

How to Engage Type II Patients with Diabetes

ERIC WISER MD FAAFP

MICHEL FARLEY RPH



Overview

- How we talk about diabetes
- Discuss concepts of harm reduction and goal setting
- Discuss simplified medical interventions

CCO Quality Metric Diabetes

Numerator

Number of patients whose most recent HbA1c level (performed during the measurement period) is >9.0%, or is missing, or was not performed during the measurement period

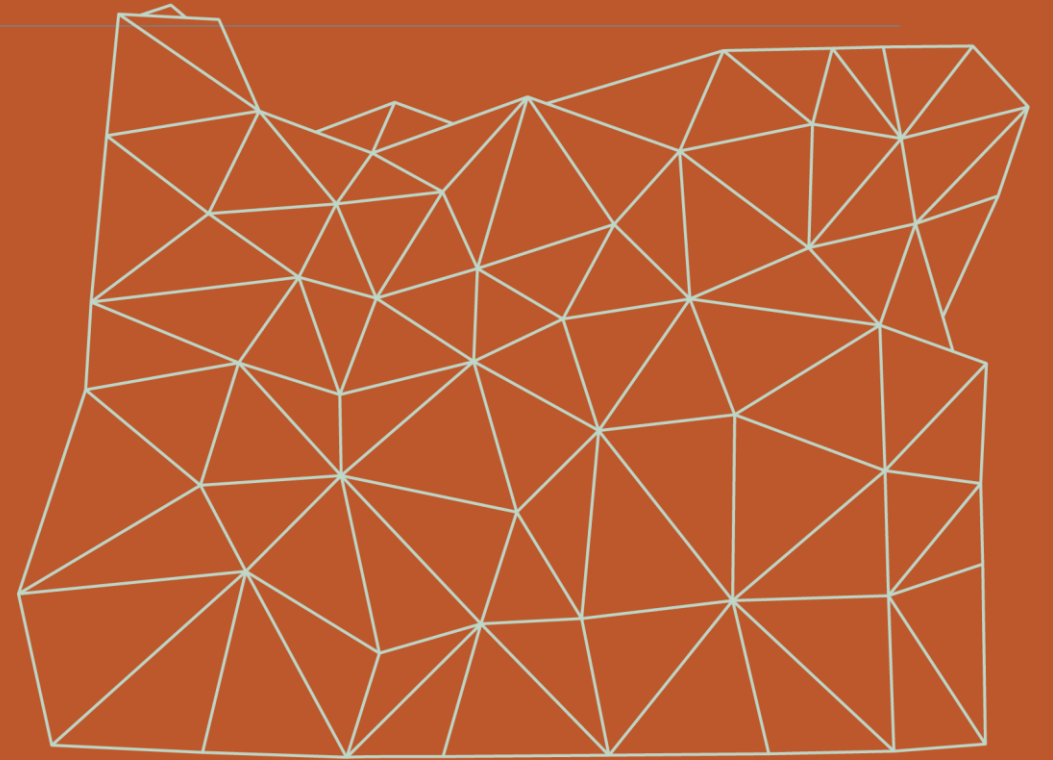
Denominator

Patients ages 18-75 with type 1 or type 2 diabetes

Patients enrolled in Hospice are excluded

