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Diabetes Educators EmpowerED: Strategies for Optimizing Patient Outcomes With Emerging Weekly Insulin Therapies

Announcer:
Welcome to CME on ReachMD. This activity, titled “Diabetes Educators EmpowerED: Strategies for Optimizing Patient Outcomes With Emerging Weekly Insulin Therapies” is provided by Clinical Care Options, LLC dba Decera Clinical Education in partnership with the Academy of Nutrition and Diabetes Dietetic Practice Group.

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Dr. Isaacs:
Why does all of this matter? We have more therapies than ever. We have more technology tools than ever. It is a really exciting time. Just because we have the tools does not mean everyone is going to benefit from them.

One, it is making sure people are aware of the tools and the therapies that are out there. The other thing is making sure that these new tools and therapies fit into someone's life. If we just offer things and throw things at people, it does not mean there is going to be uptake, especially if they are not provided with education about why these could be helpful, how they could fit into their lives. With more tools and choices than ever, it is awesome but it also means there is a real opportunity for us to individualize care.

We cannot just say, “Oh, well, let us give everybody a pill box. You are not taking your meds. Here is a pill box.” That only solves one type of medication taking problem. We really want to think about all the tools that are out there. Let people know about them and see how we can individualize them.

2026 ADA Guidelines: Care Optimization Principles

What do our ADA standards of care say about all of this? We are very fortunate that our guidelines are updated every single year. Also we have the ACE guidelines as well. The American Association of Clinical Endocrinology and their guidelines have just been updated in 2026 as well. Both emphasize person-centered care about individualizing treatment selection, but also having this shared decision-making that we let people know about the options and then we discuss together what may work or maybe what is not going to work as well.

Also, it is critical to have diabetes education and specifically DSMES is Diabetes Self-Management Education and Support. Our guidelines recommend, yes, this should occur at diagnosis, but also we should be re-evaluating the treatment regimen. When there is treatment adjustments or a new therapy being considered, we should continue to have diabetes education.

Also if we are not meeting the goals, which unfortunately about half of people out there are actually have A1Cs over 7%, meaning that most people are actually not meeting their goals, despite the fact that we have all of these different tools. We constantly want to be assessing but also reassessing.

The other thing I will say about this is maybe on paper it looks like someone's at goal. Maybe their A1C is less than 7%, but maybe they are not happy with what their treatment, the burden of their current regimen, maybe they would still benefit from a change. So we should

still be re-evaluating that.

Identifying Patients Who Require Diabetes Care Optimization

I know we are all seeing tons of patients out there. There are more people than ever living with diabetes. How do we prioritize? Who do we need to optimize versus can we let it go status quo, right?

Definitely if you see persistent A1Cs above that individualized target, and while we have an A1C goal of less than seven for many or for most, sometimes older adults, people with more complexities, more comorbidities, we might have a higher goal of less than 8%. In younger, healthier people, we may be aiming for less than 6.5%. Also, we are not just A1C focused. We are fortunate. Many people are using continuous glucose monitors or CGM, in which case we are usually aiming for 70% or more in that target range of 70 to 180.

Sometimes we see, especially if we ask about it, there is a discordance between what is prescribed and what is real world use. One of the things, we have got access to it. We can see the refill records and sometimes we can see how often is someone picking up their prescriptions, how often are they getting it? Also just by having that conversation, maybe something is prescribed a few times a day like their prescribed mealtime insulin, or they are prescribed a long-acting insulin, but they are not actually taking it.

The other day I asked someone, well, how often do you miss your long-acting insulin? He says, “Oh, not that often at all.” I said, “Well, how many doses do you think you may have missed in the last week?” He goes, “Oh, three or four.” His definition of not that often was very different than my definition of not that often.

Then also when someone has new comorbidities, we know that certain medications are really geared toward benefiting cardiovascular disease or kidney disease. Even if someone is at their glycemic goals, we may want to adjust therapy to really use evidence-based treatments to address those other conditions.

