

Virtual DiabetesEd Training Conference 2025 | Day 1

Question Asked	Answer Given
I do not agree with the answer(question 18) , adjust gargline as need that is not true	i would never suggest adjusting as needed, but best answer to this question is asking about hypo. i would also definitely want to address teh glargine dosing next.
Is there a high risk of DKA when on Jardiance and high dose NPH Humulin insulin?	if a person is insulin defecient and on jardiance, their risk for DKA increased
What are the contraception recommendations with use of GLP-1 for childbearing women?	if trying to get pregnant, don't use. Use contraception when taking gLP-Glp - need additional contraception with Tirz for first monht
I would like to know if using insulin in combination with actos increases risk HF?	it could, depeding on the individual. Start low and check for edema.
Are there certain antibiotics that can cause T1 diabetes such as Vancomycin? Or would there need to be family hx T1 first line parent and or autoimmune diseases?	more likely the infection could trigger the expression of the genes
Do you start the person on any insulin in stage 2 and 1?	usually not, it's monitoring at this point
Is there a hierarchy of effectiveness or strength in SGLT-2 meds options?	nope
For surgery how long before the surgery should the glp be held and when can it be resumed?	one week or more if needed
If switching from 1 GLP to another, how to you transition the dose from 1 to another?For example when pt cannot access Ozempic and has to go on Trulicity or Mounjaro, do you start from the initial dose or match it with the dose of the previous GLP?	start with low dose and gradually increase as tolerated
Could you speak about GLP1/GIP and pancreatitis risk?	very low
Is CGM GMI more accurate than lab A1C?	not necessarily, but time in range and average glucose may be more actionable than an a1c, especially if advanced kidney disease or anemia that could cause falsely high or low a1c.
Is there any prolonged bg coverage with XR Metformin?	it lasts 24 hours compared to the immediate release, which typically is dosed twice daily.
When would you use NPH (other than cost) for the purpose of BG mangement e?	steroid induced diabetes, pregnancy, otherwise we prefer longer acting insulins
How often can the person on MDI give corrections to avoid stacking?	no more than every 4 hours
Can GLP1/GIP be used for MASH/MASLD?	yes, it helps reduce wt so helps masld mash
Is the insulin price also the same for commercial insulins or just Medicare and is it for all types of insulins or special ones?	for people with commercial insurance, there are copay cards, and often can also be obtained for \$35/month.
Would you clarify what is MRA for CKD med?	she is talking about it now
Can you talk about any increased CVD in kidney donners?	I haven"t heard this? Only for post transplant if bG elevated
Would you recommend these for just the case of ACUTE HF without DM or pre DM?	yes, 2 of them are approved for hf without dm
I'm curious why the autoantibodies may disappear over time. Is it the introduction of insulin?	when someone has had long standing type 1, they may dissapear as they've already done their damage to the pancreas. They are more likely to bre present at diagnosis.

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What is the specific connection between CF and diabetes? Is it a medication or some sort of specific physiology?	cf destroys the exocrine function of the pancreas and for many it also destroys the beta cell funtion
Are AACE guidelines integrated into the exam?	Know the A1C goal, if taking bc-adm, be familiar with the glucocentric algorithm
Can you explain what is time in range	percentage of time spent between 70-180mg/dL
can we still held Metformin with CT scan contrast	yes, if GFR is below 60, good call out. here is what the label says: Discontinue Metformin at the time of, or prior to, an iodinated contrast imaging procedure in patients with an eGFR between 30 and 60 mL/min/1.73 m ² ; in patients with a history of liver disease, alcoholism, or heart failure; or in patients who will be administered intra-arterial iodinated contrast. Re-evaluate eGFR 48 hours after the imaging procedure
For type 1 and risk assessment- patients with autoimmune disease- is it suggested to do the lab test on anyone with autoimmune disease or would they also need to have a certain BMI, etc.	family history of type 1 most impt
If a patient has preDM but has lipid labs within normal range, it is still safe to say they are at increased risk of cardiovascular disease? I will usually educate individuals on their lipid labs and will use those to help motivate change. I feel like they will be confused if I say that but their lipid labs are within range.	PreDM in itself actually puts someone at increased risk of CVD. This meta analysis supports this. https://pubmed.ncbi.nlm.nih.gov/32669282/ Conclusions: Results indicated that prediabetes was associated with an increased risk of all cause mortality and cardiovascular disease in the general population and in patients with atherosclerotic cardiovascular disease. Screening and appropriate management of prediabetes might contribute to primary and secondary prevention of cardiovascular disease.