2019 Benchmark: 21.7% 2018 national Commercial 90th percentile

Destigmatizing Language

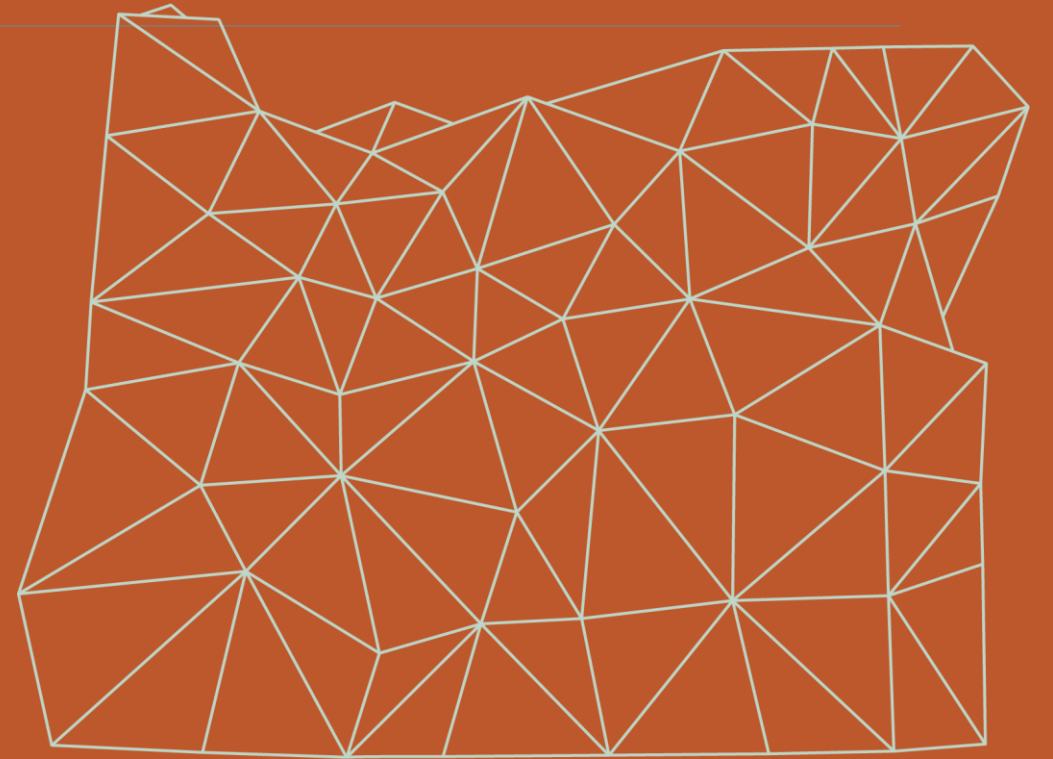


Disclaimer

We are going to try to adopt non-stigmatizing language and recognize that we may not get it correct all the time.

We also invite you to try this new style of talking about diabetes in your discussions and we recognize that you will not get it right 100% of the time.

Please feel free to give each other feedback on the language and give one another grace in trying something new.



Why Language Matters

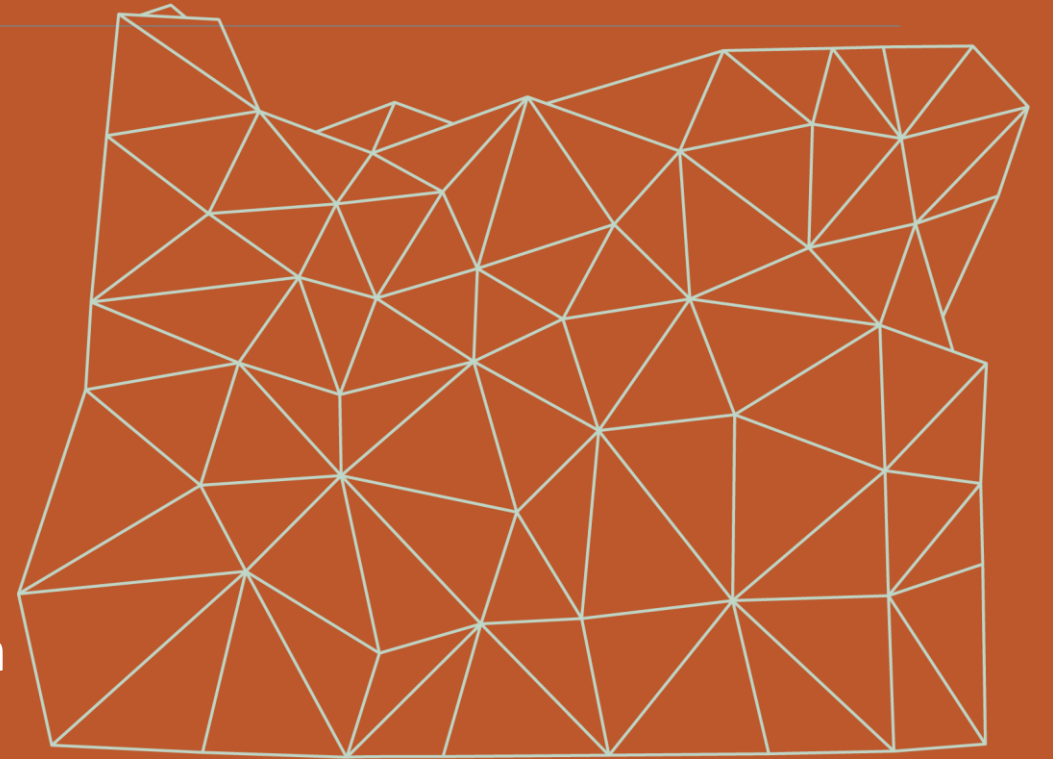
Labeling someone contributes to shame and blame