Glycemic Appraisal in Diabetes Care

In terms of glycemic appraisal. Thinking about candidates for treatment intensification, definitely if A1C or CGM metrics are not at target, maybe someone is having too much hypoglycemia or their A1C and their time in range is too much above range. If we see that there is actually fasting hyperglycemia or maybe just a basal insulin insufficiency, there is definitely hesitation amongst people to start a long-acting insulin, or we will sometimes see people are started on 10 units and it is really never optimized or it is not optimized for a couple of years.

Also really self-management capacity. Is someone able to do all the things with the monitoring and taking their medications, or would they benefit from having some help or being able to simplify the regimen?

Certainly, if there is a lot of hypoglycemia or recurrent or hypoglycemia unawareness, we really want to look at, are there ways that we can make this simpler and also decrease the burden and the risk of hypoglycemia? Maybe we do not need such intensive glycemic targets.

Also sometimes, we add things to get a little bit of benefit, but we have to ask ourselves, is this really worth it, all these extra medications when it could be adding risk of hypoglycemia or other potential adverse effects?

Comprehensive Risk Assessment in Diabetes Care

Very importantly, we want to be aware of other comorbidities. In fact, in our type 2 diabetes treatment algorithm with the ADA, they have, on the left side of the algorithm, we should really first be asking, does a person have heart failure, kidney disease, or atherosclerotic cardiovascular disease or high-risk of ASCVD? Then we want to make sure we are using the therapies that have shown benefit for those conditions. If not, then we are really selecting therapies based on their glycemic lowering, as well as often the weight decrease as many people benefit from losing weight with type 2 diabetes.

That is not enough because we also want to look at individualizing of are there functional limitations that make it difficult to use certain medications or take them at certain times or the frequency. Psychosocial stressors is a really big one as well. What is the burden? Is somebody experiencing diabetes distress or depression, which is making it difficult to take their medications? We really need to individualize all of this together.

Diabetes Treatment Optimization: Design and Implementation

What does optimization look like in practice? That could be simplifying the dosing frequency. Instead of taking something multiple times a day or multiple times a week, is there a way to decrease that to once a week for example? Can we decrease the injection burden? Can we align medication taking to a person's routine to make it easier to remember to take it?

Ideally, identifying the barriers before they even present themselves. Then in terms of some of the implementation strategies that can really help, are anchoring dosing to an existing routine. Or in the case where someone is having trouble maybe remembering, or I have got patients who just hate injections and will have a family member give their injection, which is great if their family member is home. But if their family member works all day long and they need insulin during the day, that is a real challenge, right? If we can decrease the frequency, that can really help.

I am a big fan of the teach-back method because it is really easy to ask someone like, "Do you understand?" And they nod. If you can say, "Hey, we went through a lot today. Can you show me how would you give this insulin, or how would you give this medication or this device? Or what do you remember about this?" Then that way you can see what they have learned and then just help fill in the gaps as needed.

Lifestyle and Technology Integration With Support Tools

I am a huge fan of technology. We are so fortunate now to be in a time where we have more tech than ever, and especially our guidelines really advocate for anyone on insulin now to have access to continuous glucose monitoring. They even go a step beyond that. They say anyone who would benefit, really we should be able to offer them CGM.

One of the great things about CGM is they have done a really great job of incorporating more AI into it and more education into it. For example, now people can do things like take pictures of their food and see the trends of their glucose before and after eating, and really learn how different foods or how exercise is impacting their glucose level. It can really lead to positive health behavior changes.

There is also several other mobile apps out there that have education embedded that can really support the healthcare team and the person with diabetes in between visits.

Once-Weekly Insulin: Who to Consider and Why It Matters

This brings us now to a critical topic we are talking about today, which is once-weekly insulin. It is very exciting because recently we have had a once-weekly insulin that got FDA-approved.

