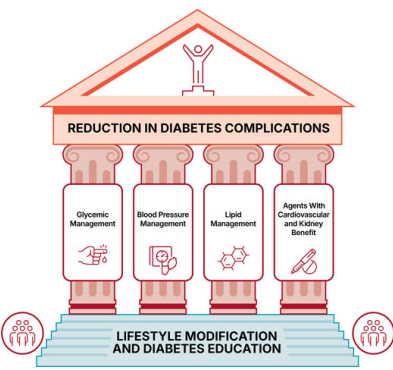
STANDARDS OF CARE | DECEMBER 09 2024

10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes—2025 FREE

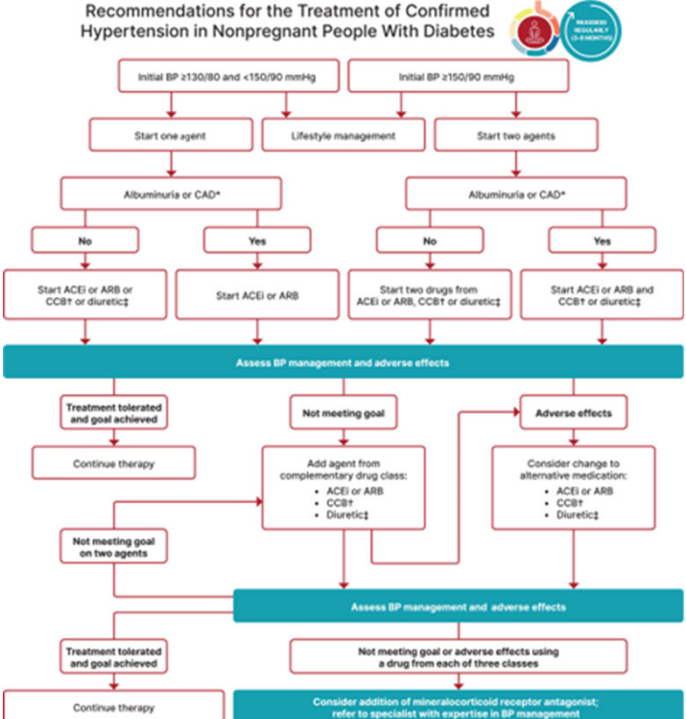
American Diabetes Association Professional Practice Committee

[Check for updates](#)

Diabetes Care 2025;48(Supplement_1):S207–S238
<https://doi.org/10.2337/dc25-S010>



Recommendations for the Treatment of Confirmed Hypertension in Nonpregnant People With Diabetes



```

graph TD
    A[Initial BP ≥130/80 and <150/90 mmHg] --> B[Start one agent]
    A --> C[Lifestyle management]
    A --> D[Start two agents]
    
    B --> E[Albuminuria or CAD*]
    C --> E
    D --> E
    
    E -- No --> F[Start ACEi or ARB or CCB† or diuretic‡]
    E -- Yes --> G[Start ACEi or ARB]
    
    D --> H[Albuminuria or CAD*]
    H -- No --> I[Start two drugs from ACEi or ARB, CCB† or diuretic‡]
    H -- Yes --> J[Start ACEi or ARB and CCB† or diuretic‡]
    
    F --> K[Assess BP management and adverse effects]
    G --> K
    I --> K
    J --> K
    
    K -- Treatment tolerated and goal achieved --> L[Continue therapy]
    K -- Not meeting goal --> M[Add agent from complementary drug class: ACEi or ARB, CCB†, Diuretic‡]
    K -- Adverse effects --> N[Consider change to alternative medication: ACEi or ARB, CCB†, Diuretic‡]
    
    M --> O[Assess BP management and adverse effects]
    N --> O
    
    O -- Treatment tolerated and goal achieved --> L
    O -- Not meeting goal or adverse effects using a drug from each of three classes --> P[Consider addition of mineralocorticoid receptor antagonist; refer to specialist with expertise in BP management]
    
```

14



15

Target: Type 2 Diabetes

For award eligibility, an HCO needs to register (once) and submit annual data between Jan – May.

PARTICIPANT (DATA SUBMISSION)
Hemoglobin A1c Poor Control
MIPS #001 / NQF 0059
AND
Statin Treatment
MIPS #438
OR
Controlling Blood Pressure
MIPS #236

GOLD (PERFORMANCE)
Hemoglobin A1c Poor Control
MIPS #001 / NQF 0059 $\geq 25\%$
AND
Statin Treatment
MIPS #438 $\geq 70\%$
OR
Controlling Blood Pressure
MIPS #236 $\geq 70\%$

DIABETES
MIPS #001 / NQF 0059-Hemoglobin A1c (HbA1c) Poor Control ($>9\%$)
Annual rate of 25% or less

CVD RISK MANAGEMENT
MIPS #438-Statin for the Prevention and Treatment of Cardiovascular Disease
Annual rate of 70% or greater
OR
MIPS #236 Controlling High Blood Pressure
Annual rate of 70% or greater

Attestation Questions

Required, but do NOT affect award level or award eligibility:

- Standard Protocols
- Guideline-Based Pharmacologic Therapy
- PREVENT Calculator Awareness
- Kidney Health

Required, and DO affect award eligibility but NOT award level:

- Confirmation that HCO diagnoses & manages diabetes
- Confirmation that data submitter is a designated representative
- Commitment to continuously improving strategies for addressing CVD risk in patients with t2d

16

Benefits of Award Achievement

Participant and Gold Achievement Award recipients will be provided with resources to help celebrate their success.