A lot of my patients are asking about bone loss/osteoporosis risk with GLP1s...They all say that that have heard this risk on social media platforms... but this also seems to be mis-information based on the data you shared earlier. Are there any studies that show bone loss isn't a risk? or that GLP1s reduce the risk of bone loss?	here is an article summarizing bone effets from different diabetes agents. https://pubmed.ncbi.nlm.nih.gov/38541119/ in general, glp1 actualaly have positive effect on bone metabolism and fracture risk.
HOfw many times more likely to die form heart Disease?	2-4
Prior to 15 weeks gestation why dont we use 5.7 -6.4 A1C as the threshold for Pre DM during pregnancy?	they do. but if the A1C is 6.0% or greater, higher risk for GDM and need for meds
both Sulfonylureas and Meglitinides make pancreas squirt insulin, how do we know which one to pick?	sulfonylureas are more widely used, more a1c lowering, easier to take (1-2x/day vs 3). may use glitinide if just need post prandial glucose lowering. glp1, metformin and sglT2i preferred over both.
what is the maximum number of diabetes med can 1 person take? if the person uses insulin, what is the factors can cause the blood sugar not under control even with 1 added diabetes medication?	There is no max, just the best tx for that person
where can you find assistance program for diabetes medication?	Go to manufacturer website of drug you're interested in. i also created cost savings toolkits that have links to these: https://www.adces.org/docs/default-source/handouts/costsavingsresources/ehandout_hcp_costsaving_noninsulindiabetesmeds2023.pdf?sfvrsn=38e56359_13 , https://www.youtube.com/watch?v=i0fAV3ArtgI
Can you use the c-peptide test and islet of langerhan test to dx type 1 diabetes?	we measure c-peptide, but we focus on autoimmunity to dx

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Question Asked	Answer Given
<p>I have a couple of questions: 1. When is Lantus recommended twice a day? And why? There are other insulins with higher concentrations. 2. What is the maximum dose that can be used with Lantus?</p>	<p>generally, giving lantus once a day works well for most people. There is no "too much" dose. But, if a person is taking more than 100 units a day, the provider may split the dose into 2 for injection comfort. However, if a person is on high dose of basal, need to consider if they would benefit from bolus add on.</p>
<p>Is correction scale like sliding scale ?</p>	<p>it is different. It is a scale you ADD on to the prandial coverage (it is not stand alone insulin dose)</p>
<p>Can you do glargine am and bedtime same day??</p>	<p>yes. you can give glargine BID, but most people get benefit taking it once a day</p>
<p>We are converting NPH to Glargine do you follow same rule 20% reduction?</p>	<p>yes.. always best to be cautious then increase : -)</p>
<p>Is weekly insulin on the exam? If so is there a cheat sheet? And can T1 persons take weekly insulin or only studies on persons with T2?</p>	<p>weekly insulin is not approved yet.. so it won't be on the exam ..when it is released, we will add to pocketcharts</p>
<p>When would you use U100 vs u200 or 300 for basal?</p>	<p>if person is one more than 100 units a day</p>
<p>When would you recommend ultrafast-acting insulins over fast acting insulin?</p>	<p>usually for people with type 1 if they are having elevated post prandial bg on their current insulin</p>
<p>Do you adjust 1:c based on 2 hr ppg or 3 hr?</p>	<p>yes, based on patterns (not one result)</p>
<p>How often can the pt give correction if their glucose is not coming down? hourly, every 3 hrs</p>	<p>every 4 hours</p>
<p>What are your recommendations for managing bg for individuals who have erratic eating and sleeping pattern on MDI and need to correct constantly to avoid stacking?</p>	<p>Automated insulin delivery system : -)</p>
<p>Could you clarify if the PM to AM drop BG should be less than 30 points or less than 50 points to adjust basal?</p>	<p>less than 30 points is optimal, but a greater than 50 drop is when overbasalization is especially concerning</p>