Why do we need this? Why does it matter? Well, many people struggle with taking insulin and many people need insulin. Of course, anyone with type 1 diabetes needs insulin to live. Even with type 2 diabetes, even with all of our latest and greatest GLP-1 drugs and SGLT-2 inhibitors, people are developing type 2 diabetes at younger ages. We are seeing kids, teenagers, young adults being diagnosed with type 2 diabetes. Thankfully, they will hopefully live very long lives with diabetes now, thanks to our new therapies.

The natural progression, when you have been living with it for 10, 20, 30, 40 years is those beta cells that make insulin, they start wearing out. So the body needs a little bit of help. It needs some insulin to maintain those glucose levels in target and hopefully prevent any potential diabetes-related complications. That is where insulin really comes in.

Insulin can be challenging, right? It is an injectable medication. Long-actings have traditionally been once or twice a day. This idea of a weekly insulin, where you only have to take it once a week. If you do not like injections, you only see that injection once a week.

You could imagine how enticing that would be for people. We have seen this with the GLP-1 agonists. Even though people did not love the idea of injections, when it was just once a week, they said, you know what, I am willing to do this. In fact, I want to do this. A once a week has so much potential.

Also, it is a lot more forgiving with missed doses. If you forget in a day, you can take it the next day and it is still in your system because it has a long half-life. There is really a lot of benefits to this unique form of therapy.

The Diabetes Playbook: Summary

Some concluding remarks in my section for this diabetes playbook. Remember, our ADA standards of care, our guidelines which are updated every year. They emphasize individualized, person-centered care. That treatment optimization really requires us to look at the whole person, have that conversation, see what their comorbidities are, see what their problems that they are having with their current regimen. Even if everything looks good on paper, we should always be asking and determining can we do more? Should we be adding a medication? Can we simplify it?

Then we follow this up with education. We also look at the technology tools that can support us in practice, like CGM, like various mobile apps. Now we have this emerging once-weekly insulin that truly has the potential when paired with diabetes education, to help people to achieve their glycemic goals and live their best lives with diabetes.

Elevate and Empower: Clinical Case Study Discussion

With that, we are now going to get into our clinical case study discussion, and we would like to keep this interactive and have you included in the discussion.

Patient Case: Meet Maria

I am going to present this patient case. Then we are going to go through a couple of questions related to this. We have Maria, who is a 56-year-old female, and she presents for a counselling visit with persistent hyperglycemia despite optimizing therapy. She has had type 2 diabetes for 12 years. She has obesity, her BMI is 33. She actually has lost 10% of her body weight over the last 10 months on tirzepatide.

She also lives with hypertension and dyslipidemia. Her most recent A1C is 8.6%. She has a GFR that is normal, and her fasting glucose is between 160 and 180. She is taking metformin 1000 milligrams twice daily, tirzepatide 15 milligrams weekly, empagliflozin 10 milligrams daily, lisinopril 20 milligrams daily, and atorvastatin 20 milligrams daily.

Some of her concerns include that she is overwhelmed by her diabetes. She is on several medications. She occasionally reports missing oral doses. She has heard she may need insulin and she is very anxious about that. She is a little curious about this emerging once-weekly insulin.

Poll 3

Our question for you is, based on Maria's presentation, which factor most strongly supports the need for care optimization? Our choices are:

A. Cardiometabolic comorbidities contributing to complexity;
B. Persistent fasting hyperglycemia despite optimized therapy;
C. Suboptimal dosing of a GIP/GLP-1 receptor agonist; or
D. Variable adherence to injectable medications.

It looks like most of you picked persistent fasting hyperglycemia despite optimized therapy. That is exactly the correct answer. She is already optimized on tirzepatide. She lost 10% of her body weight. Clearly, despite being on the best therapies, SGLT-2 inhibitor, she is on the GLP/GIP agonist. She is on metformin already. Her fasting glucose is elevated. We want to address that.

Poll 4

That brings our next question. What is the most appropriate role of the CDCES at this point in Maria's care?

