Cardiometabolic Health in Patients with Diabetes

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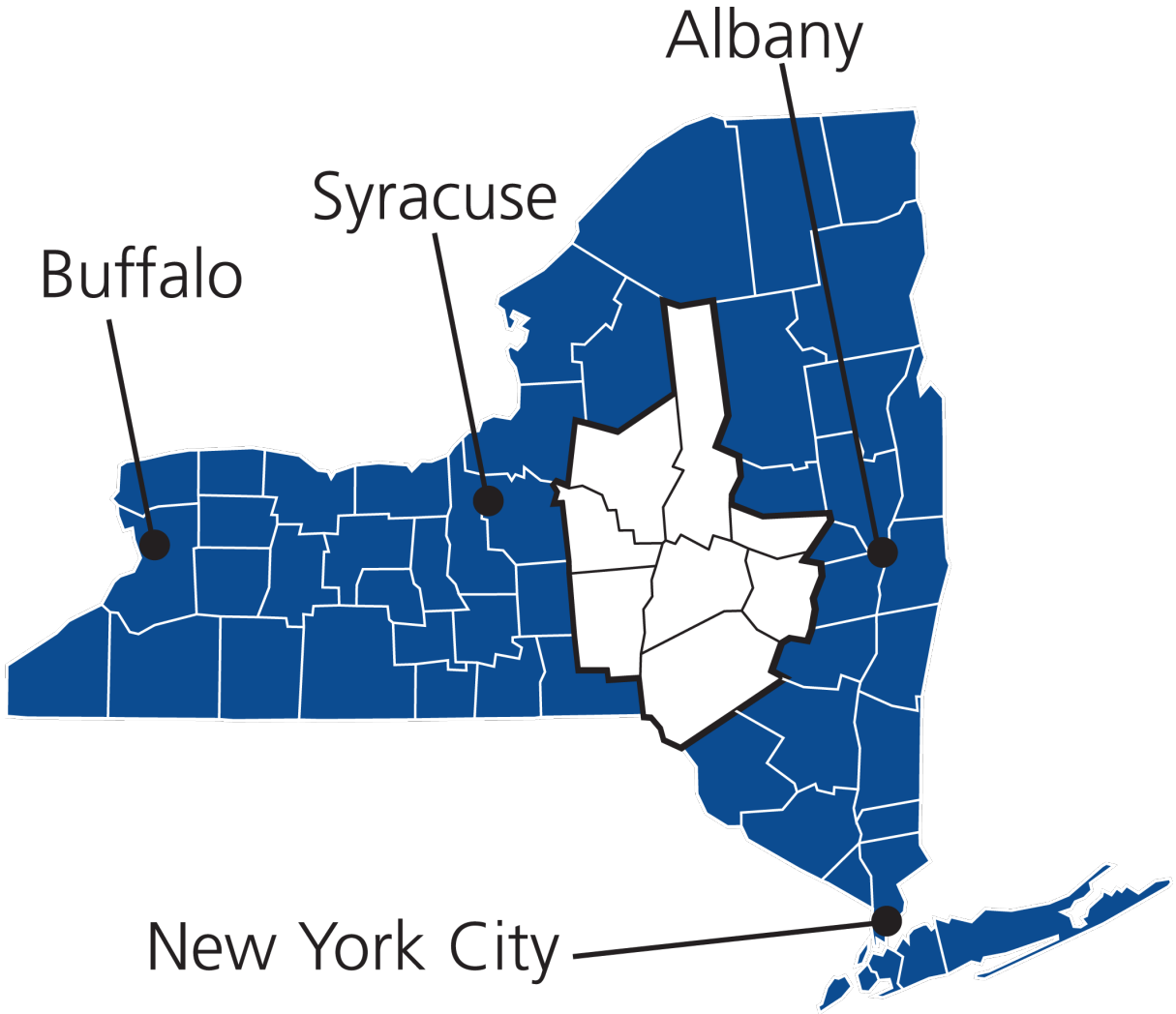
Bassett Healthcare Network

No conflict of interest to disclose



- Six affiliated hospitals (Cooperstown, Oneonta, Sidney, Cobleskill, Little Falls, Delhi)
- 33 community health centers
- 21 school-based health centers
- Primary Care Physicians
- Division of Endocrinology: 2 tele-endocrinologist, 2 endocrinologist, 2 advance practitioners
- 4 Certified Diabetes Educators
- Dietitians
- Affiliation with Columbia University (Bassett-Columbia Program)

Objectives

- Patient Story
- Define cardiometabolic health and review national quality metrics
- Guideline recommendations (ADA 2025)
- Discuss BHN barriers of providing high-quality care to promote cardiometabolic health at the individual and population level
- Discussion

- 58 y.o. woman with CAD, T2D comes to the office to establish care & ED follow-up
- Started on long-acting insulin (insulin glargine)
- Hgb A1C is 13.5% (~ 341 mg/dL)
- She does not take any BP medication and BP in the clinic is 149/88 mm Hg, BMI 30 kg/m^2
- Her diet is “unhealthy”, has never seen a dietitian
- She smokes
- She is not on a statin

Management

- Order a lipid panel, urine albumin-to-creatinine ratio ✓
- Discuss blood sugar goals and order/scheduled a Hgb A1C for in 3 months ✓
- Prescribe testing supplies and ask to keep a glucose log ✓
- Recommend seeing a diabetes educator, a dietitian and tobacco cessation program ✓
- Prescribe semaglutide 0.25 mg weekly to be up titrated every 4 weeks, a statin and an ACE-inhibitor ✓
- 3 months follow up Hgb A1C 6.7%

✓ = High Quality Care

WE CAN HELP YOU QUIT SMOKING

NOW OFFERING PERSONALIZED TREATMENT

In collaboration with the University of Rochester Medical Center, anyone living in the Bassett area is eligible to participate in a **FREE** smoking cessation program.