<p>What makes a follow on NOT interchangeable?</p>	<p>regulations - since they are biologicals and more complex to manufacture, there are different guidelines than more basic medications</p>
<p>Why is 4 units a good starting bolus dose? Just a small enough dose to not cause hypo? Can you explain the rationale?</p>	<p>yes.. this is for people with type 2 and this dose assumes people eat about 45-60gms of carb per meal, plus their bg is above target range.</p>
<p>I know these questions are med focused, but wondering how common it might be to use a CGM or CGM pro to get more BG data before making med changes?</p>	<p>sure,.. especially for those on insulin or experiencing hypo (so insurance can cover)</p>
<p>If patient needs high doses of basal insulin, is it better to divide the doses two times daily?</p>	<p>the basal doesn't work better if it split in half. if people are on more than a 100 units at a time, it can indicate that they are on too much basal and need some bolus</p>

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why did we use 1800 instead of 1700	you can use either 1700 or 1800 rule
what is the recommendation when switching an Intermediate to a slower acting insulin such NPH to LANTUS? Would it be correct to increase the dose?	we would either use the same dose if their A1C is elevated or decrease by 20% to be cautious and gradually increase dose based on fasting bg response
what does YFGN stand for	No more side effects, exact same process to make. It costs the same to manufacture, they just charge less.,it is just the chemical name
I would love to get rid of the glipizide d/t it's risk of hypoglycemia	it is very effective - lower's A1C 1-2% points and helps people in glucose toxicity . but it does have that dang side effect
Can the 40/30/30 be changed to 30/30/40 for example depending on the patient?	sure, insulin dosing is always customized based on the ind and the glucose levels
Telling the patient to decrease their basal, is that prescribing?	yes, so you if you do not prescribe in your role or have a collaborative practice agreement, you would need to recommend it to their provider.
in what A1C level you recommend to start insulin in addition of the diabetes medication?	ADA says when A1C is 10% or greater or if the person has signs of hyperglycemia.
does generic insulin have more side effect compared to brand name? what chemical difference in generic insulin the make it cheaper cost manufacturing it compared to the brand name?	no more side effects.. they use the exact same manufacturing process. same cost to make, they just sell it at a lower price.
what is the short life of regular insulin? For patient without insurance, can over the counter regular insulin be used as basal insulin or used it as bolus insulin?	regular insulin lasts 4-6 hours.. it is only a bolus insulin. You can get 70/30 insulin which combines basal + bolus and you take it before breakfast and dinner
I know not every state has a walmart but not sure if other states have a pharmacy that sell some insulin over the counter? Here in Louisiana walmart pharmacy's sell NPH, 70/30, and regular insulin over the counter for 25 dollars a vial.	yes, you are right.. reg, nph and 70/30 are sold otc : -) in the US

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Question Asked	Answer Given
if 130 gm cho is minimum per day for non diabetics, what is it for diabetes? Or if less than 130 gm cho per day must be under clinical supervision?	The American Diabetes Association (ADA) gives no specific guideline for amount of carbohydrate to consume each day. Their recommendation is to individualize based on dietary pattern. Depending upon eating pattern, people with diabetes may consume more or will consume less carb than 130 grams. Most individuals consuming less than 130 gm carb do not required medical supervision. Very Low Carbohydrate Diets (less than 26% of Carbohydrates) may warrant review with a provider depending upon medication use or other complications but as a dietary pattern it currently has evidence of being a option to support glycemic management. Very low Calorie Diets (less than 800 calories) we recommend for need medical supervision.
