DIABETES CARE IN DPC:
WHO NEEDS AN ENDOCRINOLOGIST?

Mary Tipton MD FACP

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- Navigate to https://aafp1.cnf.io/ and tap the session titled "Diabetes Care in DPC: Who needs an Endocrinologist?"
- OR just point your phone's camera at the QR code to join directly

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Learning Objectives

1. Initiate and titrate long-acting and short-acting insulin using evidence-based strategies that can be implemented in primary care practice.
2. Apply current guidelines to initiate, prescribe, and monitor diabetes technologies and therapies, including continuous glucose monitoring (CGM), insulin pumps, and non-insulin medications in adults and children.
3. Determine appropriate indications for referral to endocrinology based on patient complexity, treatment response, and technology needs.

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Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: How long is the wait to see an Endocrinologist for diabetes in your town?

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Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: If your patients go to Endocrinology for their diabetes do they see a physician?

7

Live Content Slide

When playing as a slideshow, this slide will display live content

Poll: What do you wish you knew about Diabetes?

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Did you answer "**all of the above**"?

You are in the right place!!

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Mary Tipton MD FACP

Childhood - Alaska
Chemical Engineer - Arizona
Medical School - Utah
Internal Medicine & Pediatrics - Ohio
Private Practice x 19 years - Utah

DPC opened 2024 - Utah

Blossom Health
A DIRECT PRIMARY CARE PRACTICE

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What we will cover

Medications
Choose and use appropriate diabetes medications effectively.

Continuous Monitoring
Start and manage continuous glucose monitors (CGM).

Insulin Therapy
Initiate and titrate insulin regimens for patients.

Insulin Pumps
Prescribe and manage insulin pump therapy.

Type 1 Diabetes
Manage type 1 diabetics within the DPC setting.

Endocrinology Referral
Identify when it is necessary to refer to endocrinology.

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Carla, 38 yo female

Establish care visit:

Daily Etoh use x 3 yr
Wants to get stop and get healthy
2 children, age 7 & 11
BP 186/122
Weight 173 lb
BMI 31

Labs:

Hgb 15
MCV 103
A1c 8.6
Glucose 218
AST 123
ALT 104
TSH 1.2
Creatinine 1.1
GAD-65 neg
TPO Ab neg

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Carla, 38 yo female

Family / Social Hx

CAD - Mom with heart attack x2 and MGF dead @43
DM - PGM
HTN - Mom and Dad
Sister - died of drug OD
Husband - alcoholic
Hypothyroid - sisters

Insurance deductible $5k

Medications

Olmesartan / Hctz
Libre CGM sample

And…..

what about diabetes medications?

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Diabetes Medications : How to choose?

What is the priority?

Complications & Comorbidities

OR

Glucose Levels

AND always

Patient specific factors

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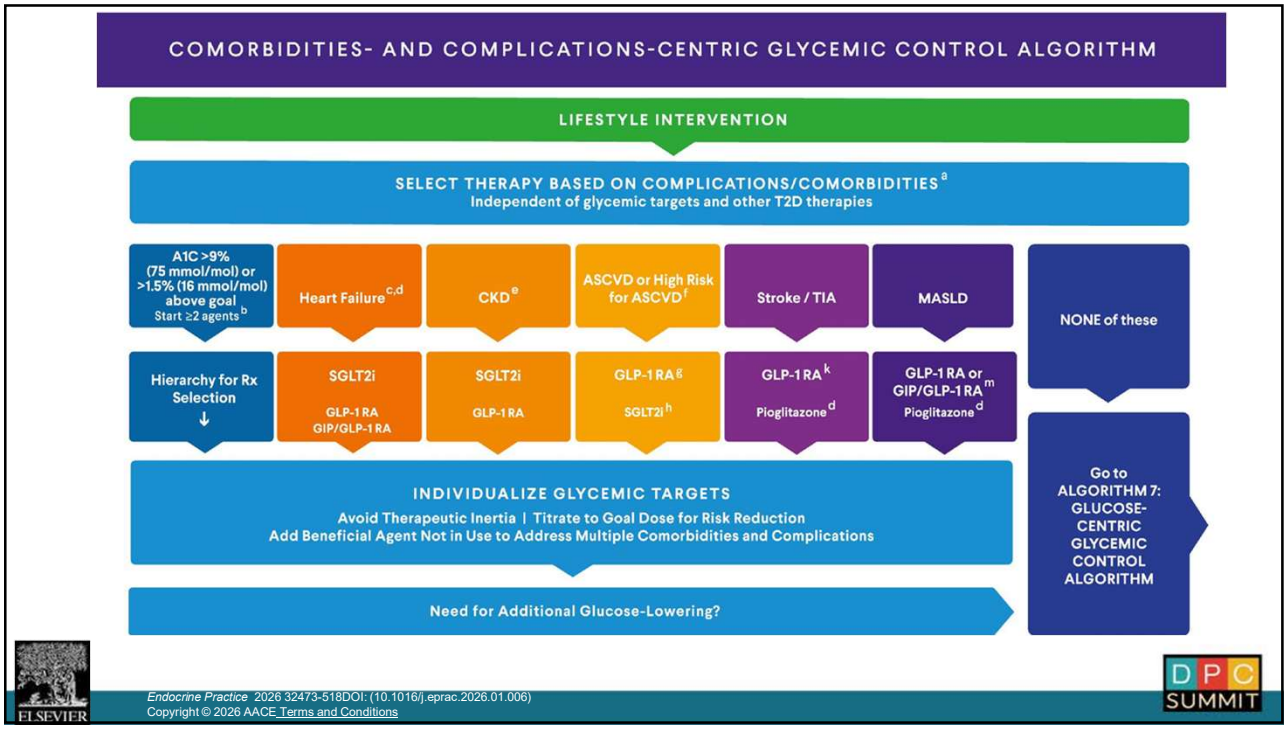