An award certificate and digital award icons for use on your website and other materials



National Achievement Award recognition on the Target: Type 2 Diabetes program website



Awards Toolkit that includes a press release template, social media messaging, and more



Recognition mentions at American Heart Association's Scientific Sessions Meeting



GOLD ACHIEVEMENT AWARD

Recognizes practices that achieve Participant Award status AND meet the specified thresholds for each of the two selected clinical measures.



PARTICIPANT AWARD

Recognizes practices that have registered, completed data submission including clinical measure entry, and committed to improvement.



17

Award Criteria

Participant Award:

Recognizes organizations who complete the data submission process inclusive of:

- Organizational information inclusive of a commitment to participate/improve and attestations that your organization diagnoses and treats patients with diabetes and that your responses are complete and accurate.
- Summary numerator/denominator data on the following measures for the previous calendar year:

Required for all:

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) (NQF 0059/MIPS #1)

AND one of the following two CVD related measures:

- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (MIPS #438)
- Controlling High Blood Pressure (MIPS #236)

Gold Achievement Award:

Recognizes organizations who achieve a Participant Award and meet specified thresholds for each clinical measure the site wishes to submit.

Required for all:


Annual rate of 25% or less for HbA1c Poor Control (>9%) based on NQF 0059/MIPS #1

AND one of the following two CVD related measures:


- Annual rate of 70% or greater for appropriate statin therapy based on MIPS #438
- Annual rate of 70% or greater for blood pressure control based on MIPS #236



18



Getting Started with TT2D




Outpace CVD

The American Heart Association's Outpace CVD™ suite offers technology solutions and quality improvement support for healthcare organizations participating in AHA programs and partnered initiatives as they target cardiovascular disease. We support and recognize your organization's commitment to improving patient outcomes.

ABOUT THE DATA PLATFORM & REGISTRATIONS


- As a registered health care organization, you will be able to:
 - Gain access to our data platform (aha.infosarioregistry.com). There, you can utilize benchmarking reports to support your quality improvement activities and submit data towards achievement awards.
 - Receive newsletters providing the latest heart health news, opportunities, and publications.



Target: Type 2 Diabetes™

2025 DATA COLLECTION WORKSHEET FOR TARGET: TYPE 2 DIABETES AWARD ACHIEVEMENT

INSTRUCTIONS
Enter your health care organization's adult patient data to prepare for the formal data submission process. Use only numbers when entering data into the data submission platform. (No commas or decimals).
The deadline to submit 2024 data for 2025 recognition is May 16, 2025, 11:59 p.m. ET. Data submission deadlines are firm to safeguard fair opportunities for all submitters. Early submission is highly encouraged to allow time for review.
All data must be submitted by the deadline to be eligible for recognition. For any questions, contact us at aha@infosarioregistry.com.





Target: Type 2 Diabetes™

Resource Guide: Clinical Practice Questions

This Resource Guide is intended as a supportive tool for answering the Clinical Practice Questions (Q7-Q11) included as part of the formal data submission process for 2024 Target: Type 2 Diabetes achievement awards. These questions are meant to serve as an assessment of your organization's practices for diabetes care, particularly assessing and managing risk for cardiovascular disease (CVD), use of guideline-based medical therapies, and preventing chronic kidney disease (CKD). These questions are required to receive an achievement award but do not affect award level. To see a full list of questions and find instructions for submitting data, please download the [2024 Target: Type 2 Diabetes Data Collection Worksheet](#).

Register at heart.org/RegisterMyOutpatientOrg




Question 7: Standard Protocols

Q7. Which of the following key characteristics do your clinical teams address for patients with type 2 diabetes as part of organizational standard protocols?

Select all that apply:

<input type="checkbox"/> Current lifestyle	<input type="checkbox"/> Social determinants of health (economic and social conditions that may affect a patient's health)
<input type="checkbox"/> Co-morbidities (i.e. ASCVD, HF, CKD)	<input type="checkbox"/> Other characteristics not listed
<input type="checkbox"/> Clinical characteristics associated with increased CVD risk (i.e. age, blood pressure, cholesterol, smoking age, weight, etc.)	<input type="checkbox"/> We don't have a standard protocol to address key characteristics of patients with type 2 diabetes
<input type="checkbox"/> Issues such as motivation and depression	<input type="checkbox"/> I don't know / I'm unsure





Question 8: Treatment Plans

Q8. When your organization operationalizes treatment plans for managing patients with type 2 diabetes, which of the following considerations does the treatment plan include as standard process?


Select all that apply:

- Comprehensive lifestyle modification recommendations
- Diabetes self-management education and support
- Use of guideline-based treatment algorithms (such as the ADA Standards of Care treatment algorithm or ACC/AHA treatment of T2DM for primary prevention of CVD algorithm) by providers and care teams
- Use of ACC/AHA ASCVD Risk Calculator for CVD risk-based treatment decisions related to hypertension and lipid management in patients with type 2 diabetes
- Use of guideline-based pharmacologic therapy inclusive of cardio/cardiorenal protective therapies, such as SGLT-2 inhibitors and GLP-1 receptor agonists
- We don't operationalize a specific treatment plan for patients with type 2 diabetes.
- None of the above
- I don't know / I'm unsure


21

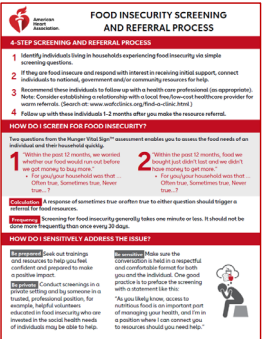


21



DECISION CYCLE FOR PERSON-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES





REVIEW AND AGREE ON MANAGEMENT PLAN

- Review management plan
- Mutually agree on changes
- Ensure agreed modification of therapy is implemented in a timely fashion to avoid therapeutic inertia
- Undertake decision cycle regularly (at least once/twice a year)
- Operate in an integrated system of care

ASSESS KEY PERSON CHARACTERISTICS

- The individual's priorities
- Current lifestyle and health behaviors
- Comorbidities (i.e., CVD, CKD, HF)
- Clinical characteristics (i.e., age, A1C, weight)
- Issues such as motivation, depression, cognition
- Social determinants of health

CONSIDER SPECIFIC FACTORS THAT IMPACT CHOICE OF TREATMENT

- Individualized glycemic and weight goals
- Impact on weight, hypoglycemia, and cardiorenal protection
- Underlying physiological factors
- Side effect profiles of medications
- Complexity of regimen (i.e., frequency, mode of administration)
- Regimen choice to optimize medication use and reduce treatment discontinuation
- Access, cost, and availability of medication

UTILIZE SHARED DECISION-MAKING TO CREATE A MANAGEMENT PLAN

- Ensure access to DSMES
- Involve an educated and informed person (and the individual's family/caregiver)
- Explore personal preferences
- Language matters (include person-first, strengths-based, empowering language)
- Include motivational interviewing, goal setting, and shared decision-making

AGREE ON MANAGEMENT PLAN

- Specify SMART goals:
 - Specific
 - Measurable
 - Achievable
 - Realistic
 - Time limited

PROVIDE ONGOING SUPPORT AND MONITORING OF:

- Emotional well-being
- Lifestyle and health behaviors
- Tolerability of medications
- Biofeedback including BGM/CGM, weight, step count, A1C, BP, lipids

IMPLEMENT MANAGEMENT PLAN

- Ensure there is regular review; more frequent contact initially is often desirable for DSMES

From: 4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Care in Diabetes—2023
Diabetes Care 2023;46(Suppl. 1):S49-S67

22

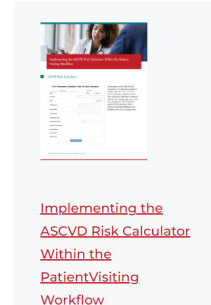


Protocols & Treatment Plans

Related Resources:

- [Pharmacologic Approaches to Glycemic Treatment: Standards of Medical Care in Diabetes—2022 from the American Diabetes Association](#)
- [2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease from the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines](#)
- [ACC/AHA ASCVD Risk Calculator](#)

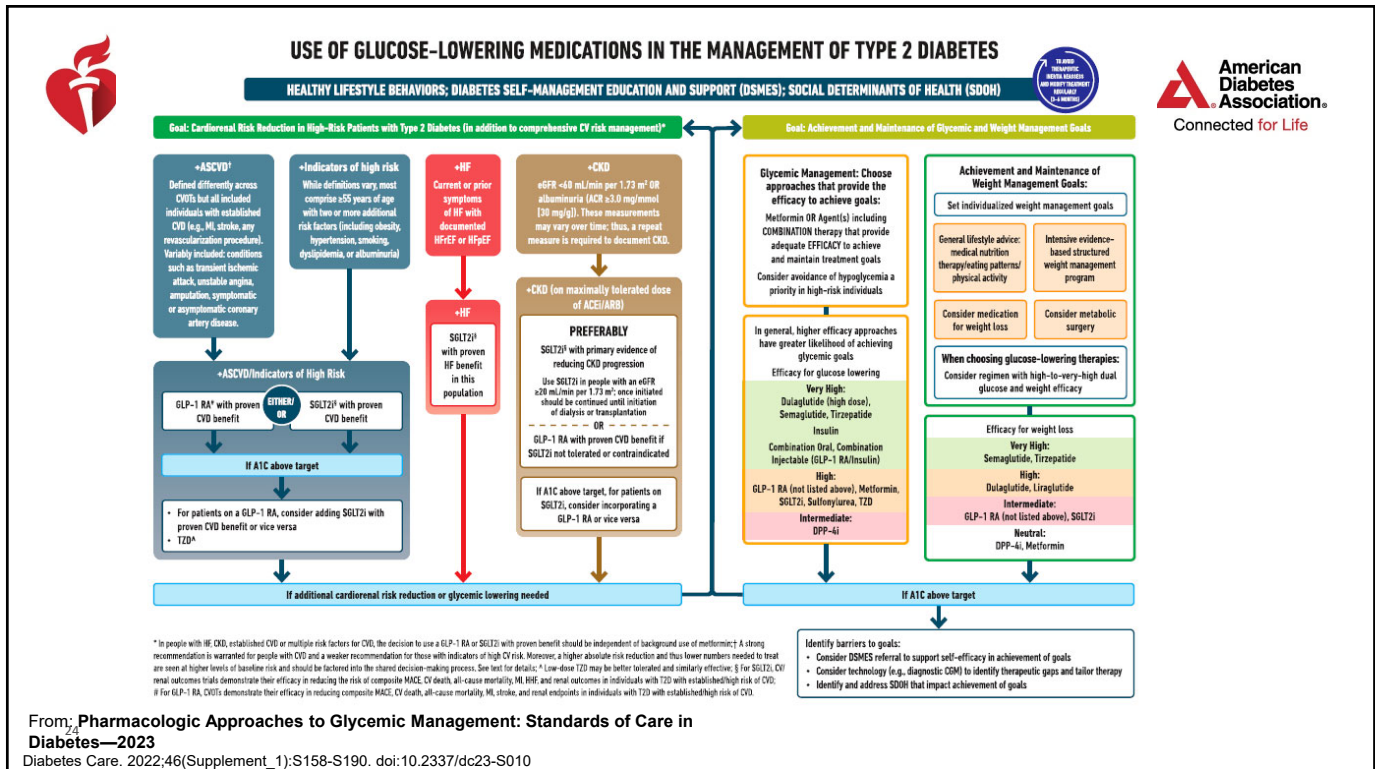
KDBH Job Aids:



[Find All KDBH Job Aids](#)

DSMES = Diabetes Self-Management Education and Support

23



24



Question 9: Prescribed Therapies

Q9. Please indicate where the following therapies are typically being prescribed for patients with type 2 diabetes, to the best of your knowledge.

