Question & Answer

Recorded September 23, 2020 from the live webinar:
Busting Inertia: Identifying and Engaging High Risk Patients

Question: How do you balance intensifying treatment and decreasing risk of retinopathy from dropping blood sugar too fast?

Answer: This is a great question. This is a difficult balance. Generally speaking, with very quick improvements in glucose, a transient acceleration of complications can be observed, and it is often retinopathy. This can happen with all glucose lowering therapies, but it has been observed mostly with the more potent agents (insulin, GLP-1RA [semaglutide]). Certainly, if we know a patient has existing retinopathy, we would want to be more cautious. In patients who have no known retinopathy, we can be more aggressive. If patients present with very high A1C, >11%, it is usually best to slowly improve their BG (blood glucose) over 3-6 months, rather than try to aggressively lower the sugars in a matter of 4-6 weeks. This not only because of the risk of complications, but also because many will experience relative hypoglycemia (feel hypoglycemia at BG in the 100 or even 200 mg/dL range) because their bodies have become accustomed to much higher glucose values for a long period of time.

-- Kevin Pantalone, DO, ECNU, FACE

Question: What is the role of digital health in improving adherence to diabetes therapy?

Answer: This is an evolving area. Digital health is a broad category, and it includes virtual office encounters, e-coaching, remote monitoring, etc. Many early studies have demonstrated promise that these interventions may help patients improve A1C goal attainment, and perhaps more importantly, maintain that A1C goal attainment for the long-term.

-- Kevin Pantalone, DO, ECNU, FACE

Virtual visits are a great way to have frequent touch points with the patient in between office visits.

--Chavi Mehta, MD

Question: As a CDCES (certified diabetes care and education specialists) what can we do to educate PCP’s (primary care providers) to refer to endocrinologists or CDCES’s for better diabetic management?
Answer:
We have developed a “Comprehensive Diabetes Clinic”, also referred to as “Diabetes Bootcamp”, for our primary care providers to refer their patients. First, we made them aware of this, and second, it is very clear that this will be beneficial for the patients. When a patient is referred to this clinic, they see the ambulatory pharmacist for 20 minutes, endocrinologist for 40 minutes, and the CDCES for 40 minutes, all on the same day, back to back to back. The goal is to be aggressive early in the course of the disease, educate the patients, and emphasize that this is a serious diagnosis but one that can be managed. Primary care providers have been very receptive to this approach. We are currently collecting data. Intuitively, this would be expected to be better than the patient just seeing one of these provider types.

-- Kevin Pantalone, DO, ECNU, FACE

Question:
How do you see telehealth impacting clinical inertia?

Answer:
It is too early to tell. I think telehealth is a great modality for many patients, and it helps to improve access to specialty care for many patients in rural settings or in communities without specialized diabetes providers. Thus, I think it has potential to help improve care by better access, but also, it may allow for more convenient, frequent, and meaningful interactions with the patients in between the standard face to face encounters.

-- Kevin Pantalone, DO, ECNU, FACE

Question:
As a CDCES (certified diabetes care and education specialist), how do I get the buy in from the internists I work with?

Answer:
It is very clear that a DSMES alone can improve A1C 1.5% to 2%, if not more. I think it is important for all provider types to recognize that the team approach is required for success, and that involves CDCES consultations, dietitian consults, referrals to ambulatory pharmacy or endocrinologists for assistance, among many other provider types, when needed. Having a CDCES implanted in the patient-centered medical homes, much like pharmacists have been placed, is a good way to demonstrate value, a slowly but surely, the A1C improvements will be very clear in a practice’s population of patients with T2D (Type 2 Diabetes)!

-- Kevin Pantalone, DO, ECNU, FACE

We have worked on a campaign to improve primary care referrals to diabetes education. As a part of this, our CDCESs (certified diabetes care and education specialists) attend physician meetings once or twice a year to give updates and information on various education programs, classes they offer and CDCESs embedded in primary care practices is very helpful. That helps
foster a team culture. In addition, it is critical that we understand and acknowledge the challenges of a primary care practice with a lot of patient priorities.

-- Chavi Mehta, MD

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**Question:**
For patients NOT on insulin, how often are you giving them a meter to check sugars so that you can decide on intensification prior to waiting for the A1c?

**Answer:**
If a patient is on basal insulin, I generally tell them to check their BG (blood glucose) 1 to 2 times per day but instruct them to ROTATE the time of the BG checks, one day before breakfast and dinner, the next day before lunch and bedtime. That way we can see where the problem areas are, and we can address them more appropriately than just “increasing the basal insulin” because their A1C is still high.

If a patient is on multi daily injections of insulin, they should be checking 3-4 times per day, at minimum.

Leveraging professional CGM (continuous glucose monitoring) or personal CGM in between A1C checks also provides tremendous insight and value in improving overall BG control.