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Diabetes Medications: comorbidity targets

Heart Failure (HF)
Preferred Medications:
- **SGLT2i**
- **GLP-1RA**

Chronic Kidney Disease (CKD)
Preferred Medications:
- **SGLT2i**
- **GLP-1RA**

ASCVD
Preferred Medications:
- **GLP-1RA**
- **SGLT2i**

Stroke / TIA
Preferred Medications:
- **GLP-1RA**
- **Pioglitazone**

Liver Disease (MASLD)
Preferred Medications:
- **GLP-1RA**
- **Pioglitazone**

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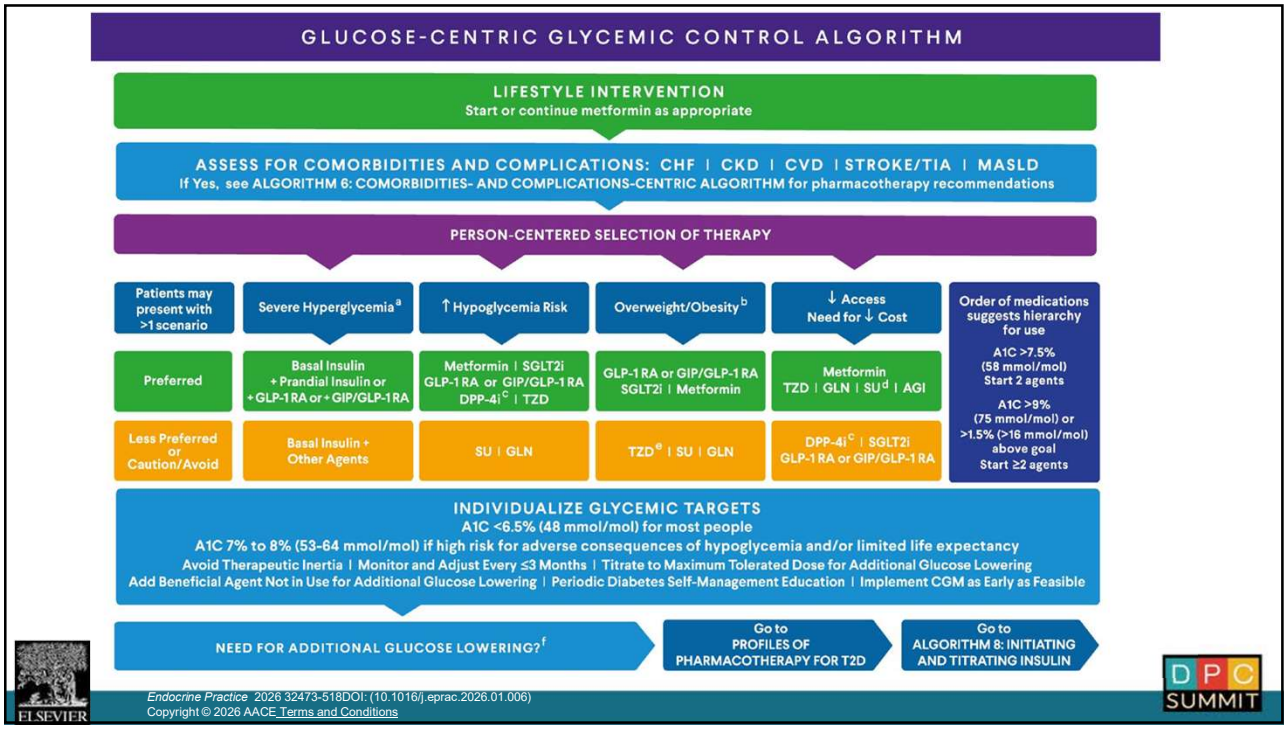

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Diabetes Medications: glucose targets

Metformin First-Line
Standard initiation unless specific contraindications are present.

Combination Therapy
Generally preferred and required for most patients to reach targets.

Side Effect Management
Consider adverse effects and steer away from high-risk medications.

Individualized Care
Tailor all aspects of treatment, including personal A1c targets.

Hierarchy of Use
The order of medication selection aligns with the established hierarchy of use.

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Diabetes Medications: *Always* Patient Centric