A. Deferring insulin-related discussions until glycemic management worsens;
B. Directing lifestyle modification as the primary intervention;
C. Evaluating readiness, addressing barriers and supporting shared decisions; or
D. Recommending basal insulin initiation and selecting a dosing plan.

It looks like most of you guys are rocking this: evaluating readiness, addressing barriers and supporting shared decisions. Even though we are probably all thinking we want to start a long-acting insulin, if we do not do that first, we could start it and she will never actually stop it. So you guys did great.

I am now going to turn it over to Dr. Pratley.

Treating for Success: New and Emerging Therapies for Improving Glycemic Management

Dr. Pratley:
Diana, that was a great overview and introduction. I wanted to touch on a couple of things you said. The first was about personalized therapy. When you think about it, we have been practicing personalized therapy in diabetes since we had the invention of insulin over 100 years ago.

We give the right amount of insulin at the right time to the right patient, and we adjust it according to their needs that change over time. Everybody else, all the other therapeutic areas are getting on this personalized therapy bandwagon. We know how to do it. We have been doing it, and CDCES are critical to educating the patient how to do that.

A couple of other things I thought as you were talking. There has been a lot of focus on the cardiovascular benefits, kidney benefits of some of our new medications. Those are great. We do need to emphasize reducing those risks. But A1C is still important. Even our best drugs sometimes do not get people to go. We need insulin as an option. Insulin is still important.

You also mentioned the GLP-1 experience. We started out with twice a day GLP-1, exenatide. Now I am old enough to remember that. I do not think anybody else online is. As we progress to once-daily and then once-weekly, we found that the patient satisfaction, your willingness to give the injections was much higher. That is part of the rationale that helps to support a once-weekly insulin. It is a little bit out of the box, we have to admit, but it is something that is well supported by our clinical experience.

Emerging and Investigational Insulin Therapies for T2D

I am going to talk about some of the new data on the once-weekly insulin therapies. We have had, of course, once-daily insulin therapies for a long time and they work great. What is the rationale for a once-weekly therapy? The idea is that exactly what you said, Diana. Fewer injections may reduce the treatment burden and improve persistence.

One of the things that you said was you had a patient who said, “Well, he missed two or three doses of his basal insulin a week.” That impacts on glycemic management, for sure. One of the strategies I use is, I say when I am talking to my patients, I want to get an idea about whether or not they are very adherent to the regimen. I say many patients have trouble taking their insulin doses on a regular basis. That is just part of the game.

How often do you think you miss? I phrase it by saying that this is a common problem and how often do you have the problem? That helps reduce the barrier to admitting that you miss injection therapy.

Now, because the once-weekly insulin therapy is, as I said, out of the box, this does require a strong implementation plan as well as monitoring when people initiate the drugs. It is not exactly set it and forget it. We do think that is going to be helpful over the long term for many patients.

There are two products. Insulin icodec, this is a once-weekly basal insulin. It has about one week half-life. It has been approved in Canada for a couple of years now, Japan, Australia, China and Europe. We have some clinical experience around the world.

The exciting news is, on March 26th, not that long ago, it was finally approved by the FDA. So it should be available, if not already, very soon.

There is also insulin efsitora alfa. This is a once-weekly Fc-fusion based basal insulin with a 17-day half-life. Now, this is a mechanism which creates a large molecule that has a very long-half life, and it has been used for other therapeutic areas, including in other products in diabetes. This is another proven approach to prolongation of drugs. It is another once-weekly type of insulin that we will investigate.

What Is Pharmacologically Different?

Pharmacologically, if you look at the pharmacokinetic profiles, what is different about these once-weekly insulins? The answer is, of course, they work for a long time. This is a time action profile for weekly insulin compared to basal insulins. Over here, these longer products like detemir, glargine and degludec.

If you can summarize it, it is just they have a flatter PK profile. You are not going to have a peak. Reduced variability is a very important feature because it helps to reduce risk for hypoglycemia and because it can be given weekly a reduced treatment burden.