-- Kevin Pantalone, DO, ECNU, FACE

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**Question:**
Can you comment on encouraging SMBG (self-management of blood glucose) on non-insulin patients? Currently my clinic is not adopting this, stating that SMBG in non-insulin patients has not been proven to improve outcomes.

**Answer:**
I would tend to agree. I am not keen on SMBG in patients on therapies that are not receiving agents that may cause hypoglycemia, especially in patients with their A1C at target. In patients that have an elevated A1C, even if they are not on hypoglycemia causing agents, having a few BG (blood glucose) checks - or CGM (continuous glucose monitoring) - can be very valuable in identifying where the problems lie, so that you can adjust therapy more precisely (add something that may lower the fasting, postprandial glucose values, or both). Currently, I think too many patients not on agents that can cause low sugars are checking their sugars. This leads to burnout and then when we really need them to start checking, they are not interested or compliant.

Now, many of my colleagues will say that I am wrong, and that all patients with T2D (Type 2 Diabetes) should be checking their blood glucose so that they can see how food choices and behaviors impact their BG levels so that they can learn, and so that they can make changes. However, in the real-world, I often see the opposite, when patients do eat something they know will raise their sugar, they will deliberately not check their BG (i.e, out of sight out of mind).

-- Kevin Pantalone, DO, ECNU, FACE
For some of the patients who are trying to learn their diet or exercise pattern in relation to their activity levels, wearing a CGM for a short period of time improves their engagement and willingness to be involved in their own care.

-- Chavi Mehta, MD

Question:
How are you navigating patients who are skipping labs due to fear of coming into the lab because of COVID? (We have a lot of patients who have to take public transportation to come in to get labs done).

Answer:
This is a challenge. It is a balance between safety precautions due to COVID and deferring care which could lead to more complications down the road. If you have mobile lab units, that can be helpful in this situation. I know that Geisinger has a “health bus” that takes a road trip to the patient instead of patients coming to them. If the patients do come in, educating them about the safety precautions at your organization would be helpful.

--Chavi Mehta, MD

Question:
Have you utilized group visits for patients with diabetes? If yes, has this been helpful?

Answer:
Yes, I have utilized group visits or shared medical visits for diabetes. It is a great way to engage patients. They learn from one another and also help each other with the challenges and barriers they face. You could have shared medical visits dedicated to one specific area - for example - starting basal insulin, starting GLP1 receptor agonists etc. This ensures that patients with similar backgrounds and experiences will be in the visit. Having a diabetes educator be part of the visit makes it very worthwhile for the patient.

-- Chavi Mehta, MD

Question:
What is the chance that the patient will be able to get off medications once an aggressive approach is initiated?

Answer:
Stopping therapies should not be the mindset. The goal is to get their diabetes under control, through medications, nutrition, education, etc. Very few patients are going to lose a significant amount of weight for their diabetes to enter remission, and this will just propagate therapeutic inertia. The patient I presented in case 2, has had an A1C < 6% for nearly 3 years, has lost 80 lbs and maintained it through continuing his medications, working out, and watching his diet. It is so hard to accomplish these types of outcomes, so in my opinion, you should leave good enough alone, continually tell the patient's they are doing a great job and that you are very proud of their continued hard work. Don't set them up for failure or disappointment by stopping medications and
allowing their control to deteriorate. This is a progressive disease, and many patients, after very prolonged periods of great control, will eventually require intensification. Thus, treat to target and keep them there! Don’t let up!

Certainly, I will try to de-intensify insulin or sulfonylurea therapy if patients are doing great, as that is a very positive thing to do. But, if I have a patient who is on metformin and a GLP-RA, or metformin and a SGLT-2i, or a combination of all three, and they are doing great, feel good, have lost weight, and have an A1C of <7%, why change anything? Remember, those medicines may provide additional benefits beyond simply maintaining their glycemic control.

-- Kevin Pantalone, DO, ECNU, FACE

Question:
I have a 65-year-old male, A1c of 6.3, no medication and a last GFR (glomerular filtration rate) 42 (down from 66). No hypertension. Could you start with SGLT-2 to protect kidneys?

Answer:
Yes, the guidelines clearly state to consider intensification with SGLT-2i (or GLP-1RA) in patients with ASCVD (atherosclerotic cardiovascular disease), CHF (congestive heart failure), CKD (chronic kidney disease), and that this decision should be made independent of the patients A1C goal status. That is, even if their A1C is at goal, adding these agents are highly encouraged to further lower their CVD (cardiovascular disease) and/or Renal risk.

This will become more common in patients without T2D (Type 2 Diabetes) too, as the studies that have recently become available have demonstrated renal and/or hospitalization for heart failure benefits in patients with and without diabetes.