Key Considerations for Treatment Selection

Patient Status
Assessment of BMI: Overweight or obese status

Healthcare Access
Impact of decreased access to healthcare services

Medication Cost
Direct financial burden and affordability concerns

Hypoglycemia Risk
Evaluating the potential for dangerous low blood sugar

Hyperglycemia Severity
Severe hyperglycemia or catabolic clinical states

Polypharmacy
Risks associated with managing multiple medications

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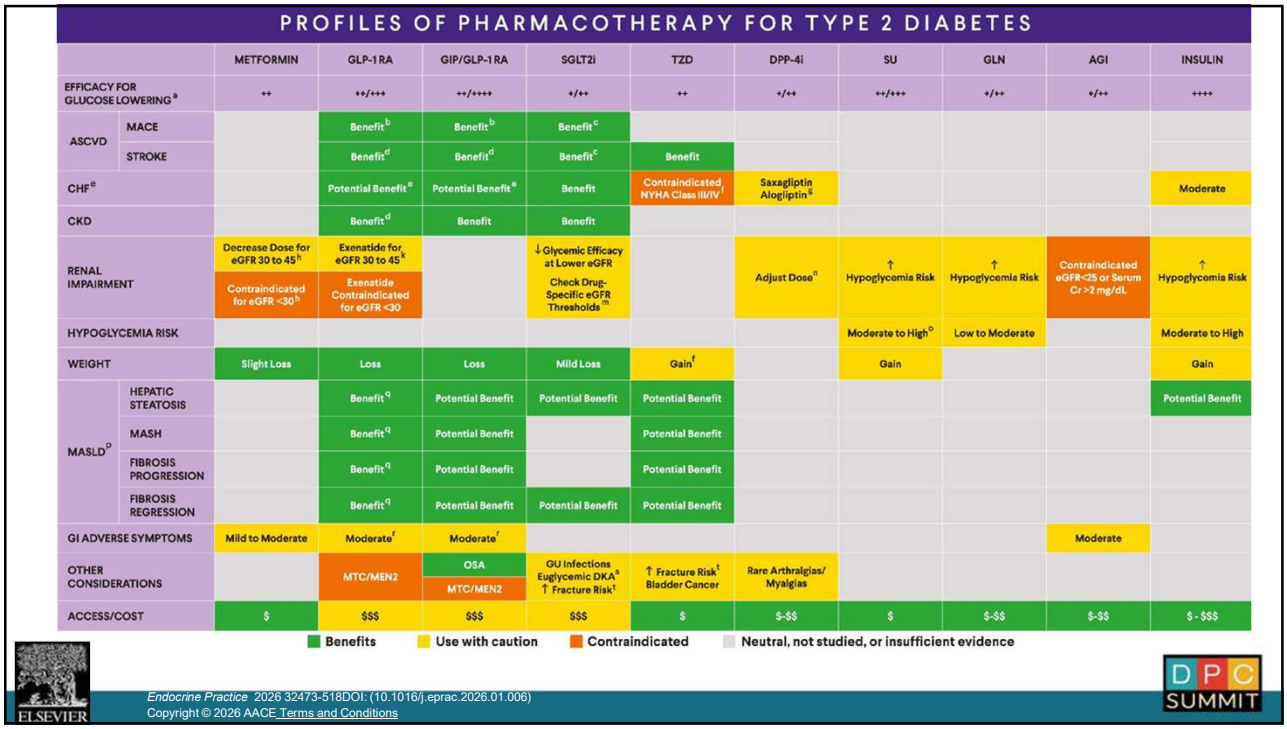

PROFILES OF PHARMACOTHERAPY FOR TYPE 2 DIABETES

		METFORMIN	GLP-1 RA	GIP/GLP-1 RA	SGLT2i	TZD	DPP-4i	SU	GLN	AGI	INSULIN
EFFICACY FOR GLUCOSE LOWERING[a]		++	++/+++	++/++++	+/++	++	+/++	++/+++	+/++	+/++	++++
ASCVD	MACE		Benefit[b]	Benefit[b]	Benefit[c]						
	STROKE		Benefit[d]	Benefit[d]	Benefit[c]	Benefit					
CHF[e]			Potential Benefit[e]	Potential Benefit[a]	Benefit	Contraindicated, NYHA Class III/IV[f]	Saxagliptin Alogliptin[g]				Moderate
CKD			Benefit[d]	Benefit	Benefit						
RENAL IMPAIRMENT		Decrease Dose for eGFR 30 to 45[h] Contraindicated for eGFR <30[h]	Exenatide for eGFR 30 to 45[k] Exenatide Contraindicated for eGFR <30		↓Glycemic Efficacy at Lower eGFR Check Drug-Specific eGFR Thresholds[m]		Adjust Dose[n]	↑ Hypoglycemia Risk	↑ Hypoglycemia Risk	Contraindicated eGFR<25 or Serum Cr >2 mg/dL	↑ Hypoglycemia Risk
HYPOGLYCEMIA RISK								Moderate to High[o]	Low to Moderate		Moderate to High
WEIGHT		Slight Loss	Loss	Loss	Mild Loss	Gain[f]		Gain			Gain
MASLD[p]	HEPATIC STEATOSIS		Benefit[q]	Potential Benefit	Potential Benefit	Potential Benefit					Potential Benefit
	MASH		Benefit[q]	Potential Benefit		Potential Benefit					
	FIBROSIS PROGRESSION		Benefit[q]	Potential Benefit		Potential Benefit					
	FIBROSIS REGRESSION		Benefit[q]	Potential Benefit	Potential Benefit	Potential Benefit					
GI ADVERSE SYMPTOMS		Mild to Moderate	Moderate[r]	Moderate[r]						Moderate	
OTHER CONSIDERATIONS			MTC/MEN2	OSA MTC/MEN2	GU Infections Euglycemic DKA[s] ↑ Fracture Risk[t]	↑ Fracture Risk[t] Bladder Cancer	Rare Arthralgias/ Myalgias				
ACCESS/COST		$	$$$	$$$	$$$	$	$-$$	$	$-$$	$-$$	$ - $$$

Benefits | Use with caution | Contraindicated | Neutral, not studied, or insufficient evidence

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Carla, 38 yo female

Comorbidities/Complications

Htn
Obesity class 2
fam hx ASCVD
Liver disease, multifactorial
Insurance deductible $5k

Medications

Olmesartan / Hctz
Libre CGM sample

Saxagliptin/Metformin ER
Pioglitazone

*generics $5 copay

A1c = 5.8 after 4 mo

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Continuous Glucose Monitoring (CGM)