All services are FREE of charge!

- Text message support
- Nicotine Replacement Therapy
- Available in English and Spanish

4 WAYS TO GET IN TOUCH!

1. Scan the QR Code
2. Text "BASSETT" to 63141
3. Call 585-504-9461
4. Email Bassett's Liaison: melinda.robinson@bassett.org

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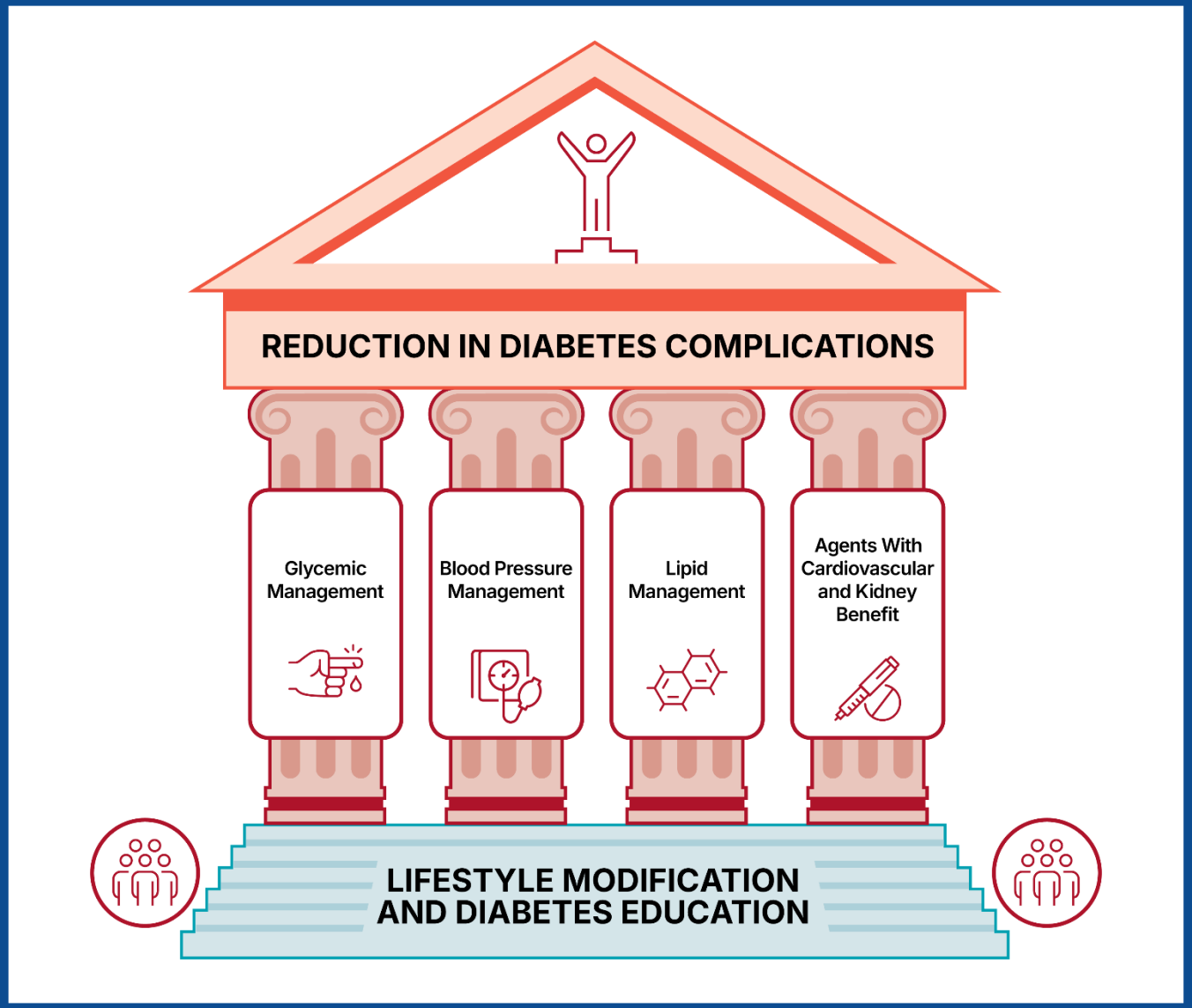
Cardiometabolic Health

- **Optimal functioning** and **absence of disease** across cardiovascular and metabolic domains (adiposity, blood glucose, lipids, blood pressure, among other)
- **Prevention and management** of obesity, diabetes, dyslipidemia, hypertension and CKD, reflecting interconnected pathophysiology that drive CV morbidity and mortality

- Diabetes is independent ASCVD risk factor
- CV disease → major cause of morbidity and mortality
- Major CV risk factors are clustered and common among patients with diabetes
- Large benefits when multiple CV risk factors (glycemic, BP and lipid management) are addressed simultaneously



Multifactorial approach to reduction in risk of diabetes complications.