I guess we can call these ultra-long-acting insulins. They provide the stable exposure. As I pointed out already, there are distinct ways to make these drugs prolonged. Albumin binding for insulin degludec. Then the large Fc-conjugated molecule which decreases the clearance.

Benefits and Risks of Once-Weekly Basal Insulin

What are the benefits and risks of once-weekly basal insulin? Now the potential benefits we have already touched on: fewer insulin injections, potentially improved acceptance, persistence. Simplified routines. This is important for many patients who are busy and have trouble working insulin therapy into their schemes. It is also important for patients, like you mentioned, Diana, who might require help from another individual for their insulin dosing.

The opportunity to pair with CGM and decision support is an evolving area. This drug class has some interesting data in that regard. Then patient-reported satisfaction. There is evidence from the clinical trials that patients are satisfied more so with these drugs than the typical basal insulin. That is all positive.

There are risks because these drugs have a longer half-life. If you over titrate, it is harder to undo that effect. One of the things that is potentially actually a benefit is that missed doses show no immediate loss of efficacy. To your point, Diana, if somebody misses a dose or delays a dose, they can still have pretty good glycemic efficacy, but we have to be concerned about the people who miss their weekly injections.

There is an issue if patients have acute illness or surgery. We have to be particularly careful in those individuals. Then as in all patients and especially those treated with insulin, we have to be concerned about hypoglycemia risk. Because we are giving large doses of insulin at a single time, people are concerned about the risk of hypoglycemia with this class of ultra-long-acting insulins. As I will show you, that turns out to be not a significant difference from what we already are very accustomed to using.

Insulin dosing with these ultra-long-acting insulins is not terribly different. We are still using a treat-to-target strategy using fasting glucose levels. That is pretty much similar. What is different though, is that the dose changes are less frequent every one to two, four weeks, for example. We will see that in some of the clinical trial data.

Then when we are switching to a once-weekly insulin, it may require a loading dose because it takes a while for these drugs to come on board. Lots to consider as we are looking at the data.

ONWARDS 1, 3, and 5: Once-Weekly Insulin Icodec in Insulin-Naive Patients With T2D

I am going to fly over some of the data for these two products. The idea here is not to make you an expert in all of the clinical trials, but to give you a flavor of what has been done and what the results are.

For insulin icodec, the ONWARDS 1, 3 and 5 trials were using this insulin in insulin-naive patients with type 2 diabetes. In ONWARDS 1, it was compared to insulin glargine. ONWARDS 3 to insulin degludec. ONWARDS 5 was a unique 52-week trial that compared it to basal insulin analogs using a dosing app.

Let us look at some of those results.

ONWARDS 2/4: Once-Weekly Insulin Icodec Switch in Patients With T2D Previously Treated With Daily Basal ± Bolus Insulin

Before I do, ONWARDS 2 and 4. You probably wondered what happened to 2 and 4, when I was presenting 1 through 3 and 5.

ONWARDS 2 and 4 were insulin degludec in patients who were previously treated with basal insulin with or without bolus insulin. This was an insulin switch type of trial. ONWARDS 2, it was icodec versus insulin degludec. ONWARDS 4 was a 26-week trial of icodec versus insulin glargine, again with daily bolus insulin injections.

ONWARDS 1-5: Mean Change in A1C ETD of Once-Weekly Insulin Icodec vs Daily Insulin in Patients With T2D

Those are the trials and the structure of the trials. What do we know from those trials? Here is the mean change in A1C, the estimated treatment difference of once-weekly icodec versus daily insulin.

What you can see is that in almost every instance, except for ONWARDS 4, there was a small but significant difference in the A1C difference at the end of the trial. Now, in not all cases was this statistically significant. But in all cases, the A1C control was non-inferior. So as good as the once-daily insulin dosing.

QWINT-1/2: Once-Weekly Insulin Efsitora Alfa in Insulin-Naive Patients With T2D

Now I want to switch over to the QWINT studies. These are the studies with insulin efsitora, the other product.