Evolution & Technology

Devices have dramatically changed during my career

Key Improvements:
Accuracy, portability, affordability, and size

Clinical Evidence

- Reduces hypoglycemia
- Improves A1c (correlated with wear time)
- Reduces health care utilization

Indications: Suitable for every stage and type of diabetes

Use a systematic way to review CGM data

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CGM go mainstream

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CGM options - Rx

Feature	Dexcom G7	Freestyle Libre 3+	Medtronic Guardian 4
Glucose measurements	5 min	1 min	5 min
Site placement	upper arm	upper arm	arm/abdomen
Duration	15d	15d	7d
Warm up	1 h	1h	2h
Calibration needed	No	No	No
Pump integration	Yes	Yes	Yes
Data Review	Clarity	Libreview	Carelink

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CGM options - Otc

Feature	Dexcom Stelo	Abbott Lingo	Abbott Rio (coming)
Cost/mo	$99	$89	TBD
Indications	diabetics/prediabetes	general health	diabetics/prediabetes
Duration	15d	14d	15d
Warm up	1 h	1h	1h
Glucose Range	70-250	55-200	40-400
Data available	Yes, Clarity	NO	?

stelo by Dexcom

Lingo

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CGM: Features

Alarms: Notify users of high or low and rapidly rising or falling glucose levels
- Low alarm fixed at <55 mg/dL
- Especially helpful for patients with hypoglycemia

Trend Arrows: Show the direction and rate of glucose changes

Real time **data sharing** with caregivers

Get logins for **Clarity** & **Libreview**

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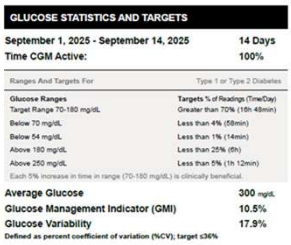
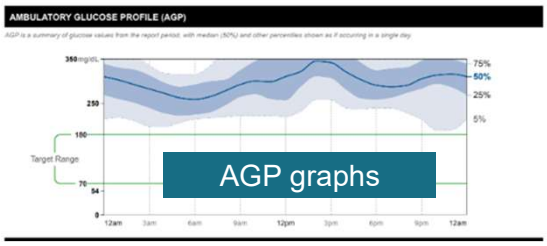
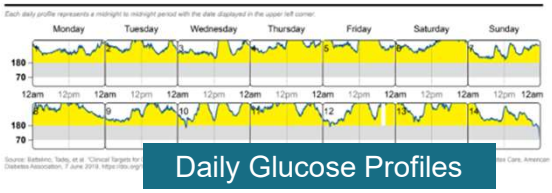
CGM: Ambulatory Glucose Profile (AGP)







Glucose Statistics and Targets

Time in Ranges

Daily Glucose Profiles

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Carla: 38 yo female: CGM at diagnosis

AGP Report

September 1, 2025 - September 14, 2025 (14 Days)

LibreView

GLUCOSE STATISTICS AND TARGETS

September 1, 2025 - September 14, 2025	**14 Days**
Time CGM Active:	**100%**

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	**Targets** % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)

Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.

Average Glucose	**300** mg/dL
Glucose Management Indicator (GMI)	**10.5%**
Glucose Variability	**17.9%**

Defined as percent coefficient of variation (%CV); target ≤36%

TIME IN RANGES

Very High >250 mg/dL	**81%**	(19h 27min)
High 181 - 250 mg/dL	**18%**	(4h 19min)
Target Range 70 - 180 mg/dL	**1%**	(14min)
Low 54 - 69 mg/dL	**0%**	(0min)
Very Low <54 mg/dL	**0%**	(0min)

250 / 180 / 70 / 54

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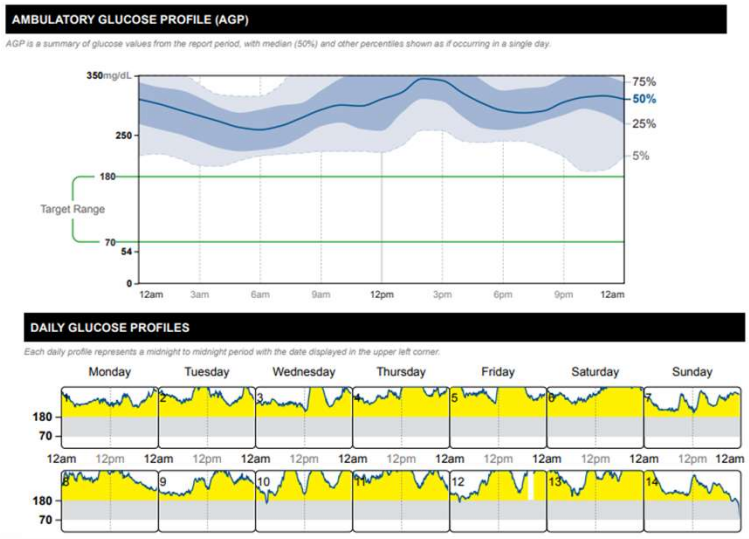
Carla: 38 yo female: initial CGM