Stigma can worsen health outcomes

Can interfere with productive conversations with providers

Inhibits people from seeking necessary care to avoid shame

Destigmatizing language changes how we talk about an illness and recognizes there is much out of anyone's control.



Lifestyle Disease?

Genetics

ACEs (Adverse Childhood Experiences)

Diet preconception

 Prenatal

Breastfeeding

SDOH

 Access to food

 Access to medical care

 Access to exercise

What Can We Do?

Use language that is neutral and nonjudgmental

Person Centered approach

Respectful

Inclusive

Hopeful

Language that is collaborative and supportive

Individuals have preferences and priorities beyond diabetes

Factors that influence care may be beyond patients' control

When referring to people

Instead of

Diabetic

Victim, suffer, stricken, afflicted,
diagnosed

Difficult, challenging

Obese

Try

Person with or (living with) diabetes

Has concerns about,

Has other priorities right now

Focus on what they are doing right and
find out what (or if) they have more
capacity to do in the future.

Has excess weight, has obesity

When referring to complications

Diabetic complications

Diabetes-related (associated) complications

Complications related to diabetes

Vasculopath

Person with vasculopathy

When referring to managing diabetes

Adherence/compliance

Use specific behaviors

Taking medications half the time

Checking CBS weekly

Control (poorly controlled)