Is the 6% fat or less for total kcals per day or fat grams per day?	There is no specific ADA recommended fat or saturated fat intake limit. The ADA guidelines focus on quality vs quantity- Eating less saturated fats and more polys and monos. The mentioned less than 6% of Calories from Saturated fat is not an ADA guideline but is based on American Heart Association recommendations. The Dietary Guidelines state less than 10% of calories from saturated fat.
Is the risk of DKA with low carb+SGLT1 independent of being on insulin or with insulin?	people with type 1 or taking insulin are at higher risk.
How much carbs for low bg treatment would you recommend when on an insulin pump?	Usually we would say 15gm, but we need to individualize our recommendations, esp on AID pumps, as Diana discussed yesterday.
Do you deduct added sugar for insulin dosing only for T1DM or also for T2DM on insulin?	Hmmm, added sugar is included in insulin dosing for type 1 and type 2 since it is a carbohydrate. We consider subtracting sugar alcohols but not total added sugar (that is part of the total carbs).
is the protein goal based on current wt or ideal wt?	Current weight
For Omega 3and TG reduction, would an over-the-counter omega3 work or it has or be the ester rx form?	Here is a helpful resource https://www.nccih.nih.gov/health/omega3-supplements-what-you-need-to-know
in terms of vitamin Da and calcium supplements, are there any data on worsening of atherosclerosis and arterial calcification with these supplements?	It looks like this topic is under investigation https://e-enm.org/upload/pdf/enm-2022-1644.pdf
Without being judgmental, how do you address food access issues with a homeless individual with an a1c of 10?	We could ask them if they are interested in accessing resources for food in their area or provide referral to social worker. We could also provide support in problem solving around lowering BG levels, exploring the many ways we can support glucose lowering. As long as we are in a person centered zone and we listen with compassion, we are less likely to engage in judgment.
Regarding net carbs, the ADA recommends not subtracting fiber or sugar alcohols. However, it makes sense to subtract them due to insulin needs. So...to subtract or not to subtract, that is the question. :) https://diabetes/food-nutrition/understanding-carbs/get-to-know-carbs	For a person with type 1 who is very insulin sensitive, it may be helpful. For people with type 2 or less insulin sensitivity, it may not impact glucose that much. Agree, for most people we don't recommend subtracting fiber or sugar alcohols but even with older guidelines the recommendation was never to subtract all of the fiber/sugar-alcohols because we do see both are both still partially digested. Definitely keep is simple and only recommend this when applicable.

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Question Asked	Answer Given
<p>if patient is told to follow a low fat diet for gallbladder issues or something like that, how much fat is considered "low" fat And is there a number that defines "food high in saturated fat"?</p>	<p>Less than 30% of calories from fat is generally recommended. Here is a great link to the Academy Resource: https://www.eatrightpro.org/news-center/practice-trends/medical-nutrition-therapy-recommended-post-cholecystectomy. In practice I have also found addition of soluble fiber to be supportive.</p>
<p>I suppose if having a mixed drink, you would need to add the soda, the fruit juice, and the shot of alcohol? or is there a quick general rule for patients going to the bar and wouldn't know this? Same kind or thing with dry vs sweet wines</p>	<p>our general rule of thumb is to eat 15gms of carb with each drink (wine, beer, hard liquor.) If they are drinking a mixed drink with added sugar, they may experience elevation of bg first, followed by hypo .. depending on insulin, food in stomach etc</p>
<p>is the hypoglycemia from alcohol a delayed response or would that be more immediate? any idea on how long we should be monitoring for that?</p>	<p>If a person drinks on a empty stomach without eating food, the effect can be within the hour. If someone has food on board or is eating along with drinking, the impact can be delayed for up to 8 hours. Type of alcohol or mixed drink may also impact this.</p>
<p>Did I mishear or did she say earlier that >9 hours of sleep increases risk?</p>	<p>yes, you heard right : -) A study found that those who regularly slept longer than 9 hours, or those who regularly bounced back and forth between sleeping less than 7 hours and longer than 9 hours, had a 50% higher risk of diabetes compared to those who regularly slept 7-9 hours.</p>