Source: 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2025

- No or only marginally increased mortality, MI and stroke risk when all major CV risk factors are managed to goal levels
- **Focus**: deliver high-quality comprehensive cardiovascular care and address barriers to risk factor management

National Quality Metrics

- **2015 – 2018**:
  - 50.5% community dwelling adults with diabetes achieved A1C <7% and 75.4% achieved <8%
  - 47.7% of adults with diabetes achieved BP <130/80 mm Hg and 70.4% achieved <140/80 mm Hg
  - 55.7% achieved non HDL cholesterol <130 mm/dL
- **All three risk factors were treated to goal in just 22.2%**

Source: 1. Improving Care and Promoting Health in Populations: Standards of Care in Diabetes - 2025

Guideline Recommendations

1. Hypertension
2. Lipid management
3. Antiplatelet
4. Cardiovascular disease

1. Hypertension

- Screening and diagnosis
- Treatment goals
- Lifestyle interventions
- Pharmacologic interventions

Source: 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2025

2. Lipid management

- Lifestyle interventions
- Monitoring lipids
- Statin treatment
  - Primary prevention
  - Secondary prevention
- Treatment of other lipoprotein fractions or goal

Source: 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2025

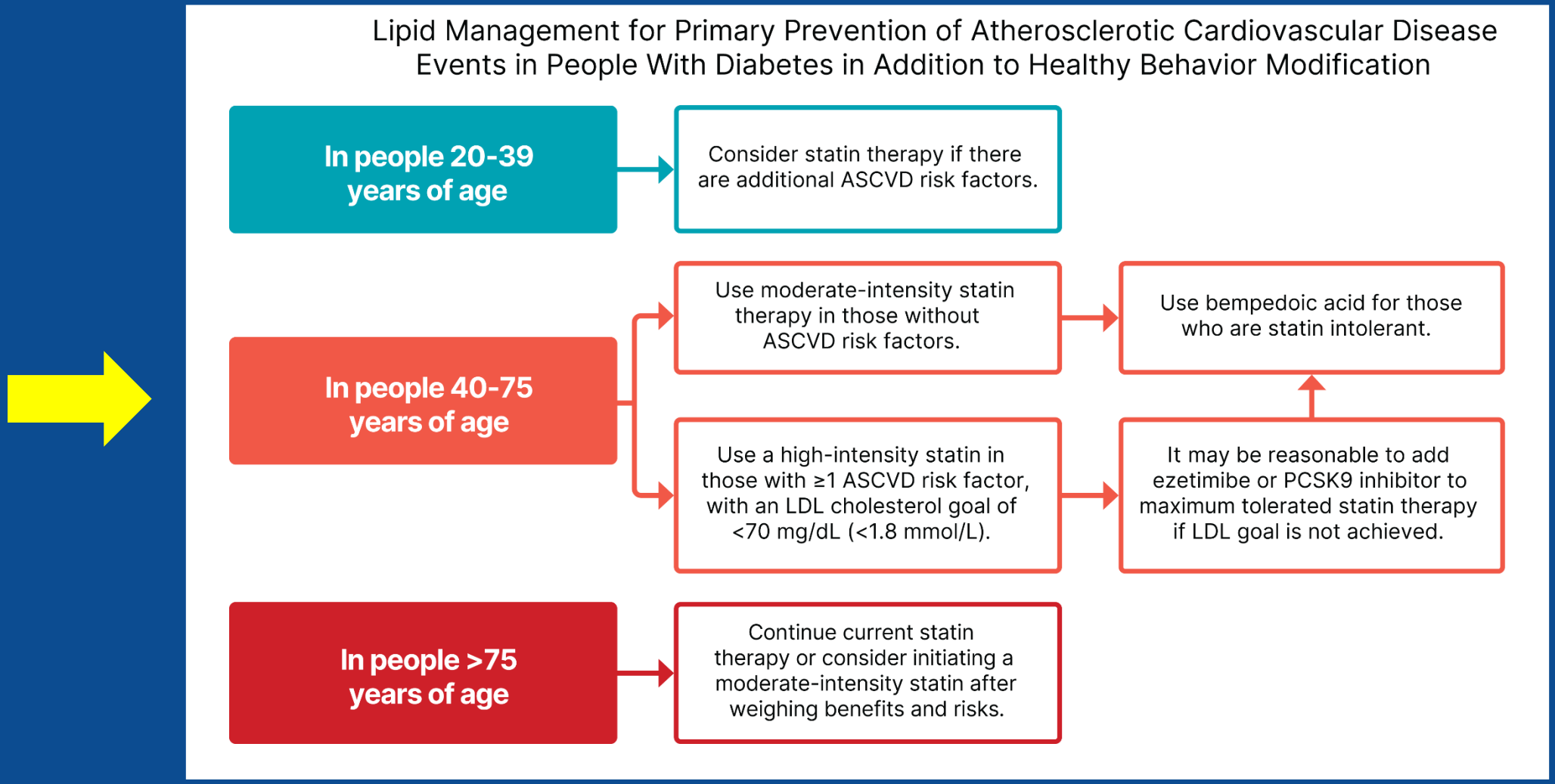


Figure - Recommendations for primary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with diabetes using cholesterol-lowering therapy.

