Question & Answer

Optimize the Patient Journey: A Case Based Approach
Recorded March 10, 2021 from the live webinar:

Question:
With regard to goals, how will time in range change vs a1c change how we care for patients and look at inertia?

Answer:
As the availability of continuous glucose monitoring continues to increase, time in range will likely be the metric that is utilized to assess a person’s diabetes management and in reporting a practice’s overall quality of care. However, many things need to happen before time in range overtakes A1C because of how readily available and accessible A1C testing is. Even though A1C has not been replaced, there is no reason why you couldn’t use time in range to evaluate glycemic targets if the patient is already using it. The 2021 ADA Standards recommend a time in range > 70% with time below range < 4% approximately equating to an A1C < 7%.

Question:
What is your experience with medication discount cards like GoodRx or other similar WellRx? Do you have other suggestions for helping patients with the cost of meds?

Answer:
I see medication discount cards as one of many options available to assist patients with affording their medications. In my experience, sometimes the cost savings can be significant, while at other times it is not. Other options to evaluate include copay cards, patient assistance programs, and low-price generic programs offered by various pharmacies. A helpful summary maintained by the Association for Diabetes Care & Education Specialists can be found here: https://www.diabeteseducator.org/practice/practice-tools/app-resources/affordability-resources.

Lastly, it may be worth enlisting a navigator to assist a patient with evaluating their insurance coverage and search for viable alternatives (especially for patients on Medicare). A plan that worked for a patient 5 years ago may no longer meet the patient’s needs today.

Question:
Can you define diabetes distress and share a tool to assess for diabetes distress?

Answer:
Diabetes distress refers to the worries, concerns, and fears among individuals with diabetes over time as they struggle with managing a chronic, progressive disease like diabetes. It is distinct from clinical depression, which may need to be assessed separately. The Diabetes Distress Scale (DDS) is a helpful 17-item tool that evaluates adults 19 years and older with type 2 diabetes in 4 domains - emotional burden, regimen distress, interpersonal distress, and physician distress. There is also a Type 1 Diabetes Distress Scale (T1-DDS) for adults 19 years and older.
with type 1 diabetes. These surveys can be found at the following website: https://diabetesdistress.org/take-dd-survey.

**Question:**
There are so many issues to screen for. Can you suggest how to prioritize which to do first?

**Answer:**
Start with the one that you think is the highest priority to YOUR PATIENT. Then you can bring back for more frequent follow up to address other issues. More frequent touch points (in-person and/or in combination with telehealth/phone) is a great strategy for a patient with multiple issues and competing priorities.

**Question:**
Is it alright to stop diabetes meds when blood sugar is in the low 100s or A1C in 5 or 6, with the idea of getting the patient off some meds or decreasing the chance of low blood sugar with varied po in the elderly/85y/o+?

**Answer:**
There are several factors to consider in this scenario, but my answer would be yes. Given the patient’s advanced age, their life expectancy is likely to be limited (although it’s possible they may still have another 10+ years!). In this situation, I would recommend gradually tapering off the medications, starting with the agents that are highest risk for hypoglycemia - secretagogues and insulins. Depending on the patient’s situation, stopping all of the medications abruptly can precipitate significant hyperglycemia which can also cause acute issues.

**Question:**
How do you feel about a CGM study (professional CGM) to find out the blood sugar variable for your patient and seeing if there any lows?

**Answer:**
Professional CGM can be extremely helpful for patients who do not have access to personal CGM. It can serve as an educational tool for the patient regarding the impact of eating habits and physical activity on their glucose and can also help the clinician identify patterns not previously identified with traditional periodic glucose checks.

**Question:**
How can PCP’s address the inertia busting checklist in 15 minutes? Do you rely on care managers to assist with this checklist as well?

**Answer:**
Inertia busting cannot be in just 1 visit - it is an ongoing process. Each visit can focus on different elements of the checklist and can bring back for more frequent follow-up visits (in-person and/or telehealth) and touch points.

**Question:**
What are all your thoughts about Telemedicine for Diabetes care?
Answer:
Telemedicine was part of diabetes care pre-COVID, but its expansion in the COVID era is now here to stay. Also, it is important to differentiate between what we consider telehealth (i.e. remote patient monitoring) and telemedicine (i.e. direct patient care replacing in-person visit). Regardless of telemedicine delivery, telehealth is an integral component of diabetes care in the current era and access is a fundamental issue. Learn more about the ADA’s health equity campaign: #HealthEquityNow. Health equity is a human right. We must solve it together. Now is the time.

Question:
What do you think of diabetes group visits?

Answer:
The shared visit model has multiple benefits. They can reduce A1C, improve blood pressure and cholesterol, boost adherence to ADA Standards of Care and decrease hospitalizations. The shared visits optimize patient and provider time and the format of the visits can be modified and personalized for the group utilizing various members of the care team. There could be a podiatrist at one visit, maybe a pharmacist at the next etc. to share information with the patients present. There have been some studies that indicate that patients learn more about managing their diabetes with shared visits than with traditional models and they report an increased sense of empowerment and peer support. Some caveats of the visits...there needs to be adequate space for the number of patients, staff to support checking in and checking out and a private area for brief one on one component with the provider.