QWINT-1 was a 52-week trial, again compared to daily insulin glargine. QWINT-2 was a 52-week trial compared to daily insulin degludec. The advantage of all these trials is that we are getting a very good picture of how these long-acting insulins compared to our usual once-daily insulin degludec and glargine.

QWINT-3/4: Once-Weekly Insulin Efsitora Alfa Switch in Patients With T2D Previously Treated With Daily Basal ± Prandial Insulin

QWINT-3 and 4 are similar in that they are looking at insulin efsitora in patients who were previously treated with basal insulin with or without prandial insulin. Again, we are comparing to insulin degludec in QWINT-3 and glargine in QWINT-4.

QWINT-1, -2, -3, and -4: Key Outcomes of Once-Weekly Insulin Efsitora Alfa vs Daily Insulin in Patients With T2D

Here is the main results from these studies. You can see that compared to daily insulin comparator in blue, very similar, if not better reductions in hemoglobin A1C over the course of the studies.

Now, in terms of things like hypoglycemia, there was a suggestion with efsitora that there was less hypoglycemic events versus glargine. Now with hypoglycemia and events like that, we do not typically do statistical testing. We are looking at trends in the number.

In QWINT-2, no reported severe hypoglycemic events with efsitora versus degludec. QWINT-3, similar rates of severe and clinically significant nocturnal hypoglycemia events. QWINT-4, nocturnal and clinically significant events were actually a little bit lower with efsitora compared to insulin glargine.

Now, again, these give us a range of events. The take-home message is that with both once-daily insulins and with once-weekly insulins, the rates of these significant events are low, and they are not significantly different between the two groups of patients.

Ensuring Safety in the Real World With Insulin Therapy

How do we ensure safety in the real-world with insulin therapy and in particularly the long-acting insulins?

During illness, surgery, other stressors where we are not anticipating that usual intake and activity levels, we have to be aware of fluid intake, the potential for dehydration and potentially insulin sensitivity shifting. This is where glucose monitoring is critically important, and specifically continuous glucose monitoring can play a very important role. We need to adjust insulin therapy cautiously to avoid risk for ketosis or hypo or hyperglycemia.

Hypoglycemia risk mitigation occurs with individualization of targets, teaching patients how to recognize and act on hypoglycemia. Importantly, how to use their continuous glucose monitors to predict risk for events. Prescribing glucagon for patients with insulin, reviewing events when they come back to clinic and discuss with us, and importantly, down-titrating insulin therapy.

If people are having frequent events that are unexplained, then we should really think about whether or not they need to have their dose decreased.

This all comes down to education. CGM use, we talked about. Using the teach-back approach. Then digital titration support with apps can be very helpful as well.

Practical Management: Once-Weekly Insulin Icodec

For insulin icodec, specifically, the concentration of insulin icodec is U700. That in and of itself is a difference. It is a very concentrated insulin. We need that in order to provide enough insulin to make it through the week. In insulin-naive patients, the starting dose is 70 units per week.

Now that sounds like a lot to start somebody on insulin. Remember, this is over a week's worth of insulin. That really works out to about 10 units per day. Not so bad. Then it is adjusted weekly based upon the fasting glucose levels.

When people are switched from a daily insulin, you calculate the dose by taking the total daily insulin dose of the basal insulin that they were on, multiplying it by seven. If they were on, say, 30 units, that would be about 200 units of once-weekly insulin. Then add an additional 50% for the first injection only. The purpose of this is, again, because the insulin is very long-acting, it takes a while to get on board, so you need a little bit of a loading dose there.

To titrate, we are targeting self-monitored fasting blood glucose levels, could be done with CGM or self-monitored blood glucose levels. Then with insulin-naive patients adjusting once-weekly. In switch patients, titrating as necessary weekly, every other week, or even less often to maintain their fasting glucose target.

Keep in mind that if the fasting glucose is at target, but the A1C remains elevated. These are individuals in whom prandial hyperglycemia is likely to play an important role. And CGM, again, can be very helpful.