Therapies:

A) Angiotensin system blockers (ACE inhibitor, ARB, or ARNI), **B)** Other antihypertensive medications such as beta-blockers, diuretics, etc. EXCEPT ACE/ARB/ARNI, **C)** lipid-lowering therapies, including statins or non-statin alternatives, **D)** Dipeptidyl Peptidase-4 (DPP4) inhibitors, **E)** GLP-1 receptor agonists, and **F)** SGLT-2 inhibitors

Within my organization, [A-F individually], are prescribed for patients with type 2 diabetes in:

Select all that apply:

- Family medicine or internal medicine
- Another specialty or specialties (example: cardiology, endocrinology, etc.)
- Specialty clinic(s), such as those for lipid or cardiometabolic care
- None of the above – we refer to external specialty providers
- None of the above – my organization neither prescribes these therapies nor has a process for referral
- I'm not sure

25



25



Question 10: Prescribing Barriers

Q10. What barriers does your organization experience related to prescribing initiation of guideline-directed medical therapy for cardio/cardiorenal protective medications, such as SGLT-2 inhibitors and GLP-1 receptor agonists, for patients with type 2 diabetes?

Select all that apply:

- System-based barriers such as formulary or prior authorization limitations (*NOTE: Selecting this option will prompt an additional question*)
 - Please select the factors that impact accessibility of cardio/cardiorenal protective medications:*
 - Medications not on formulary
 - Limited resources to assist with prior authorization
 - Other factors
- Limited clinician awareness of the guideline-directed medical therapies or their application
- Clinicians unsure who is the primary lead in prescribing cardio/cardiorenal protective therapies, i.e., whether to refer to specialty provider for prescribing
- Prescriber reluctance to modify or add to patients' medications
- Lack of access to specialist for referral
- Patient reluctance, such as concerns about adverse effects or negative perception of pharmacotherapy in general
- Cost/affordability concerns expressed by patients
- Other circumstantial barriers for patients, such as lack of transportation, lack of pharmacy access, homelessness, etc.
- Other barriers not listed
- No barriers
- I'm not sure.

26



26



Guideline-Based Pharmacological Therapy

Related Resources:

- [Comprehensive Management of Cardiovascular Risk Factors for Adults With Type 2 Diabetes: A Scientific Statement From the American Heart Association](#)
 - This statement includes a wide variety of therapies available based on each patient's history, conditions, and risk as part of patient-centered care

Unlocking Medication Access: Navigating Drug Formulary and Prior Authorization Challenges

Webinar: Unlocking Medication Access: Navigating Drug Formulary and Prior Authorization Challenges
November 6th, 2023 | 2 PM Eastern Standard Time

Please join us for a presentation covering navigation of drug formularies and prior authorization challenges in the management of diabetes. Dr. Michelle Chu will address cost issues related to prescribing diabetes medications.

Participants will learn:

- Describe the purpose and process of formulary.
- Discuss benefits and barriers to prior authorization.
- Explain how different entities are involved in drug cost.
- Summarize resources including pharmacists to help with patient's access to medications.

KDBH Job Aids:

[Treatment Algorithms and Recommendations for CVD Risk Management, Microvascular Complications and Foot Care and the Pharmacologic Approach to Glycemic Treatment](#)

[Implementing a Medication Adherence Program Targeting Patients with T2D at Risk for CVD](#)

[Find All KDBH Job Aids](#)



Kidney Health

WHY include a question on evaluating kidney health?

Patients with type 2 diabetes and kidney disease are at **3 times higher risk** of dying from a cardiovascular event.

Early detection and use of medications designed to protect the heart and kidneys can help to prevent cardiovascular events like heart attack or stroke.

People with type 2 diabetes should have a UACR (urine albumin to creatinine ratio) test every year to measure kidney function and detect early signs of trouble.

Circulation

REVIEW ARTICLE | Originally Published 9 October 2023 | [Check for updates](#)

Cardiovascular-Kidney-Metabolic Health: A Presidential Advisory From the American Heart Association

Choud E. Ndiume, MD, PhD, FAHA, Chair; Janani Rangaswami, MD, FAHA, Vice Chair; Sheryl L. Crow, PhD, FAHA, Vice Chair; Ian J. Neeland, MD, FAHA; Katherine R. Tuttle, MD; Sadya S. Khan, MD, MSc, FAHA; Josef Coresh, MD, PhD; ... [BSDE, JAL](#) ... on behalf of the American Heart Association

AUTHOR DISCLOSURES

Circulation • Volume 148, Number 20 • <https://doi.org/10.1161/CIRC.0000000000002136>

129,466 / 216





Question 11: Evaluating Kidney Health

Q11. Does your organization routinely evaluate kidney health for patients with type 2 diabetes?

Yes / No / I'm not sure.