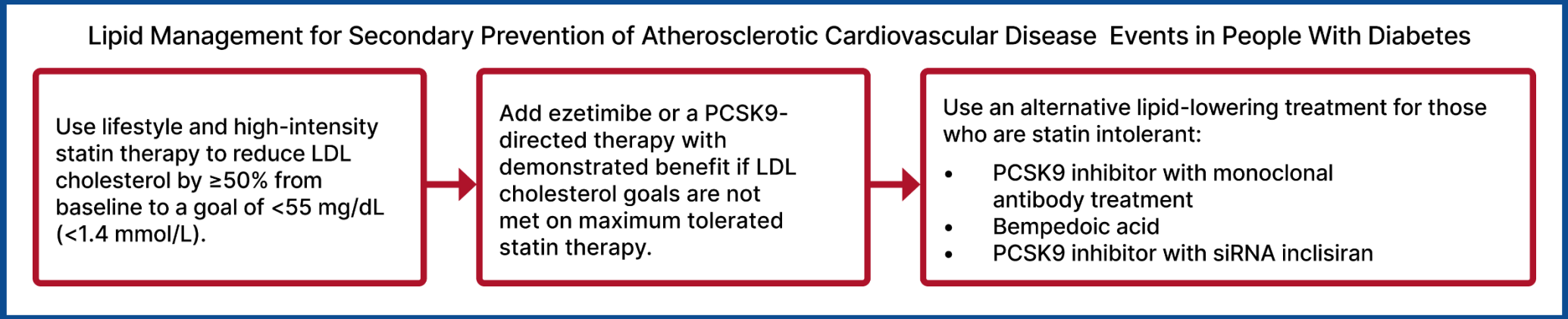


Figure - Recommendations for secondary prevention of atherosclerotic cardiovascular disease (ASCVD) in people with diabetes using cholesterol-lower

3. Antiplatelet

Source: 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2025

4. Cardiovascular disease

- Screening

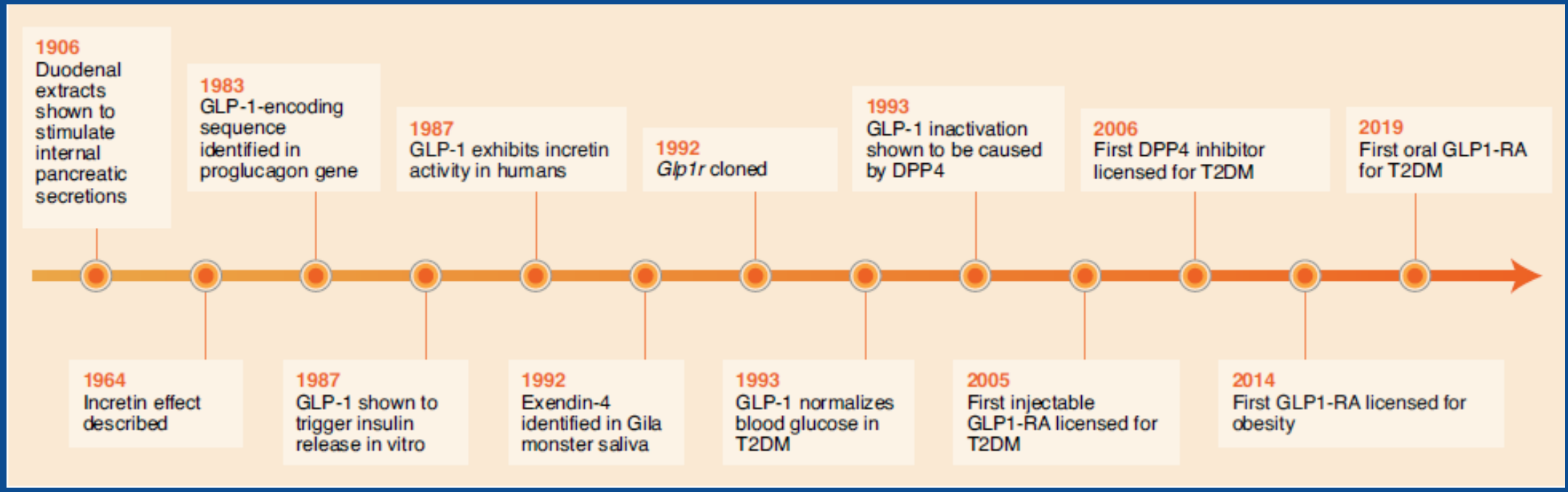
Screening for Undiagnosed Cardiovascular Disease

Who to Screen?