-- Kevin Pantalone, DO, ECNU, FACE

Question:
Why is only HbA1c used for gauging clinical inertia? What about the role of CGMs (continuous glucose monitoring) and flash monitoring?

Answer:
Yes, CGMs and flash monitoring should be leveraged to avoid clinical inertia, particularly between A1C measures. The reason the focus is on A1C is because it is a structured lab value that can easily be followed in an EMR (electronic medical record). Currently, CGM data and flash glucose data is not integrated that well in the EMRs, and thus, it must be followed on an individual patient basis, not from a population health standpoint. But certainly, for every patient you see, these modalities are great at helping patients reach their glucose targets and help to reduce the risk of therapeutic inertia. Remember, the best way to avoid therapeutic inertia is to act early, quickly, and aggressively to get the A1C to goal. If you get the A1C to goal, you have avoided therapeutic inertia entirely.

-- Kevin Pantalone, DO, ECNU, FACE
**Question:**
In patients with high HbA1c and hypoglycemia - what can be the role of CGMs (continuous glucose monitors) in deintensifying the therapy?

**Answer:**
CGMs can be used to observe the patterns of where the low blood sugar is occurring and what is happening both before these events (too much correction) and afterwards (over-treatment of hypoglycemia). It is very important to do this, since most of the time patients on insulin have high A1Cs because they are skipping or reducing doses of insulin to avoid the lows or eating to avoid the lows – and that is why their A1C is high. They don’t need further intensification because their A1C is high, rather, they need de-intensification, insulin dose adjustments, or switched to another type of glucose lowering therapy (if possible).

--- Kevin Pantalone, DO, ECNU, FACE

**Question:**
What tools can we use for addressing therapeutic inertia and getting patients to goal faster?

**Answer:**
Use tools that you ensure that high risk patients get frequent touch points with the care team. This can be implemented by maintaining a no-show list and outreaching to them on a regular basis and also trying to understand what the barriers for the no shows. By doing a patient survey we found out that we needed a different timing for our diabetes education classes.

EHR (electronic health record) can help generate reports of patients who have a persistently elevated A1C and who do not have a follow up appointment and then year-round outreach could be done. Having point of care A1C testing can be very helpful. Flagging the visits as “Diabetes-Only” visits can ensure that the focus of the visit would be diabetes, and the most important thing is to make sure that primary care clinicians have the tools and resources they need for their patients. This would include access to diabetes education programs, obesity programs and diabetes specialists and experts.

--- Chavi Mehta, MD

**Question:**
Who is more to blame for clinical inertia - physicians or patients?

**Answer:**
Neither alone, rather it is related to both physician and patient factors, as well as social determinants of health, the system, payor environment, etc. There are many factors that may or may not be under the control of either the patient or physician. It is important that each party (patient and clinician) take ownership over what they can change. I believe that the big problem is that when patients are diagnosed with diabetes, they are often told you have “early” or “mild” diabetes. This does not paint the picture seriously enough, and this drives inertia. If you have diabetes, you have diabetes, and need to be aggressively managed to get to target from day one.
**Question:**
If you can’t take Metformin due to chronic kidney disease (CKD), what other drug(s) would you suggest?

**Answer:**
Use other drugs that do not cause hypoglycemia: GLP-1RA, SGLT-2i, DPP-4i, pioglitazone, etc.

GLP-1RA can be used even in patients on hemodialysis. There are no dose adjustments that need to occur. The only exception is for exenatide products/formulations, which are not recommended in patients with GFR (glomerular filtration rate) < 30.

SGLT-2i can be used down to GFR of 30-45, but many labels are more restrictive. Available data suggests it is safe, although the glucose lowering effect will not be as pronounced at lower GFRs (but they still can provide the CV (cardiovascular) or renal benefits).

The key is to make sure they truly do not tolerate the metformin (try XR variant in low dose before abandoning metformin all together) and in those with CKD, use it down to GFR of 30. While you can use it down to a GFR of 30 in those who are already taking it, starting it de novo in patients with GFR 30-45 is discouraged by some, or if started, should be limited to only 1000 mg per day. But I think most experts would recommend the highest tolerated dose of metformin be used in this group (up to 2,000 mg per day), so long as they are compliant patients, get their labs when ordered, etc.

-- Kevin Pantalone, DO, ECNU, FACE

I always struggle with elderly patients in their 80’s with CKD and elevated A1Cs. They need minimal treatment escalation, or the dose of metformin may have to be cut back. We generally try to avoid using agents that can cause hypoglycemia in these types of patients, but in real-world clinical practice, because of cost and other issues (donut hole gaps in Medicare drug coverage), we are often forced to use SFUs. If affordable, DPP-4 inhibitors are a great treatment option in these patients.

--Chavi Mehta, MD