If YES is selected:

Select all that apply:

- Assessment of estimated glomerular filtration rate (eGFR) at least once per year, per patient
- Assessment of estimated glomerular filtration rate (eGFR) less frequently than once per year per patient (such as once every 2 years)
- Assessment of urine albumin-creatinine ratio (uACR) at least once per year, per patient
- Assessment of urine albumin-creatinine ratio (uACR) less frequently than once per year per patient (such as once every 2 years)
- Assessment of kidney health using some other metric
- We do not have a process to evaluate kidney health in patients with diabetes
- I don't know / I'm not sure

American Heart Association
Cardiovascular-Kidney-Metabolic Health Initiative

More than 89 million adults in the U.S. are at risk for or are living with cardio metabolic disease. Recent science shows that cardio kidney disease and cardiometabolic disease are interrelated, suggesting they should be viewed together as cardio kidney metabolic disease. A holistic, person-centered approach to cardiovascular-kidney-metabolic (CKM) syndrome is essential, as it aligns guidelines with real-life experiences of patients and healthcare professionals.

Controlling four of Life's Essential 8 — weight, blood pressure, lipids, and blood glucose — improves cardiovascular health and reduces the risk of heart disease, stroke, metabolic disorders, and kidney disease.



The Cardiovascular-Kidney-Metabolic Health Initiative is made possible by the American Heart Association and founding sponsors, Novo Nordisk and Boehringer Ingelheim.



CKD is classified based on: • Cause (C) • GFR (G) • Albuminuria (A)				Albuminuria categories		
				Description and range		
				A1	A2	A3
				Normal to mildly increased	Moderately increased	Severely increased
				<30 mg/g <3 mg/mmol	30-299 mg/g 3-29 mg/mmol	≥300 mg/g ≥30 mg/mmol
GFR categories (mL/min/1.73 m ²) Description and range	G1	Normal to high	≥90	1 if CKD	Treat 1	Refer* 2
	G2	Mildly decreased	60-89	1 if CKD	Treat 1	Refer* 2
	G3a	Mildly to moderately decreased	45-59	Treat 1	Treat 2	Refer 3
	G3b	Moderately to severely decreased	30-44	Treat 2	Treat 3	Refer 3
	G4	Severely decreased	15-29	Refer* 3	Refer* 3	Refer 4+
	G5	Kidney failure	<15	Refer 4+	Refer 4+	Refer 4+

Figure 11.1—Risk of chronic kidney disease (CKD) progression, frequency of visits, and referral to nephrology according to glomerular filtration rate (GFR) and albuminuria.

Microvascular Complications and Foot Care:

Standards of Care in Diabetes - 2023. Diabetes Care 2023;46(Suppl. 1):S191-S202

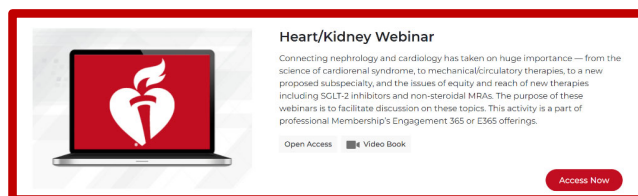


Kidney Health

Supporting Resources

Related Resources:

- [Cardiorenal Protection With the Newer Antidiabetic Agents in Patients with Diabetes and Chronic Kidney Disease: A Scientific Statement From the American Heart Association](#)
- Related Recordings (Webinars & Panels)
 - [ADA 82nd Scientific Sessions Recap – Latest Research on CVD and Diabetes including Renal Risk Management](#)
 - [Managing CV and Renal Risk in Patients with T2D](#)
 - [Renal Disease in Patients with Heart Failure and Diabetes](#)
 - [FAQs for Patients with Renal Disease, Heart Failure and Type 2 Diabetes](#)



31



Clinical Practice Takeaways

- Modern management of diabetes is not just about lowering blood glucose. It is also about protecting the heart, the brain and the kidneys from vascular injury related to hyperglycemia.
- In addition to HgbA1c goals, it is important to track weight, activity, blood pressure, lipids and renal function (by eGFR and urine albumin Cr ratio) for our population with diabetes.
- In 2023 we have a broad array of tools for diabetes care. The job of the clinician is to assemble and tailor the best combination of for each patient.

Webinar

American Heart Association's Scientific Sessions Highlights: Latest Research on CVD and Diabetes

November 29, 2023

Join Know Diabetes by Heart™ for an expert panel discussion on new science released at the American Heart Association's Scientific Sessions. Panelists will discuss clinical highlights from the 2023 Scientific Sessions related to cardiovascular disease risk management in patients with diabetes, including renal disease.







32




33

Target: Type 2 Diabetes Quality Collective Overview

-  Six health care organizations were chosen to participate in the quality collective. A mixture of FQHC's and health systems were chosen.
-  Participants attended a quarterly learning collaborative call. At each call one participating organization would present a model share and an area of opportunity for discussion.
-  Annual data review calls were completed with each site one-on-one to identify specific areas for improvement in each organization.
-  The goal of the quality collective was to improve diabetes care and outcomes through collective learning and quality improvement implementation.

TARGET: TYPE 2 DIABETES QUALITY COLLECTIVE



34

Cohort Highlights

5 out of 6 organizations participating in the TT2D Quality Collective **saw improvements in their diabetes control** from 2022 to 2024

Across the quality collective there were **14,484 patients with diabetes** included in the diabetes measure in the 2024 award year

All sites who submitted data for statin therapy improved in this measure over the initiative



TARGET: TYPE 2 DIABETES ABSTRACT AND POSTERS

AHA Scientific Sessions Global Quality Showcase

Poster Presented at AHA Scientific Sessions November 15-18th 2024

GLOBAL QUALITY SHOWCASE
SCIENTIFIC SESSIONS IN CHICAGO

Saturday, November 16 | 3:30 - 5:00p at HeartQuarters in the Exhibit Hall

Join the American Heart Association and collaborators for the Global Quality Showcase at Scientific Sessions 2024. This event features poster presentations and model-sharing encounters from health care teams across the globe.