	Coronary Artery Disease	Heart Failure	Peripheral Artery Disease
Who to Screen?	Routine screening is not recommended for asymptomatic individuals.	Screen all adults with diabetes, which increases risks for asymptomatic (stage B) and symptomatic (stage C) HF.	Screen individuals with diabetes and age ≥65 years, any microvascular disease, foot complications, or end-stage organ damage from diabetes, if a PAD diagnosis would change management. Consider screening anyone with a diabetes duration ≥10 years.
	If signs or symptoms of cardiac or associated vascular disease, or electrocardiogram abnormalities are present, screen using routine methods.	Measure BNP or N-terminal pro-BNP. Echocardiography is recommended for those with abnormal BNP levels.	Screen with ankle-brachial index testing.

Source: 10. Cardiovascular Disease and Risk Management: Standards of Care in Diabetes - 2025

Treatment: GLP-1 RA



Source: Reimann F, Gribble FM. Metabolic Messengers: glucagon-like peptide 1. Nature Metabolism. 2021.

Do long-acting glucagon-like peptide 1 receptor agonists, including subcutaneous and oral formulations, improve cardiovascular and kidney outcomes and mortality in type 2 diabetes?

Systematic review & meta-analysis of randomized placebo-controlled trials including new data from SOUL & FLOW

Major adverse cardiovascular events*

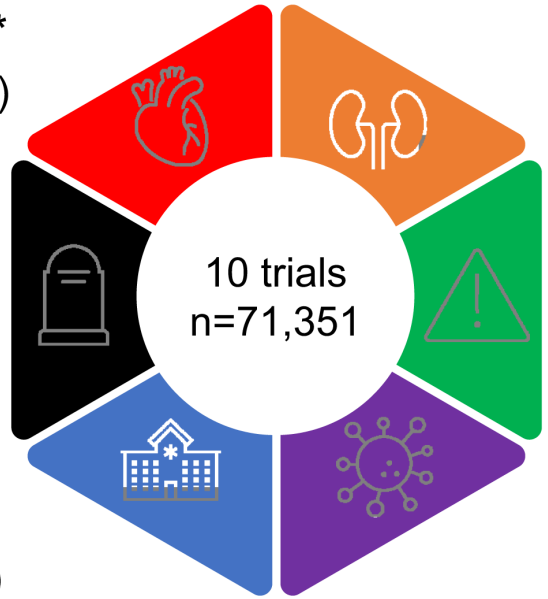
↓ 14% (HR 0.86; 95% CI 0.81, 0.90)

All-cause mortality*

↓ 12% (HR 0.88; 95% CI 0.82, 0.93)

Hospitalization for heart failure*

↓ 14% (HR 0.86; 95% CI 0.79, 0.93)



Composite kidney outcome*

↓ 17% (HR 0.83; 95% CI 0.75, 0.92)

Safety outcomes

↔ severe hypoglycemia, retinopathy, pancreatitis

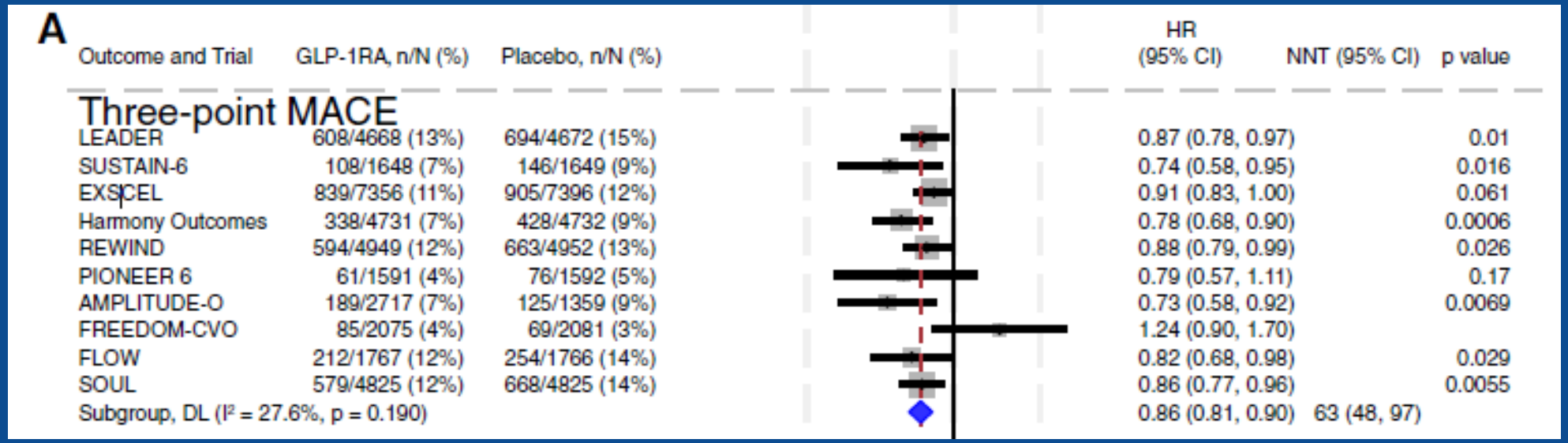
Safety outcomes (cancers)

↔ total cancer, pancreatic cancer, any thyroid cancer

*No significant heterogeneity by drug route (subcutaneous vs. oral)

