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Webinar Series

COVID-19: CALTCM Weekly Rounds

October 26, 2020

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Housekeeping

- Review your name and make any necessary adjustments.
- Close all other windows and apps, especially mail and messaging programs.
- We invite you to turn on your camera and unmute your line to ask questions or participate in the discussion.
  - Feel free to raise your hand when you have a question.
  - To help keep background noise to a minimum, make sure you mute your microphone when you are not speaking.
  - Don't talk over others.

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Webinar Faculty

Timothy L. Gieseke, MD, CMD

Member, California Partnership for Improving Dementia Care; 2018 CALTCM Leadership Award Recipient

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Webinar Faculty

Jay Luxenberg, MD
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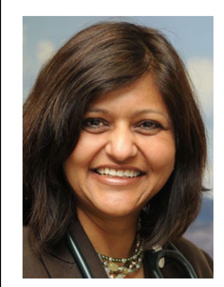

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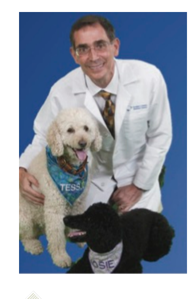

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President-Elect, AMDA: The Society for Post-Acute and Long-Term Care Medicine; CALTCM BOD Member; Chief Medical Officer, Mariner Health Care; Past Chair, Coalition for Compassionate Care of California

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Webinar Faculty & Moderator

Michael Wasserman, MD, CMD
Geriatrician
CALTCM Immediate Past-President
Medical Director, Eisenberg Village,
Los Angeles Jewish Home

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Visitation

Recommendations for Welcoming Back Nursing Home Visitors during the COVID-19 Pandemic: Results of a Delphi Panel

Christian Bergman, MD, CMD • Nathan M. Stall, MD • Daniel Haimowitz, MD, CMD • Louise Aronson, MD • Joanne Lynn, MD • Karl Steinberg, MD, CMD • Michael Wasserman, MD, CMD •
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JAMDA

https://www.jamda.com/article/S1525-8610(20)30836-7/fulltext

1) Maintain strong infection prevention and control precautions;
2) Facilitate indoor and outdoor visits;
3) Allow limited physical contact with appropriate precautions;
4) Assess individual residents' care preferences and level of risk tolerance;
5) Dedicate an essential caregiver and extend the definition of compassionate care visits to include care that promotes psychosocial wellbeing of residents.

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Sliding Scale and DM Management

Meenakshi Patel, MD, FACP,MMM, CMD
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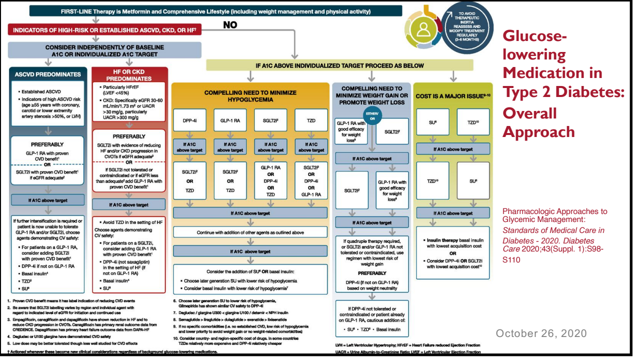

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PHARMACOLOGIC APPROACHES TO GLYCEMIC TREATMENT

Intensifying to injectable therapies

Use Principles in Figure 9.1, including reinforcement of behavioral interventions (weight management and physical activity) and provision of DSMES to meet individualized treatment goals

TO AVOID THERAPEUTIC INERTIA REASSESS AND MODIFY TREATMENT REGULARLY (3–6 MONTHS)

If injectable therapy is needed to reduce A1C[1]

Consider GLP-1 RA in most patients prior to insulin[2]
INITIATION: Initiate appropriate starting dose for agent selected (varies within class)
TITRATION: Gradual titration to maintenance dose (varies within class)

If already on GLP-1 RA or if GLP-1 RA not appropriate OR insulin preferred

If above A1C target

Add basal insulin[3]
Choice of basal insulin should be based on patient-specific considerations, including cost. Refer to **Table 9.3** for insulin cost information.