Each poster presentation includes insight derived in part from one of the American Heart Association's quality improvement programs or initiatives. Use the QR code to vote for your favorite poster in the Showcase Showdown. The top 3 winners will be announced live!

Vote to vote for the winning poster

- To Improve Care for Acute Coronary Syndrome Patients: Registration of Baseline Characteristics, Treatment and Results - A Step by Step Analysis**
Josef Hain Trankl, MD and Peter Braun-Lanzetta, MD, PhD
XXI National Medical Center, Cardiology Hospital, Mexico City, Mexico
- Acute Stroke Neuroimaging Quality Results**
Michelle Legrand, Vikas Choudhry, MD, PhD
XXI National Medical Center, Cardiology Hospital, Mexico City, Mexico
- Primary Care Outreach in Moderate and Severe Asthma**
Scott Houser, University of Nebraska Medical Center
- Using Ethical Surveillance to Identify Acute Stroke**
Miguel Pineda, Lake Charles Memorial Hospital, Louisiana
- A Comprehensive Clinical Pathway for Acute Stroke**
Elizabeth Rogerson and Rochelle Rubio, University of California San Francisco
- Early Structural Heart Evaluation Leads to Timely Intervention in Aortic Stenosis**
Peggy DiMatteo, Inspira Health Network, New Jersey
- Clinical Excellence Bundles and Cardiovascular Risk Reduction**
John Whalen and Thomas Aronson, WakeMed Health and Hospitals, Raleigh, North Carolina
- Skilled Nursing Facility Heart Failure Certification**
Santitas Hospital and Improving Patient Outcomes
Suzanne Lawson, Nico Helle and Steve Daniel, Laurel Brook Rehabilitation and Healthcare Center in Morristown affiliated facility, New Jersey
- A Specialized Program for Hospital Patients Using End Stage Heart Failure**
Monica Swanson, Hospice of Cincinnati
- 500,000 Education for Patients with Diabetes is a Critical Part of Chronic Disease Management**
Karee Lichtenhan, Sharp HealthCare, San Diego, California
- Implementing a Personalized Learning Platform for Hyperlipidemia Care**
Catherine (CHC) Dattani, a Community Health Practitioner, Worcester Community Hospital, Worcester, MA
- Setting to the Heart of Stroke: St. David's Medical Center**
Rachelle W. Housley, St. David's Medical Center, Sugar Summit, St. David's Medical Center, Texas
- Setting to the Heart of Stroke: Baylor Medical Center**
Debra Pilgour, Baylor Medical Center, Tennessee

"A Model-Sharing Approach for Quality Improvement of Diabetes and Cardiovascular Disease"

A Model-Sharing Approach for Quality Improvement of Diabetes and Cardiovascular Disease

Kyle Ripstein, MD, Srinivas Chinnaiyan, MPH, MS, Patricia Lammie, PharmD, PhD, PhD, Steven Sussman, MD, MBA, MPH, BMJ, Rishi Saha, MD, PhD, PhD, John Whalen, MD, Bianca Peralta, MPH, MSW, Renee Sedow, MPH, Sara Duckert, Meghan Pollack, MD, COCCS, Katherine Oertgen, Michelle Congdon, MBA, CHCQ, on behalf of the Target, Type 2 Diabetes Quality Collective

Background

Opportunities exist to improve health outcomes for patients with diabetes and cardiovascular disease (CVD) who are at an increased risk for CVD. The American Heart Association (AHA) established the Target, Type 2 Diabetes (TT2D) national recognition program to recognize hospitals and health centers for adherence to guidelines for diabetes and CVD. To focus on care and strategies for team-based care, coordination of care, and guideline implementation models for diabetes and CVD, the AHA launched the TT2D Quality Collective in 2022.

Methods

Three health systems and three Federally Qualified Health Centers (FQHCs) were invited to participate in the TT2D Quality Collective from January 2023 - February 2024. Participation includes technical support for diabetes management, peer-supported model sharing, and ongoing quality improvement support as part of AHA's inpatient and outpatient TT2D recognition programs.

Peer-supported model sharing is conducted through quarterly meetings for each Quality Collective participant sharing a successful component of their diabetes care pathway, followed by feedback, comments, and/or suggestions for identified challenges within their respective systems. Quarterly meetings with AHA staff to discuss these issues and other strategies related to guideline-directed care.

Questions are administered at baseline, midpoint, and end to monitor quality improvement changes over time.

Results

The AHA team identified themes from participant questions and activities based on submitted responses to baseline and midpoint questionnaires and quarterly peer-supported model sharing discussions. Table 1 displays a summary of identified themes.