PROSPERO registration number: CRD42024607253

Source: Lee M et all. Cardiovascular and Kidney Outcomes and Mortality with Long-Acting Injectable and Oral Glucagon-Like Peptide 1 Receptor Agonists in Individuals with Type 2 Diabetes: A Systematic Review and Meta-analysis of Randomized trials. Diabetes Care. 2025



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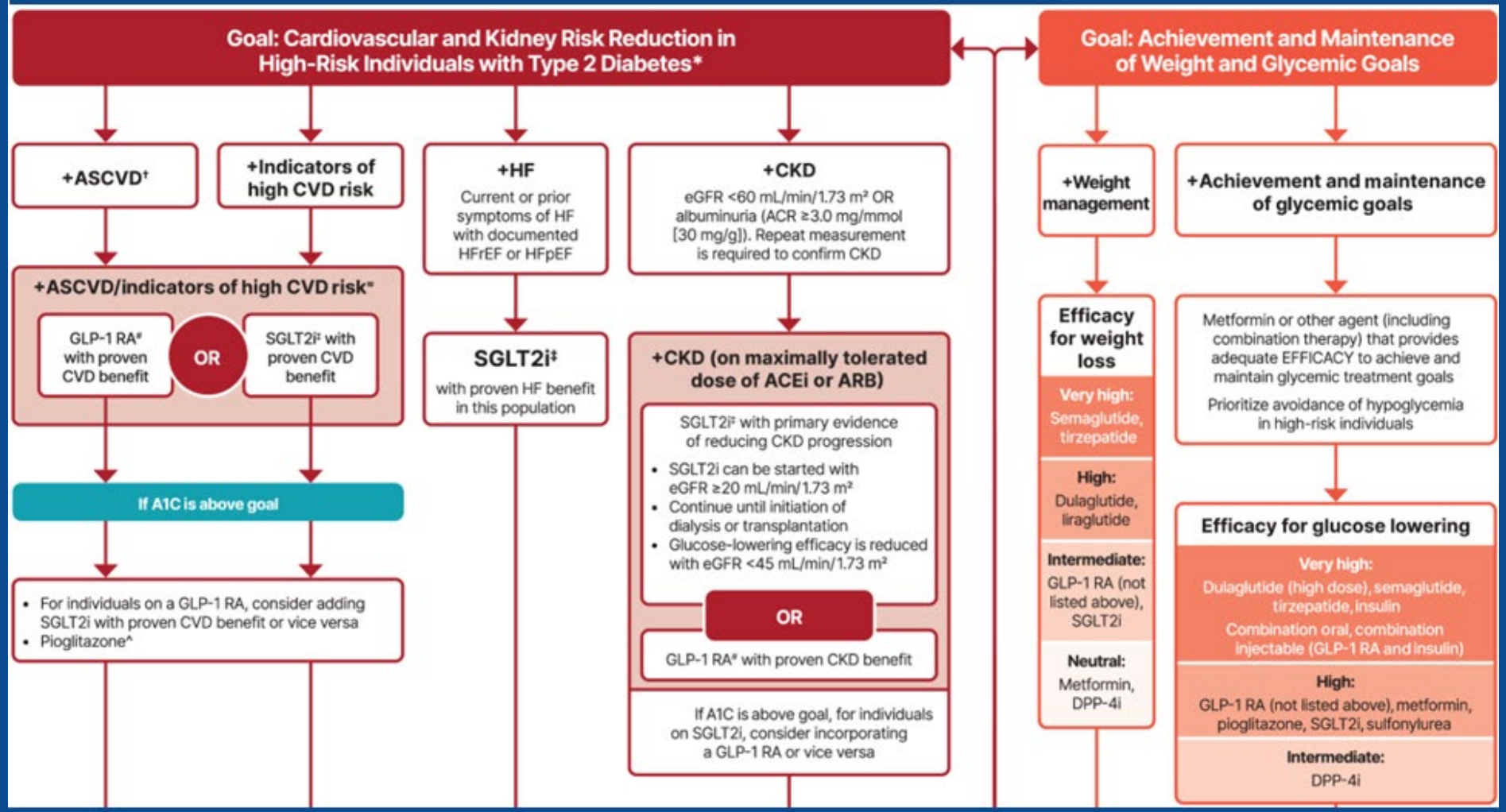
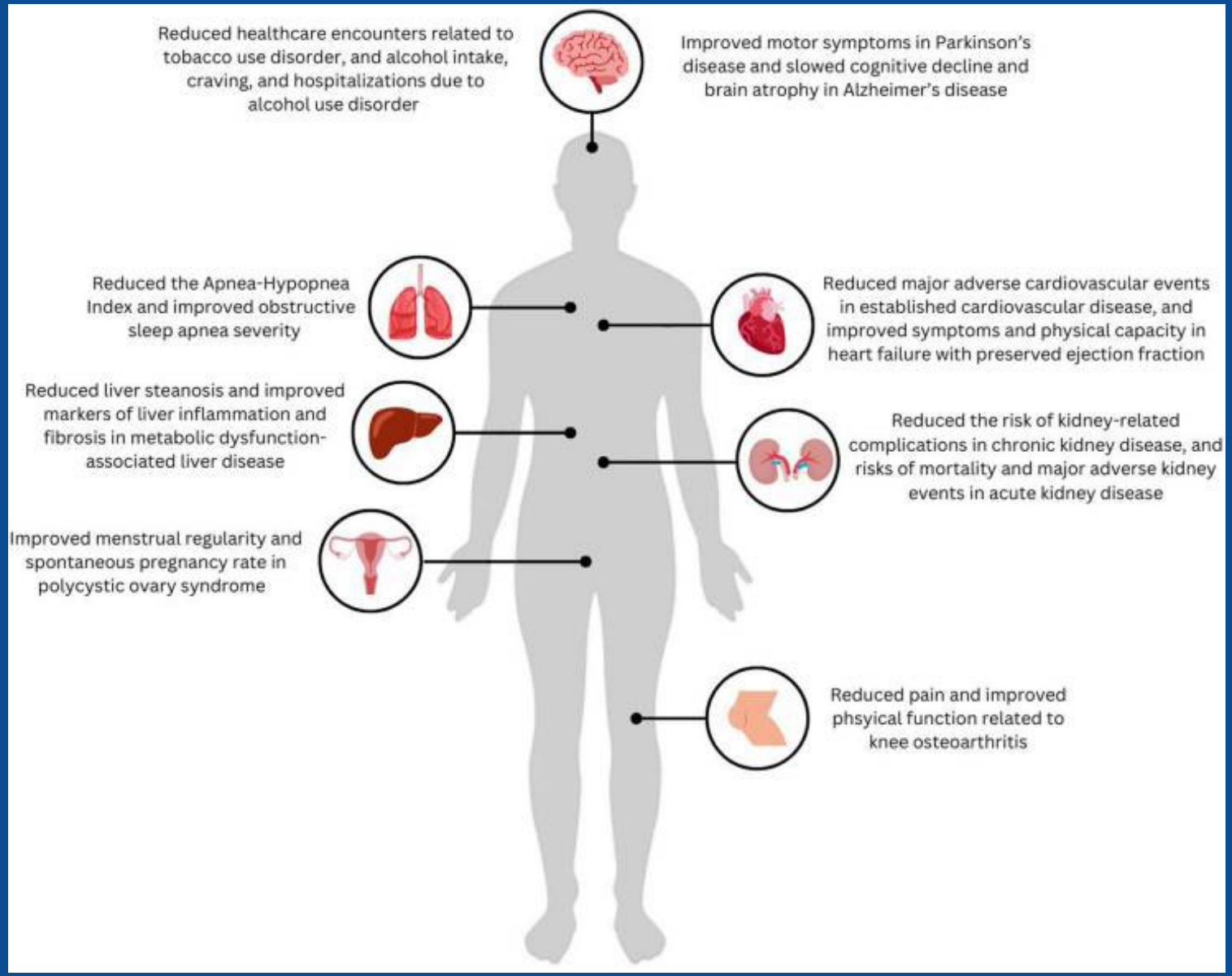
Use of Glucose-Lowering Medications in the Management of Type 2 Diabetes