Outside target range

A1C is 13

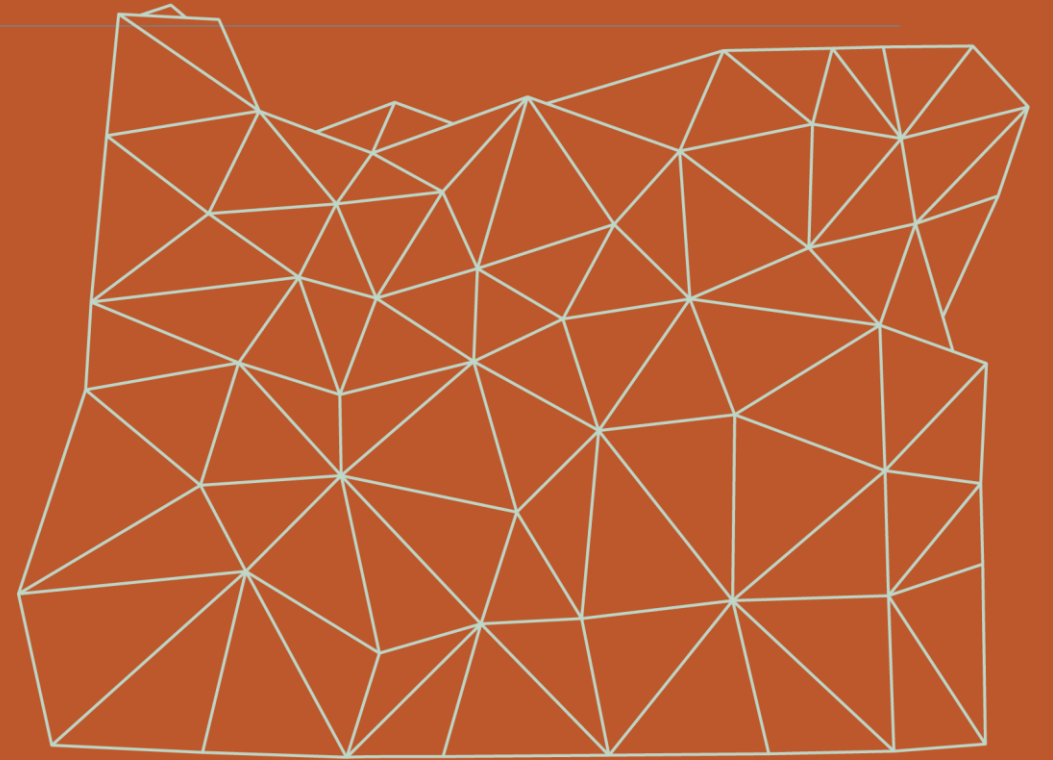
Escalate treatment

Tailor treatment

Cheating

Making choices

Harm Reduction Strategies



Harm Reduction

”Harm reduction” is defined as interventions aimed to help people avoid negative effects of drug use, but many understand harm reduction as a way to meet people where they are with kindness and respect.

National Institute on Drug Abuse NIH

Harm reduction as applied to chronic disease management

- 1) Setting mutual goals and targets
 - 1) Goals may differ from national guidelines and/or providers goals
 - 2) Often resetting goals at later time
- 2) Minimizing risks of major adverse events
 - 1) DKA or HHS
 - 2) Hospitalizations
 - 3) Hypoglycemia
 - 4) Falls
 - 5) ASCVD events
- 3) Maximizing patients' abilities and resources

Shared Goals

Tips:

Ask open ended questions

Give time and space for the patient to answer

Be prepared to set treatment course outside of your agenda

Build on success

Examples

Of all your medical problems which one would you like to focus on?

Which one are you worried about the most?

You have implemented your goal last time, what is next?

Target Setting

- A1C
 - 7-8
 - Target of 7 or less compared to 8 or less did not reduce deaths or macrovascular events
 - ACP analysis, 2018
 - Better than today
- BP
 - 135/85
- Cholesterol
 - Medium or High intensity statin

Easy insulin regimens

Basal only (40% of patients can reach target A1C)

- Once daily administration
- Once daily BG testing

Basal plus

- Just as effective as basal bolus
- Titrate basal insulin to a fasting glucose of 120
- Then give fast acting insulin at the largest meal of the day half the basal dose (typical)
- Two injections, to bg tests, same results as 4

Premix 70/30 (NPH/regular) or 75/25 (NPH/Humalog)

- Once daily (30 minutes prior to meal)
- BID (2/3 in am 1/3 pm. Or 1/1 pick a round even number)

Basal plus GLP 1

Unpredictable meals

Use rapid active up to 15 min AFTER the meal.

Creative Ideas When Cost Is A Barrier

Michael Farley, RPh

Winding Waters Medical Clinic

EOCCO Summit

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Disclosures

Speaker: Michael Farley has nothing to disclose.

Learning Objectives

- Discuss Issues That Arise When Developing A Care Plan
- Review Strategies That Can Stretch The Health Care Dollars For Patients
- Identify Resources That Can Be Tapped And How To Access Them

Obstacles To Optimizing Care Plan

Transportation

Fear

Complexities Of Regimens

High Prescription Plan Deductibles

High Prescription Co-Pays As Part Of Insurance Benefit Structure

Social Determinants

Cost of transportation to medical visits

- Gas cards to help with fuel costs
- Connect Patients with local resources to provide rides

Fear

- Scared of injections
 - Schedule a visit to walk patient thru the process
 - If weekly injections, maybe offer a visit to help administer for a while
- Concern disease is getting worse
 - Reassure Diabetes is a progressive disease and we have options to help at each stage
- Worried About Cost Of Medications And Supplies