Conclusions

Diabetes health systems can utilize peer-supported model-sharing and rapid feedback to identify opportunities, solutions to known barriers, and strategies to improve implementation of guideline-directed care for type 2 diabetes and CVD. Initial findings from this ongoing initiative reveal the need for deeper discussions in areas such as:

- Availability, access, and barriers to evidence-based pharmacological treatments
- Treatment decision-making algorithms
- Full integration and utilization of pharmacists as part of team-based care
- Strategies for increasing patient engagement in diabetes self-management

Type 2 Diabetes Resources

www.heart.org/TargetType2DiabetesOutpatient
www.knowdiabetesbyheart.org

Know Diabetes by Heart™

Webinars | Podcasts | Clinical Support | Quality Improvement | Latest Guidelines | Resources | Alliances | Newsletter Signup

Clinical Tools

- CVD Case Study
- T2D & CKD
- DSMES Services
- COVID-19
- A1CVD Pro App

COVID-19 and your patients

eModule
Meet three patients with T2D and discover how to "treat the whole patient" with education, screenings, prescriptions and a team-based care approach to managing their T2D and risk for CVD.
[LEARN MORE >](#)

Toolkit
Access resources to help patients with T2D commit to a healthy lifestyle and take action to lower their risk of complications and live their best lives.
[LEARN MORE >](#)

Job Aids
Quickly access abbreviated resources that help you implement programs, processes and recommendations for diagnosing and supporting patients with T2D.
[Job Aids >](#)

American Heart Association. Target: Type 2 Diabetes™

37

PATIENT FACING RESOURCES

DOWNLOADABLE PATIENT RESOURCES

- What is Diabetes?*
- Types of Diabetes*
- Take Care of Your Heart When You Have Type 2 Diabetes*
- 4 Questions to Ask Your Doctor About Diabetes and Your Heart*
- 7 Tips to Care for Your Heart When You Have Type 2 Diabetes*
- Where to Begin on Your Heart Care Journey
- ADA's Ask the Experts Overview Sheet
- Medication Chart

OTHER PATIENT PROGRAMS/RESOURCES

- Monthly Email Series
- ADA's monthly Ask the Experts virtual events and audiocasts
- ADA's Living with Type 2 Program*
- Recipe of the Month

*Available in Spanish

KNOW DIABETES BY HEART HEALTH LESSON


Let's Talk About Diabetes, Heart Disease, & Stroke

- What is My Risk?
- What Can I Do?
- How Can I Be an Active Member of My Health Care Team?


Hablemos de diabetes, enfermedades cardiacas y ataques o derrames cerebrales

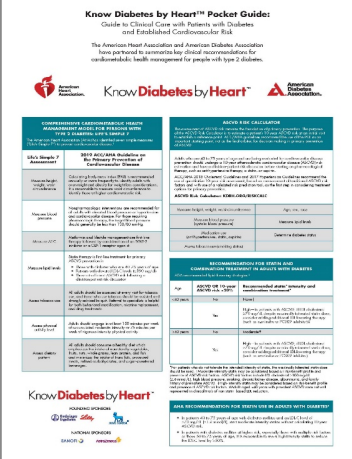
- ¿Qué riesgo corre?
- ¿Qué puedo hacer?
- ¿Cómo puedo ser un miembro activo de mi equipo de atención médica?

38



HEALTH CARE PROVIDER RESOURCES





Know Diabetes by Heart™ Pocket Guide:
Guide to Clinical Care with Patients with Diabetes and Established Cardiovascular Risk


The American Heart Association and American Diabetes Association have partnered to create this clinical recommendation for cardiovascular health management for people with type 2 diabetes.


WEBINAR SERIES

- Translating Guidelines into Practice
- Supporting Your Patients in Managing their CV Risk through Lifestyle Management


PODCAST SERIES


- Know Diabetes by Heart™ Initiative
- Management and Treatment of Diabetes to Prevent CVD
- AHA's 2018 Cholesterol Guidelines and the Implications for T2D
- Shared Decision-Making
- ASCVD Risk Calculator
- Diabetes and Heart Failure





WEBINAR: TOMORROW (1.23.25 @ 12 PM CST)







WEBINAR
A Case Study Approach to Type 2 Diabetes Care
January 23, 2025 • 12:00 PM - 1:00 PM (CST)


This webinar will explore unique cases related to diabetes care. The presenters will walk through a case from their clinics and share their management process. Special consideration will be given to team-based care, navigating prior authorization challenges, and prescription of guideline directed care for the patient with diabetes. An interactive question and answer session will be held to provide a deeper understanding of each case.


REGISTER TODAY

SPEAKERS


Theresa Amerson
MS, CDE, MEdP
Chief Medical Officer,
Population Health
Wakarusa Health &
Hospitals


Kyle Elliger
MD
Site Medical Director,
Fair Haven Community
Health Care


Rona Schechter
MD, MEd, CDE
System Director,
Diabetes Service Line
Sharp Health Care


John Whelan
MD
Lead Physician,
WPP Primary Care
North Raleigh
Wakarusa Health &
Hospitals

FOUNDING SPONSOR


[REGISTER HERE](#)

Learn About Diabetes and the Heart

Tuesday, February 11, 2025
2:00 pm – 3:00 pm ET




Did you know cardiovascular disease is the leading cause of death and a major cause of heart attacks, stroke and heart failure for people living with type 2 diabetes? Learn how caring for your heart and diabetes is a two-way street.

Professional Education




A mix of free / \$\$ options.


- [Health Equity](#)
- [Hypertension](#)
- [Resuscitation](#)
- [Stroke & Brain Health](#)
- [Telehealth Prof. Cert.](#)
- [Tobacco Treatment Cert.](#)


Future & Past webinars.



Innovating Care for Patients with Type 2 Diabetes



A CHW Resource for Addressing Disparities in Cardiovascular...



Removing Barriers to Equitable Health: Public Health


Community Facing Resources

Collections of Presentations

- [Healthy For Life Nutrition Lessons](#)
- [Empowered To Serve Modules.](#)


Answers By Heart includes dozens of fact sheets on [Cardiovascular Conditions](#), [Treatments and Tests](#), and [Lifestyle and Risk Reduction](#). A great way to help make health information accessible. [Many sheets are also available in Spanish.](#)

[Life's Essential 8](#) are the defining markers of good heart health. Resources include infographics for adults (also in Spanish) and [kids](#), along with the [MyLifeCheck](#) heart health score tool.



