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Wireside Chat: Diabetes Medications - What Do I Need to Know?

Q&As from 10.31.2018 Webinar

Practice or Medication-Specific

1. *In Case #1, what if the patient refuses to take injections?*

   With patient conversations, assessment of barriers, and appropriate education – many patients who "refuse" to take insulin can change their minds. Sometimes patients still refuse – in which case it's reasonable to trial an alternative medication, with the expectation that it will be stopped if it is costly, has possible side effects, and is not helping.

2. *What are the challenges/barriers with you've seen with APM? (both clinically and operationally)*

   Having patients understand that APMs are diabetes care experts, and that they are as good as or better than the PCP at managing diabetes (they are doing this all the time, day and and day out). The other challenge is that an effective therapeutic relationship requires close relationships between PCPs and APMs, and this needs to be fostered.

3. Are there any updates on how we should be managing the B12 deficiency with metformin risk? Should we be monitoring and how often?

   We don't have any specific guidelines on B12 monitoring – the ADA states "Long-term use of metformin may be associated with biochemical vitamin B12 deficiency, and periodic measurement of vitaminB12 levels <u>should be considered</u> in metformin-treated patients, especially in those with anemia or peripheral neuropathy."

4. Do you only start NPH once daily? And are most of your controlled patients on NPH bid?

   We start NPH once daily, provide self-titration instructions, and once the patient is up to 40 units at bedtime, we start them on a morning injection.

Yes, most of the controlled patients are on NPH bid, but some patients do fine with bedtime NPH alone.

5. If a patient was on Metformin 2g daily, and GFR falls below 45. Would you recommend to continue 2g daily or reducing the dose?

   The dose should be reduced if the GFR falls below 45 -- our guidelines state to reduce the dose to 1 g/day for GFR <45, and stop metformin for GFR <30

6. Would love to have heard a bit more about how wins/challenges with the algorithm use -- how often is it followed? what challenges are found and at what point in the algorithm are these challenges most seen?

   The algorithm is followed most of the time. Challenges may include patient or provider concerns about weight gain, concerns about hypoglycemia, or patients having biases against insulin.

7. How many patients per APM's/care managers panel? What factors drives variation in panel size (e.g. RN vs. PharmD, APM/PCP agreements, patient complexity)?

   The APMs have panels of about 1300 patients. There are some adjustments based on patient complexity, but for the most part, this is a consistent regional recommendation. More complex patients (ex: type 1 diabetes) are removed from the denominator and followed by endocrinology and T1D-focused care managers.

Safety Net Population/Medi-Cal related

8. Are there patient characteristics (in terms of socioeconomic status, cultural diversity, other barriers to care or access, affordability of medications) that would limit the scalability of this model to other systems?

   We have significant cultural diversity and have been specifically addressing ways to enhance this model for our Latino patients who tend to have lower rates of optimal a1c control. The use of providers other than physicians and an algorithm that includes inexpensive medications as first line agents should make this a very appealing model for other systems in which SES and med affordability are issues.

9. Do the medication costs/recommendations apply to Medi-Cal patients?

We have Medi-Cal patients, so I assume that the costs are the same. The recommendations are the same.

10. Would like to see more detail about additional insulin therapies ie (Long acting, ultra long acting, rapid acting... etc). None of our patients have Kaiser insurance, and a lot of the managed Medi-Cal plans will cover these meds.

    We don't use these insulin types often outside of type 1 diabetes management, due to high cost and similar efficacy of NPH in most patients. Just because insurance covers it doesn't mean it's the best treatment (particularly if more expensive but not more efficacious!)