Complexities Of Regimen

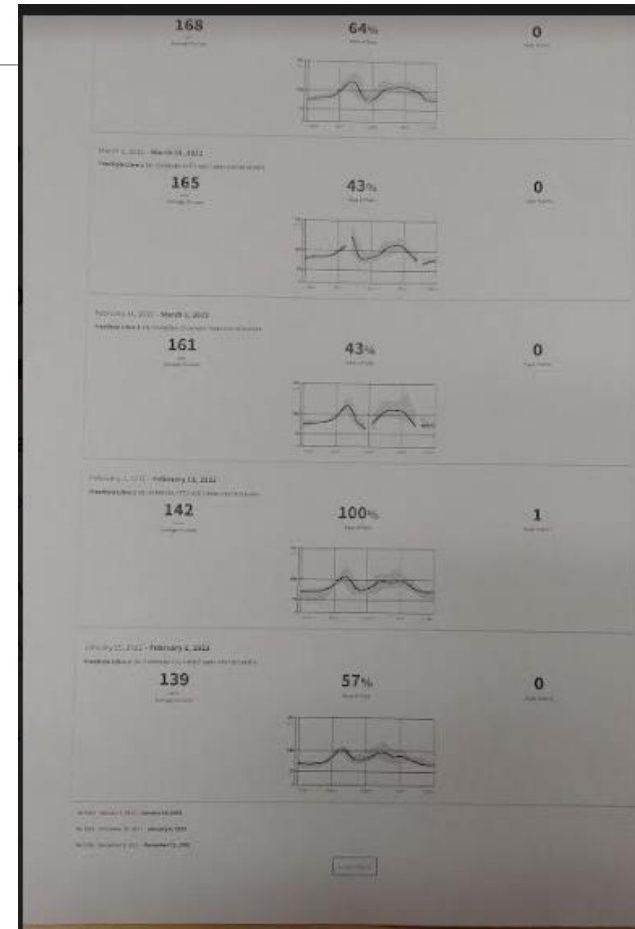
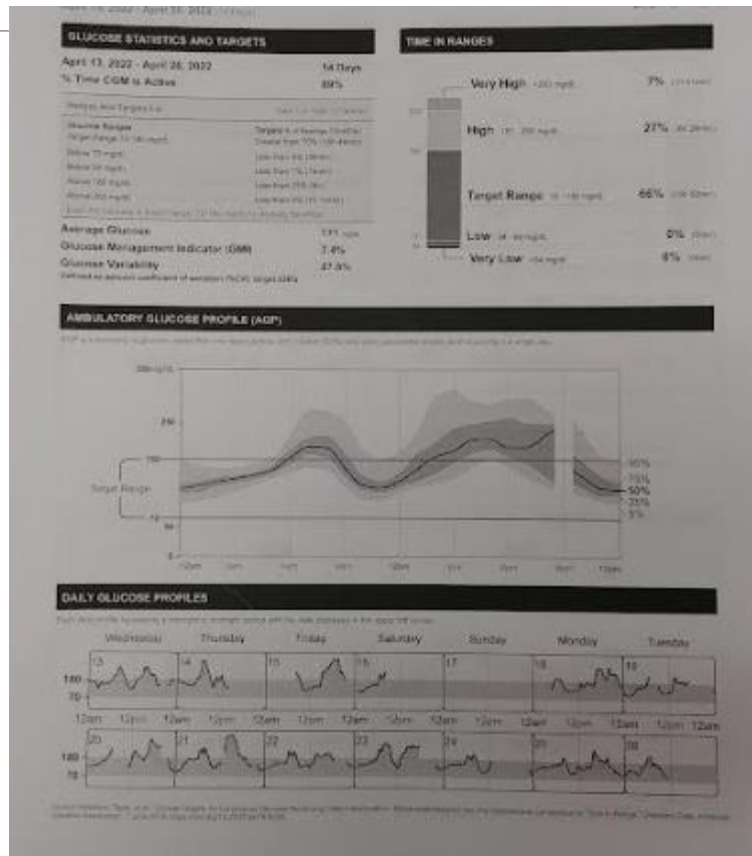
Multiple Medications To Manage

- Look for ways to simplify
- Use of pill planners

SMBG

- Pattern Management
- Desire fasting AND Post-Prandial levels
- Medicare limits testing frequency in non-insulin using patients
- Cost can be a barrier

Benefit Of CGM Data



Overcoming SMBG Barriers

Rotate testing times

- Monday – Fasting
- Tuesday – 2 hrs after breakfast
- Wednesday -2 hrs after lunch
- Thursday – 2 hrs after dinner
- Friday – Bedtime
- Can add pre-meal levels if desired

Look then for patterns after a couple weeks.