41

Funding Opportunities for Rural KS




Blood Pressure & Beyond - in the Rural Midwest Grant for Health Care Organizations*

Receive up to \$2000* for your efforts in addressing rural health outcomes.

In July of 2024, the American Heart Association released a [Presidential Advisory: Forecasting the Burden of Cardiovascular Disease \(CVD\) & Stroke in the U.S. Through 2050—Prevalence of Risk Factors and Disease](#). The report emphasized the role that a growing incidence of high blood pressure and diabetes will play in the overall growth of CVD while anticipating a continued disproportionate impact on rural areas.

Furthermore, the Advisory encourages the need for a comprehensive approach to prevention and management. Thus, we are working with health systems, Rural Health Clinics, Federally Qualified Health Centers, free clinics, and, more recently, pharmacies, dentists, behavioral health clinics, etc. to improve the clinical response to chronic disease disparities. In many cases, we are working with those same organizations to integrate opportunities to address the Social Drivers of Health (SDOH) and improve resource access in coordination with local community based organizations.

DEADLINE 1.31




Meeting People Where They Are Improving Health in Collaboration with the Places Where Rural Communities Gather

Receive up to \$1500 for your efforts to improve health in your community.

The American Heart Association's mission to be a *relentless force for a world of longer, healthier lives* is a prospect that is increasingly difficult in many rural communities. Among other health challenges, rural Americans face higher rates of [high blood pressure](#), [nutrition insecurity](#), [tobacco use](#), [cardiac arrest death rates](#), and more. At the same time, rural communities have strong assets – organizations and individuals who are dedicated to making a difference and thinking creatively to overcome challenges. That reality aligns with our Guiding Values which include a focus on “meeting people where they are” and “building powerful partnerships.”

DEADLINE 2.7



42

Next Steps

- Visit heart.org/RegisterMyOutpatientOrg to sign up for **Target: BP**, **Target: Type 2 Diabetes**, and/or **Check. Change. Control. Cholesterol.**
- Evaluate existing or potential **practice gaps** around chronic disease management and access American Heart Association tools to help close those gaps.
- Consider applying for one of AHA's rural health grants, either for your organization or in conjunction with a local partner.
- Reach out to Tim.Nikolai@heart.org for further information or to examine opportunities for collaboration.



43

February is American Heart Month



AMERICAN HEART MONTH 2025

JOIN US IN CREATING A NATION OF LIFESAVERS™



National Wear Red Day 2025 Resources

National Wear Red Day is almost here! Grab your friends and get red-y. These resources are everything you need to get started!

Guides

- [National Wear Red Day Activation Guide \(PDF\)](#)
- [National Wear Red Day Fundraising Guide \(PDF\)](#)

Posters

- [National Wear Red Day Poster 1 \(PDF\)](#)
- [National Wear Red Day Poster 2 \(PDF\)](#)
- [National Wear Red Day Poster 3 \(PDF\)](#)
- [Wear Red and Give Poster \(PDF\)](#)

Print Ads

- [National Wear Red Day Print Ad \(PDF - full page\)](#)
- [National Wear Red Day Print Ad \(PDF - half page horizontal\)](#)
- [National Wear Red Day Print Ad \(PDF - half page vertical\)](#)

Social Media

- [Wear Red Day and Give Facebook Cover Images \(ZIP\)](#)
- [Wear Red Day and Give LinkedIn Cover Images \(ZIP\)](#)
- [National Wear Red Day Social Media Posts \(ZIP\)](#)

Posters in Spanish

- [National Wear Red Day Poster 1 \(PDF\)](#)
- [National Wear Red Day Poster 2 \(PDF\)](#)

Print Ads in Spanish

- [National Wear Red Day Print Ad \(PDF - full page\)](#)
- [National Wear Red Day Print Ad \(PDF - half page horizontal\)](#)
- [National Wear Red Day Print Ad \(PDF - half page vertical\)](#)

Social Media in Spanish

- [National Wear Red Day Social Media Posts \(ZIP\)](#)



@AHAKansas




44

Questions or Assistance


Tim Nikolai
 Sr. Rural Health Director, Midwest
Tim.Nikolai@heart.org
 M 414.502.8780


Erin Gabert
 Sr. Community Impact Director, Kansas City
Erin.Gabert@heart.org
 M 816.682.2005



45

Questions?





46

46

Upcoming Education and Important Dates

- [1/23 KHA Advocacy Day](#)
- [1/30 Kansas Virtual Career Day](#)
- [2/26 KHC Office Hours - Resources for Treating Hypertension and CVD](#)
- [3/26 KHC Office Hours - Best Practices for Success in APMs](#)
- 3/31 MIPS Submission Window Closes - Last Day to Submit



47



Malea Harvickson
Executive Director



Mandy Johnson
Senior Director,
Programs



Treva Borchert
Director of Operations



Eric Cook-Wiens
Data & Measurement
Director



Liz Warman
Quality Improvement
Advisor



Jill Daughette
Director of Education
and Communications



Azucena Gonzalez
Health Care Quality
Data Analyst



Erin McGuire
Quality Improvement
Advisor



Jenni Peters
Quality Improvement
Advisor



Julia Pyle
Quality Improvement
Advisor



Patty Thomsen
Quality Improvement
Advisor



Rebecca Wagner
Grants Coordinator

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- [Kansas Healthcare Collaborative](#)

→ Find contact info
and more at:
www.KHCOnline.org/staff



48

48



49