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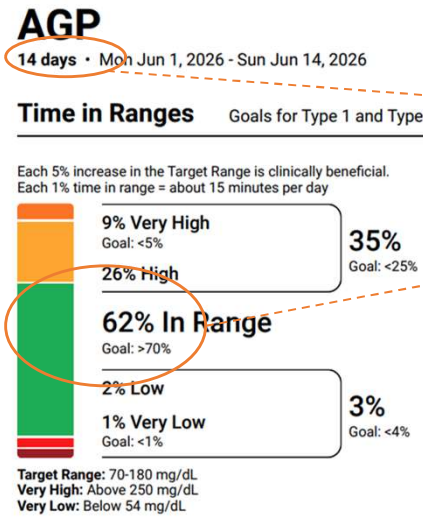
CGM interpretation: Ambulatory Glucose Profile (AGP)

73 yo Diabetic on insulin pump



Flexible Reporting Periods

Report time can be adjusted: 14d, 30d, 90d

Standardized Glycemic Goals

- Goal is 70% in green (target range)
- Target range and goals are standardized

Collaborative Patient Care

- Review with patient via shared screen
- Consistent view across clinical and mobile apps
- Clarity or Libreview

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CGM: Ambulatory Glucose Profile (AGP)

Glucose Metrics Overview

Glucose Metrics	
Average Glucose Goal: <154 mg/dL	162 mg/dL
GMI Goal: <7%	7.2%
Coefficient of Variation Goal: <36%	36.9%
Time CGM Active	93.9%

Average Glucose: Must be evaluated in context with other glycemic metrics.

GMI (Glucose Management Indicator): Highly similar to and correlates with Lab A1c.

Coefficient of Variation (CV): The primary measure of glucose variability.

CGM Activity: The clinical goal for data sufficiency is over 70%.

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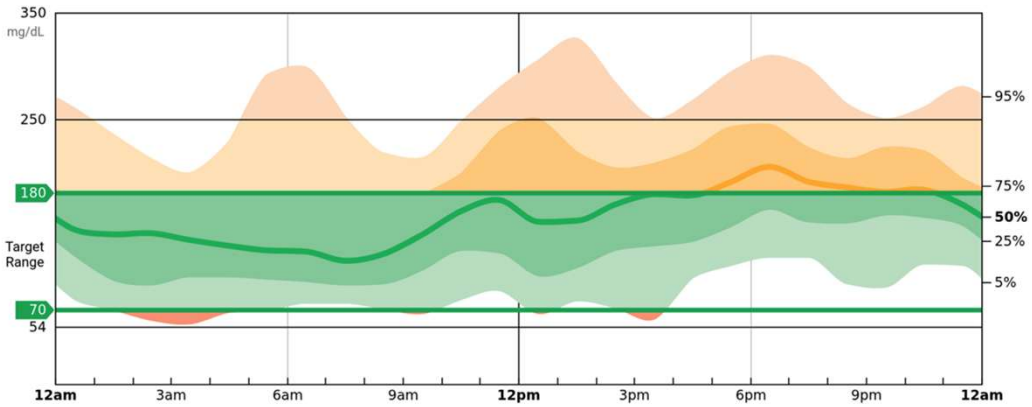
CGM: Ambulatory Glucose Profile (AGP)

Ambulatory Glucose Profile (AGP)

AGP is a summary of glucose values from the report period, with median (50%) and other percentiles shown as if they occurred in a single day.



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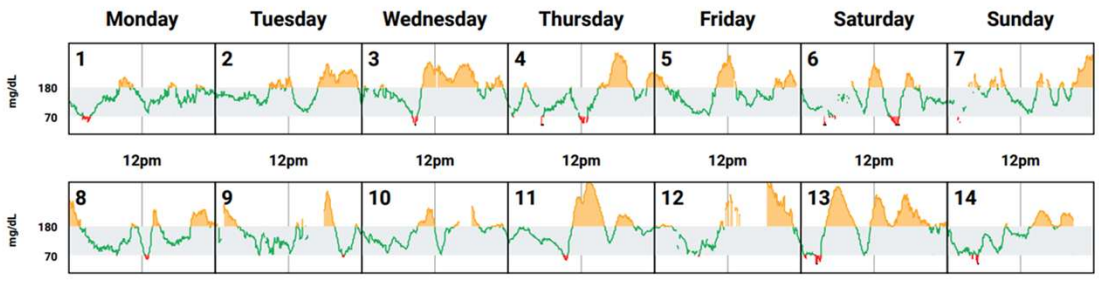
CGM: Ambulatory Glucose Profile (AGP)



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Carla, 38 yo female, after 4 mo treatment

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Choose and use appropriate diabetes medications effectively.

Continuous Monitoring
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Insulin Therapy
Initiate and titrate insulin regimens for patients.

Insulin Pumps
Prescribe and manage insulin pump therapy.

Type 1 Diabetes
Manage type 1 diabetics within the DPC setting.

Endocrinology Referral
Identify when it is necessary to refer to endocrinology.

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Sione, 65 yo male

Urgent care visit:

No doctor visits x 5 yr
Notes nocturia and blurry vision
↓ 20 pounds last 3 mo
BP 155/93
Weight 280 lb (127 kg)

Labs:

Hgb 14
A1c 12.1
Glucose 375
AST 70
ALT 55
TSH 1.1
GFR 59
GAD-65 neg

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Sione, 65 yo male

Family / Social Hx

DM - parents and sibling
HTN - Dad
Lives with extended family
Rice at least 2x per day

Medicare insurance

Medications

None

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Insulin: Initiate & Titrate

When to Initiate

- After failure of non-insulin glucose lowering agents
- In the setting of symptomatic hyperglycemia

How to Titrate

- Start with basal insulin
- Avoid hypoglycemia
- Using CGM is best
- Use body mass for initial calculations