Add basal analog or bedtime NPH insulin
INITIATION: Start 10 IU a day **OR** 0.1–0.2 IU/kg a day
TITRATION:
- Set FPG target (see Section 6: Glycemic Targets)
- Choose evidence-based titration algorithm, e.g., increase 2 units every 3 days to reach FPG target without hypoglycemia
- For hypoglycemia determine cause, if no clear reason lower dose by 10–20%

Pharmacologic Approaches to Glycemic Management:
Standards of Medical Care in Diabetes - 2020. Diabetes Care 2020;43(Suppl. 1):S98-S110

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OLDER ADULTS

Table 12.2—Considerations for treatment regimen simplification and deintensification/deprescribing in older adults with diabetes. (1 of 2)

Table 12.2—Considerations for treatment regimen simplification and deintensification/deprescribing in older adults with diabetes (56,82)

Patient characteristics/health status	Reasonable A1C/ treatment goal	Rationale/considerations	When may regimen simplification be required?	When may treatment deintensification/ deprescribing be required?
Healthy (few coexisting chronic illnesses, intact cognitive and functional status)	A1C <7.5% (58 mmol/mol)	• Patients can generally perform complex tasks to maintain good glycemic control when health is stable • During acute illness, patients may be more at risk for administration or dosing errors that can result in hypoglycemia, falls, fractures, etc.	• If severe or recurrent hypoglycemia occurs in patients on insulin therapy (even if A1C is appropriate) • If wide glucose excursions are observed • If cognitive or functional decline occurs following acute illness	• If severe or recurrent hypoglycemia occurs in patients on noninsulin therapies with high risk of hypoglycemia (even if A1C is appropriate) • If wide glucose excursions are observed • In the presence of polypharmacy
Complex/ intermediate (multiple coexisting chronic illnesses or 2+ instrumental ADL impairments or mild-to-moderate cognitive impairment)	A1C <8.0% (64 mmol/mol)	• Comorbidities may affect self-management abilities and capacity to avoid hypoglycemia • Long-acting medication formulations may decrease pill burden and complexity of medication regimen	• If severe or recurrent hypoglycemia occurs in patients on insulin therapy (even if A1C is appropriate) • If unable to manage complexity of an insulin regimen • If there is a significant change in social circumstances, such as loss of caregiver, change in living situation, or financial difficulties	• If severe or recurrent hypoglycemia occurs in patients on noninsulin therapies with high risk of hypoglycemia (even if A1C is appropriate) • If wide glucose excursions are observed • In the presence of polypharmacy

Older Adults:
Standards of Medical Care in Diabetes - 2020. Diabetes Care 2020;43(Suppl. 1):S152-S162

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OLDER ADULTS

Table 12.2—Considerations for treatment regimen simplification and deintensification/deprescribing in older adults with diabetes. (2 of 2)

Patient characteristics/health status	Reasonable A1C/ treatment goal	Rationale/considerations	When may regimen simplification be required?	When may treatment deintensification/ deprescribing be required?
Community-dwelling patients receiving care in a skilled nursing facility for short-term rehabilitation	Avoid reliance on A1C Glucose target: 100–200 mg/dL (5.55–11.1 mmol/L)	• Glycemic control is important for recovery, wound healing, hydration, and avoidance of infections • Patients recovering from illness may not have returned to baseline cognitive function at the time of discharge • Consider the type of support the patient will receive at home	• If treatment regimen increased in complexity during hospitalization, it is reasonable, in many cases, to reinstate the prehospitalization medication regimen during the rehabilitation	• If the hospitalization for acute illness resulted in weight loss, anorexia, short-term cognitive decline, and/or loss of physical functioning
Very complex/poor health (long-term care or end-stage chronic illnesses or moderate-to-severe cognitive impairment or 2+ ADL dependencies)	A1C <8.5% (69 mmol/)†	• No benefits of tight glycemic control in this population • Hypoglycemia should be avoided • Most important outcomes are maintenance of cognitive and functional status	• If on an insulin regimen and the patient would like to decrease the number of injections and fingerstick blood glucose monitoring events each day • If the patient has an inconsistent eating pattern	• If on noninsulin agents with a high hypoglycemia risk in the context of cognitive dysfunction, depression, anorexia, or inconsistent eating pattern • If taking any medications without clear benefits
Patients at end of life	Avoid hypoglycemia and symptomatic hyperglycemia	• Goal is to provide comfort and avoid tasks or interventions that cause pain or discomfort • Caregivers are important in providing medical care and maintaining quality of life	• If there is pain or discomfort caused by treatment (e.g., injections or fingersticks) • If there is excessive caregiver stress due to treatment complexity	• If taking any medications without clear benefits in improving symptoms and/or comfort