Source: Moiz Areesha et al. The expanding role of GLP-1 receptor agonists: a narrative review of current evidence and future directions. eClinical Medicine. 2025

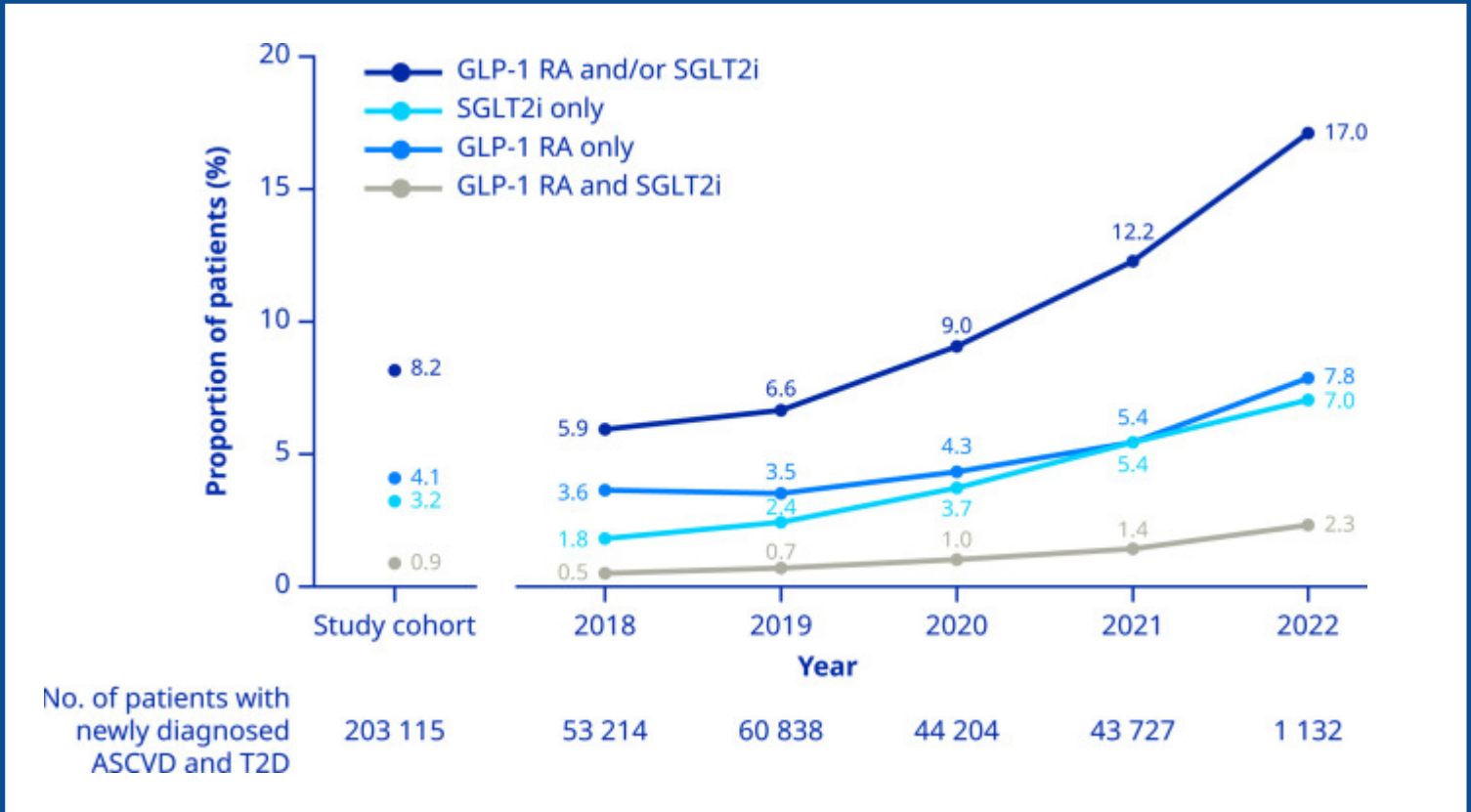


Figure – Proportion of patients with T2D and newly diagnosed ASCVD who were newly prescribed GLP-1 or SGLTis, overall by year.

Source: King A et al. Recent trends in GLP-1 RA and SGLT-2 use among people with type 2 diabetes and atherosclerotic cardiovascular disease in the USA. BMJ

Barriers to High Quality Diabetes Care

- Fragmentation and uncoordinated care, lack of longitudinal care
- Lack of information capabilities (eg. registries that can provide person specific and population-based support)
- Not appropriately incentivized and funded
- Does not engage people with diabetes and community (identifying or developing resources to support healthy lifestyle)
- Lack of quality-oriented culture

Cardioprotective Medications – GLP-1 RA

- High cost, insurance coverage
- Provider clinical inertia and lack of familiarity
- Clinical inertia
- Lack of practical knowledge on the use of these agents
- Concerns about potential adverse effects
- Fear of injections
- Challenges of polypharmacy in elderly patients

Source: King A et al. Recent trends in GLP-1 RA and SGLT-2 use among people with type 2 diabetes and atherosclerotic cardiovascular disease in the USA. BMJ

“Improving individual and population health for people with and at risk for diabetes requires engagement of a collaboration between people with diabetes and their caregivers, inter-professional health care teams, health systems, community partners, payors, poliycymakers and public health agencies “

Source: 1. Improving Care and Promoting Health in Populations: Standards of Care in Diabetes - 2025

MVHS DIABETES FELLOWSHIP PROGRAM INAUGURAL

DIABETES CONFERENCE

Saturday, November 22, 2025, from 8 a.m. to 5:30 p.m.
Utica National Building, 201 Lafayette Street, Utica

This free event, presented by the MVHS Diabetes Fellowship Program, is open to providers at all levels, (MD/DO, NP/PA), residents, medical students, pharmacists, RNs and other allied healthcare professionals. Registration is required and can be accessed via the QR code.

SPEAKERS INCLUDE:

- Domenic Aiello, MD, FACE
- Nay Linn Aung, MD, BC-ADM, DACD
- Scott Brehaut, MD
- Jody W. Brouillette, MS, RCEP, CCRP
- Kristen Conway, MS, RD
- Shana Pughe Dean, MA
- Juan Jose Delgado Hurtado, MD, MPH
- Caroline Jacobus, MS, RN, CDCES, CFCN
- Dayal Davis Raja, MD, FACE
- Nandita Rao, MD, FACS, DABOM
- Katherine Warden, PhD, MSCP

PROGRAM MODERATORS:

- Nay Linn Aung, MD, BC-ADM, DACD
- Megan Coombs, MSN, RN, NEA-BC, NPD-BC, CCRN
- Karishma Circelli, MD
- Caroline Jacobus, MS, RN, CDCES, CFCN
- Kristin Luke, MSN, C-NP, CCD
- Alexandra Pellecchia, MD
- Dayal Davis Raja, MD, FACE
- Heng Yeh, MD

Scan for registration information, conference program and presenter bios.
Registration ends Friday, November 14.

In partnership with:

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QUESTIONS? Contact **Caroline Jacobus** at 315-624-5620 or cjacobus@mvhealthsystem.org.