Addressing Medication Costs

Watch Formularies

Co-Pay Cards

○ I want a savings card*

With commercial insurance: Pay as low as \$0 and no more than \$99* for a 30-day supply, valid up to 10 packs per fill.

With no commercial insurance: Pay \$99* for your monthly supply of one or multiple Sanofi insulins, valid up to 10 vials or packs of SoloStar pens per fill or up to 5 packs of Max SoloStar pens per fill.



Lilly Diabetes Solution Center

Sometimes you still need a little help paying for medicine for you or your child. Whether you have no insurance or have a high-deductible commercial insurance plan, you may be able to find help.

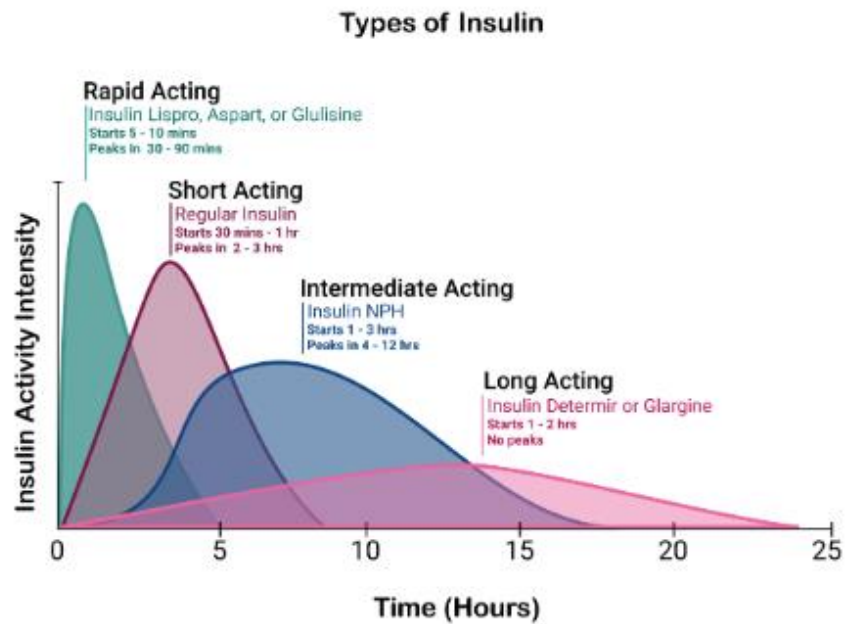
If you are struggling to afford the medication or diabetes care you need, raise your hand. Call us at [1-833-808-1234](tel:1-833-808-1234).

Solutions vary by product and are subject to change and eligibility.

Patient Assistance Programs

- Offered by most manufacturers through a foundation
- Patients do need to apply and provide financial information to support the need
- Patients often receive 6 months of medication

Using Human Insulin



Timing is more of a challenge

- Regular needs to be dosed 30-60 minutes prior to a meal
- NPH has a wide range of peak times which can result in mis-timing meals and insulin peaks
- Tricky to mix for concurrent use

However, studies have shown attainment of glycemic control with minimal hypoglycemia

Cost is about \$25/vial

Other Possibilities

Clinic Sponsored Co-Pay Support

- Schedule Of Discounts
- Funded via grants or 340b proceeds

Compassionate Care Pricing

CCO “Flex Funds”

- New requirements
- Address housing, food insecurities, utilities

Thank You For Your Attention!

Mike Farley, RPh
Clinical Pharmacist
Winding Waters Medical Clinic
mike.Farley@windingwaters.org





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