Treatment regimen simplification refers to changing strategy to decrease the complexity of a medication regimen, e.g., fewer administration times, fewer fingerstick readings, decreasing the need for calculations (such as sliding scale insulin calculations or insulin-carbohydrate ratio calculations). Deintensification/deprescribing refers to decreasing the dose or frequency of administration of a treatment or discontinuing a treatment altogether. ADL, activities of daily living. †Consider adjustment of A1C goal if the patient has a condition that may interfere with erythrocyte life span/turnover.

Older Adults:
Standards of Medical Care in Diabetes - 2020. Diabetes Care 2020;43(Suppl. 1):S152-S162

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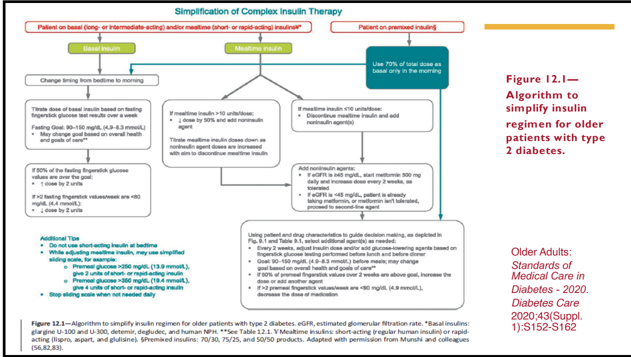

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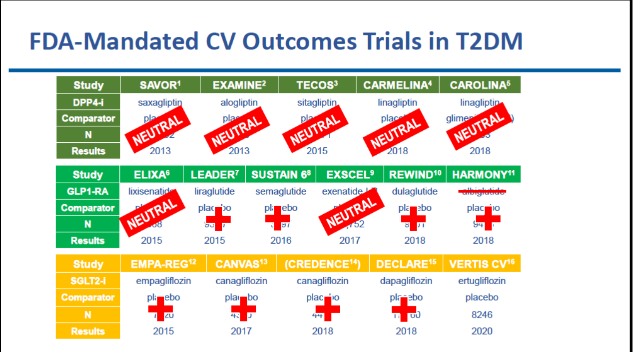

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Transitioning Away From Sliding Scale Insulin

- Replace with basal insulin (50-75% of average daily requirement)
- Add 50–75% of the average insulin requirement used as SSI to existing dose of basal insulin
- Use noninsulin agents or fixed-dose mealtime insulin for postprandial hyperglycemia
- Increase basal dose by average correction dose given at breakfast
- Short-term SSI may be needed for acute illness or irregular meal intake
- Reduce frequency of glucose checks
- May use a simple scale, such as "give 4 units of mealtime insulin if glucose >300 mg/dL" if dementia and persistent irregular meal intake
- Stop SSI as glucose levels stabilize

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How Often Should Blood Glucose be Checked?

- Nonpharmacologic or oral agent
  - Twice per day for 1–2 weeks after admission, then once or twice per week; postprandial may be helpful
- Simple insulin regimens (1 or 2 daily injections)
  - Twice daily, at least 3 to 4 days per week; postprandial may be helpful
- Complex insulin regimens (3 or more daily injections)
  - Three or more times every day; postprandial may be helpful

Mallery LH,et al. Diabetes Care Program of Nova Scotia (DCPNS) and the Palliative and Therapeutic Harmonization (PATH) program. J Am Med Dir Assoc 2013; 14(11)

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