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Insulin: Types

Insulin Type	Duration (Hours)	Brand Names / Formulations
Long Acting	24 h	Lantus, Glargine, Toujeo, Basaglar, Semglee, Tresiba
Short Acting	3-5 h	Humalog, Novolog, aspart, lispro
Medium Acting	6-12 h	Regular (Humulin/Novolin)
Mixtures	18-24 h	Novolog Mix 70/30

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INITIATING AND TITRATING INSULIN ALGORITHM

SEVERE HYPERGLYCEMIA: A1C >10% (86 mmol/mol) and/or glucose >300 mg/dL (16.7 mmol/L) with symptoms, start basal +/- prandial insulin[a]

GOALS: Individualize glycemic targets[b] | Use CGM to achieve glycemic targets[c] | Recommend GLP-1 RA, GIP/GLP-1 RA if not already in use[d] | Lifestyle intervention[e] | Continue other DM therapies that benefit complications and comorbidities, if appropriate[f]

Starting Basal Insulin

- A1C <8% (64 mmol/mol): 0.1 to 0.2 U/kg/day
- A1C ≥8% (64 mmol/mol): 0.2 to 0.3 U/kg/day

Titrate every 2 to 5 days to reach glycemic target[g]

FIXED TITRATION:
- Adjust basal dose by 2 U until glycemic goal is met

ADJUSTABLE TITRATION:
- FBG >180 mg/dL (>10.0 mmol/L): add 20% more basal
- FBG 140 to 180 mg/dL (7.8-10.0 mmol/L): add 10% more basal
- FBG 110 to 139 mg/dL (6.1-7.7 mmol/L): add 1 U basal

FASTING HYPOGLYCEMIA:
- BG <70 mg/dL (3.9 mmol/L): decrease basal 10% to 20%
- BG <40 mg/dL (2.2 mmol/L): decrease basal 20% to 40%

- Discontinue SU
- Basal analogs preferred to NPH[h]

GLYCEMIC GOALS UNMET
Basal insulin >0.5 u/kg/day
BeAM Score (bedtime minus fasting glucose) >50[k]

Starting Prandial Insulin[m]

STEPWISE ADDITION TO BASAL:
- Begin prandial insulin at largest meal (10% of basal or 5 U)[n]
- If not at goal, progress to injections before 2 or 3 meals

SIMULTANEOUS ADDITION TO BASAL:
- Goal TDD is ~50% basal, ~50% prandial divided by 3 meals

PREMIXED INSULIN:
- TDD: Start 0.2 to 0.3 U/kg/day or base on current basal dose
- Give 2/3 before breakfast and 1/3 before supper

Rapid-acting analogs preferred to regular insulin

Titrate insulin every 2 to 3 days to reach glycemic goal

HYPERGLYCEMIA:
- Increase prandial dose by 10% to 20% for the previous meal
- Titrate to individualized glycemic goals[b]

HYPOGLYCEMIA (PRANDIAL BG <70 MG/DL [3.9 MMOL/L]):
- Decrease prandial dose by 10% to 20% for the previous meal
- For immediate treatment of hypoglycemia: Administer rapidly absorbed oral glucose (juice, glucose tablet) if able to safely swallow. If unresponsive, subcutaneous/intramuscular/intranasal glucagon or glucagon analogue can be administered by a trained member of the household.

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Insulin: Calculations

Basal Insulin

Starting Dose:
0.1 - 0.3 U/kg

Titration:
Adjust every 3-5 days based on FBG goal

Can be on a fixed schedule or adjustable

Prandial Insulin

Initiate after Basal is titrated if goals are unmet.

Basal-Bolus ratio:
Basal ≈ Bolus (approx. 50/50)

Total Daily Dose (TDD):
TDD = Basal + Bolus

Correction Factor (CF):
1700 / TDD

Carb Ratio (CR):
CF / 3

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Sione, 65 yo male (127 kg)

Insulin Initiation

Criteria & Initial Dosing

- A1c > 8, thus 0.2-0.3 U/kg = **32 U**
- Start **30 U daily glargine**
- Initiate CGM

Titration Phase

- Increase by 2 U every 2-3 days
- After 4 weeks: **70 U glargine**
- High Dose: > 0.5 U/kg
- FBG = 150 (not at goal)

Prandial Insulin

Total Daily Dose (TDD) calculation assuming **Basal = Bolus**:

TDD = 140 U

Correction Factor (CF):
1700 / 140 = **12**

Carbohydrate Ratio (CR):
12 / 3 = **4**

Final Regimen Note:
1:12 + 1:4 > 110

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Insulin: Pearls

Optimization Strategies

Key Recommendations:

- Add **GLP 1-RA** instead of prandial insulin
- Consider **Soliqua** for Medicare patients ($35 copay)
- Mixture insulin for certain settings (e.g., jail / nursing home)
- Options for no-math folks
  - basal + 1 meal, set # units
  - write out sliding scale for CF

Pros & Cons

Advantages:

- Fast and reliable glycemic control
- Cheaper than GLP1-RA / SGLT2i for many patients

Drawbacks:

- Risk of hypoglycemia
- Potential for weight gain
- Must have CGM/glucose meter

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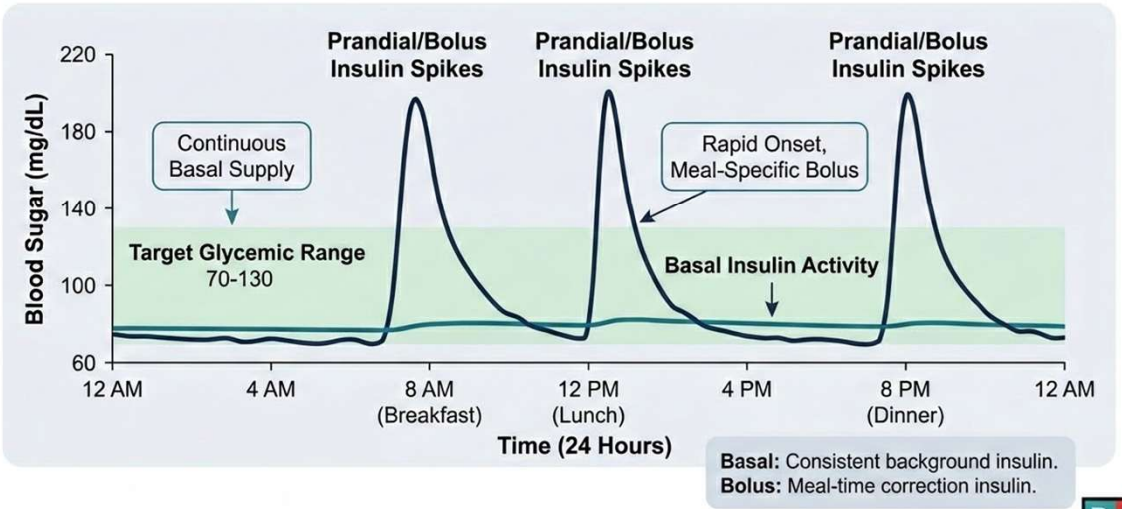
Visualizing Basal-Bolus Insulin Therapy



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Type 1 Diabetes
Manage type 1 diabetics within the DPC setting.

Endocrinology Referral
Identify when it is necessary to refer to endocrinology.

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Joyce, 73 yo female

Past Medical History

Type 1 diabetic since 20's
Recurrent life threatening hypoglycemic episodes
Exercises daily
Breast cancer
Hyperparathyroidism 1° and 2°
CKD 3b
Osteoporosis
Hypertension
Hypothyroidism
Anemia

Labs:

Hgb 9.7
A1c 8.3
Cr 1.65

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Insulin Pumps

Feature	Tandem	Omnipod	Medtronic
Closed Loop System	Control IQ	Smart Adjust	Smart Guard
Battery	rechargable	disposable pod	AAA battery
Tubing	yes	no	yes
Sensor	Dexcom/Libre	Dexcom/Libre	Instinct/Guardian
Data Review	Tandem One Source	Glooko	Carelink

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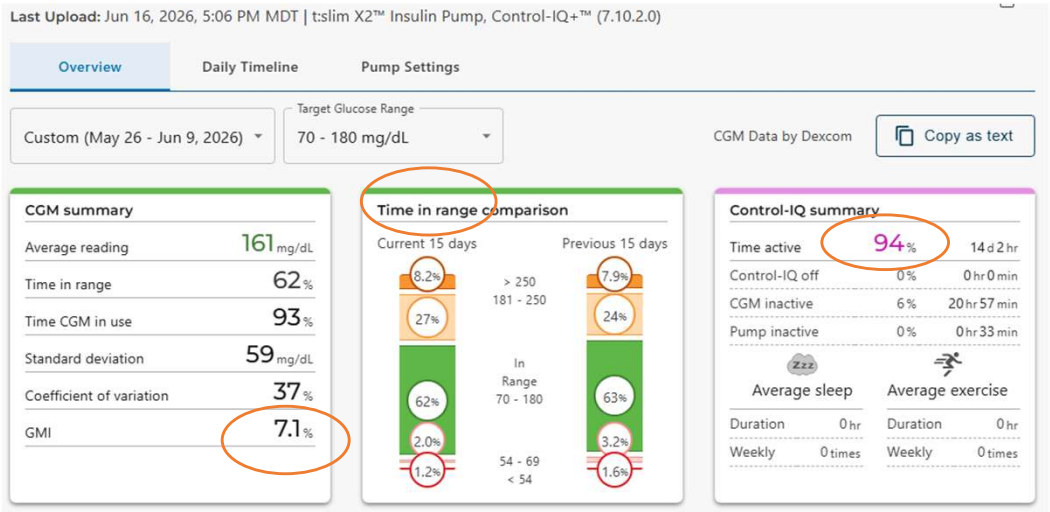
Pump: Data overview



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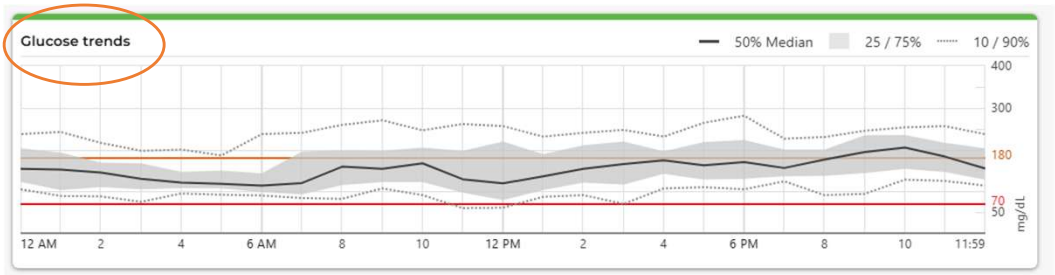
Pump: Glucose Trends & Pump Settings