<p>Did you say <6 & > 9 hrs. of sleep increase risk for DM?</p>	<p>Yes.. A study found that those who regularly slept longer than 9 hours, or those who regularly bounced back and forth between sleeping less than 7 hours and longer than 9 hours, had a 50% higher risk of diabetes compared to those who regularly slept 7-9 hours.</p>
<p>how many visits per month does insurance allow for patients to see outpatient dietitian for diabetes management?</p>	<p>Commercial insurances can vary but Medicare coverage is as follows: Initial MNT: During the first year, individuals may receive up to 3 hours of individual MNT counseling from a registered dietitian. Follow-up MNT: Subsequent years may have coverage for 2 hours of MNT. If medical necessity warrants with an additional an additional referral within the same calendar year can be provided. Here is a great resource: https://www.medicareinteractive.org/understanding-Medicare/Medicare-covered-services/preventive-services/medical-nutrition-therapy#:~:text=You%20can%20receive%20more%20hours,you%20qualify%20for%20this%20service.&text=If%20you%20qualify%2C%20Original%20Medicare,services%20from%20a%20participating%20provider.</p>

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Question Asked	Answer Given
<p>some patients with diabetes are very interested in weight loss through intermittent fasting (fasting at least 12 to 16 hours). I had some non-diabetic patients whom had success with intermittent fasting. For individuals with diabetes, I am concerned about hypoglycemia. How do you counsel patients on this? I think as long as patients not on insulin/sulfonylureas/meglitinides, maybe intermittent fasting will be ok?</p>	<p>Yes, we agree some people have great success with intermittent fasting. You're right, if they are not on insulin or sulfonylurea, there is very low risk of hypoglycemia. When on high risk of hypo meds they will need to match med timing to meals. If available, CMS can be helpful to understand individual glucose patterns and hypoglycemia risk.</p>
<p>How many hours after consuming alcohol the patient may start experiencing hypoglycemia?</p>	<p>If a person drinks on a empty stomach without eating food, the effect can be within the hour. If someone has food on board or is eating along with drinking, the impact can be delayed for up to 8 hours.</p>
<p>if the patient has twins or triplets, how much carbs per day should the person take?</p>	<p>Additional carbohydrates needs is based on fetal brain development- When pregnant with twins or triplets we individualize and calculate nutrients needs to meet individual demand. IOM suggests carbohydrates intake comprise 45-65% and ACOG states 40-50% in GDM. The RDA is based on meeting needs for most women = 175 grams. ACOG does not have a specific carbohydrate amount for twins, but some reviews have suggested minimum of 208 grams per day to support fetal development, prevent ketones, and aid in weight gain. It's also important to choose complex carbohydrates like fiber-rich foods for digestive health. For an update addressing carbohydrate needs in pregnancy this article is interesting for review: https://doi.org/10.1016/j.ajcnut.2022.09.005.</p>
<p>for patients does not want stool softener and prefers prunes or dates for bowel movement, how many dates or prunes can they eat in a day to avoid big spike in their blood sugars?</p>	<p>3 prunes is about 15gms of carb.. so they could certainly incorporate that into meal plan without too much worry of glucose spikes. Kiwi is another fruit shown to increase bowel movements. I think it is also important to assess fluid intake and daily movement to support reduced constipation, esp with Incretin therapy use.</p>
<p>I love the case study examples. Is there a separate book that can be purchased with just case studies to help prepare for the Exam.</p>	<p>Yes, the ADCES Desk Reference has lots of case studies that are very helpful for the exam https://diabetesedstore.net/collections/books-study-tools/products/e-book-adces-desk-reference-6th-edition</p>
<p>Would you recommend using an app like MyFitness Pal to individuals to help them track?</p>	<p>Many people enjoy using apps and gamifying their healthy eating and activity goals. Others, may not resonate with apps. So, I think it is up to the individual. We have a great cheat sheet on diabetes app that you might find useful.</p>