Pump Profile settings - Wtf

Time	Basal Rate (units/hr)	Correction Factor (units:mg/dL)	Carb Ratio (units:grams)	Target BG (mg/dL)
12:00 AM	1.400	1:40	1:10.0	110
2:00 AM	1.100	1:40	1:10.0	110
11:00 AM	1.900	1:40	1:10.0	110
3:00 PM	2.200	1:40	1:10.0	110

Total Daily Basal: 40.100 units Insulin Duration: 5 hr Carbohydrates:On

Pump Profile settings - New

Time	Basal Rate (units/hr)	Correction Factor (units:mg/dL)	Carb Ratio (units:grams)	Target BG (mg/dL)

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Pump: Insulin use summary

Insulin summary

Average daily dose		26.91 units
Basal	58%	15.71 units
Bolus	42%	11.20 units
Average daily boluses		14 boluses
Manual	35%	5 boluses
Control-IQ	65%	9 boluses
Average daily carbs		69 g

Bolus review (daily average)

Type		
Food	40%	4.50 units
Correction	13%	1.47 units
Override	0%	0.00 units
Control-IQ	47%	5.23 units
Delivery Method		
Standard	53%	5.97 units
Extended	0%	0.00 units
Quick	0%	0.00 units
Control-IQ	47%	5.23 units

Load activity

Cartridge change	every	3.1 d
Tubing fill	every	3.1 d
Cannula fill	every	3.0 d

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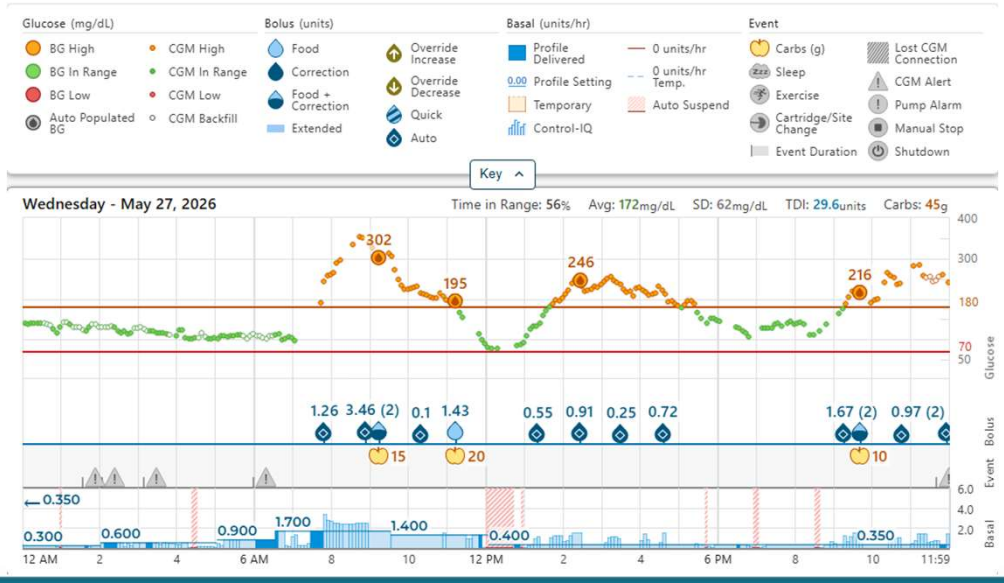
Pump: Daily Timeline



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Pump: Ordering & Implementation

Streamlined Ordering

- Parachute Health DME platform
- Preferred local supply partners
- Direct manufacturer procurement
- Omnipod - from pharmacy

Expert Setup & Support

- Clinic or manufacturer reps may initiate settings
- Hybrid training: Live sessions paired with digital modules

minimed

Tandem Pump Rx

Parachute Health

Byram HEALTHCARE

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Joyce, 73 yo female

Update

I have been taking care of her for 20 years
A1c is better than ever (~7.1)
Very rare critical lows
Full adoption of pump, CGM, glucagon pen, smart phone, apple watch all synced
No progression of retinopathy or nephropathy

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What we will cover

Medications
Choose and use appropriate diabetes medications effectively.

Continuous Monitoring
Start and manage continuous glucose monitors (CGM).

Insulin Therapy
Initiate and titrate insulin regimens for patients.

Insulin Pumps
Prescribe and manage insulin pump therapy.

Type 1 Diabetes
Manage type 1 diabetics within the DPC setting.

Endocrinology Referral
Identify when it is necessary to refer to endocrinology.

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T1D: Caring for a Type 1 Diabetic

Patient Perks

These will be your happiest patients, especially the teens/young adults

My T1D patients are highly motivated and tech savvy

Clinical Guidelines

ADA (2021)
American Diabetes Association

AACE (2022)
American Association of Clinical Endocrinology

Management Essentials

- Insulin always and forever
- Usually pump/CGM, otherwise multiple daily injections
- Regular screening for other autoimmune diseases (celiac, thyroid)
- Check autoantibodies in adult with new onset diabetes. (GAD-65)
- 40% of T1D > 30 yo are misdiagnosed initially as T2

DPC SUMMIT

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DPC SUMMIT

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When to refer to **Endocrinology**

Clinical Indicators

- Other competing diagnoses are too great
- Comorbid conditions
  - Panhypopituitary
  - Thyroid cancer
  - Pregnancy
  - Lymphoma
  - Dialysis

Patient Preference

When a patient explicitly requests specialist consultation.

Refractory Cases

Poor control despite optimized primary care treatment strategies.

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Live Content Slide

When playing as a slideshow, this slide will display live content

Social Q&A for Diabetes Care in DPC: Who needs an Endocrinologist?

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QUESTIONS?

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