Practical Management: Once-Weekly Efsitora Alfa

For insulin efsitora, the instructions are different. The fixed dose insulin efsitora is U100. It is adjusted as needed. The target is around U400 to U500. U300 is the starting dose on week one, then U100 starting at week two in the QWINT-2 trials. It is a little more complicated.

For switch from daily basal insulin, again, we are multiplying the total daily basal insulin dose by seven. Then at the first dose, we are using that total insulin dose multiplied by three if the fasting glucose is above 120. A little bit more complicated for calculating your insulin doses, but very doable.

Titration, we are again, following fasting glucose levels, in this case every two to four weeks or so. Then every four weeks thereafter. When we are switching from daily basal insulin, we are going to look to see where the fasting glucose stays and then titrate accordingly.

Clinical Pearls for Patient Selection

Just to summarize some of the clinical pearls for patient selection. Who would we select for a once-weekly insulin? You could look at insulin-naive patients who have insulin injection reluctance. Patients who do not want a big burden of insulin therapy, as Diana already mentioned.

People who have relatively predictable routines and are currently monitoring glucose levels or pre-meal glucose levels are ideal

because we are going to need that information in order to titrate effectively. There is no issue in using incretin therapies or SGLT-2 inhibitors with basal insulin as well.

Those who require some extra caution could be those who have hypoglycemic unawareness. You can assess this using either the Clarke or Gold score, but just ask questions about hypoglycemia. Then also look at their CGMs if they are wearing one.

Individuals who had three prior episodes of severe hypoglycemia would be at higher risk. So we have to go carefully with those individuals, as we would with older and frail adults. Individuals that have variable food intake, and particularly individuals who schedule changes from day to day or week to week, could be at higher risk and might require extra education.

Then people who are already making frequent basal insulin adjustments may not be the ideal candidate at that point.

Take-home Message

Our take-home messages, the high level messages are that once-weekly basal insulins are consistently noninferior, and in some cases, slightly better at improving A1C versus daily basal insulins across the large phase III trials. That is really good positive news.

In general, the hypoglycemia risk is very low with these ultra-long-acting insulin and very comparable to daily basal insulin therapy. The long-term use means the titration and monitoring strategies are very important, especially during transitions, so from a basal daily insulin to these ultra-long-acting insulins.

Fewer injections, we have already seen in GLP-1 space can improve treatment satisfaction and improve medication taking behavior. Ways we can help to further improve adherence are to pair the insulin with CGM with reminders and apps. Then these medications are ideal for adding on to incretin or SGLT-2 inhibitor therapy. The fact that somebody is on one of these drugs for cardiovascular disease or kidney disease and are not at glycemic goal makes them a good candidate for a basal insulin therapy.

Elevate and Empower: Q&A Session 1

Let us then move on at this point. We have a little bit of time to do some questions at this midpoint. I think you would probably like the chance to ask a few questions rather than just hear us talk. Let us see if there is anything in our Q&A chat. I see a couple of questions here.

One question is, given the typical constraints in consultation time, how can we best structure the initial patient education for once-weekly insulins? It is really important question. Diana, do you want to take a stab at that?

Dr. Isaacs:
Yeah, sure. It is really important to have a team. Every clinician hopefully has a team and thinking about who is available on your team, whether it is nursing, whether it is diabetes care and education specialist, whether you have a pharmacist, but it is not just weekly insulin. I mean, it is CGM, it is other therapies, making sure we can counsel people and provide that needed education to ensure they understand how to use it and keep them safe.

I would really try to think, who can you partner with? Do you have pharmacies you can partner with to ensure they are getting counselled at the pharmacy? Think about who you have on the team to ensure every person gets that education.

Dr. Pratley:
Very good. Let us take one more question. There are a lot of great questions online. Everybody is really engaged. Can we talk more about adjustment of these medications? For example, we can adjust glargine by a couple units every three days or so. What would that look like for these medications?

I tried to give you a little bit of a high level of that. Again, think of the insulin dose as being one seventh of what a daily dose is. You need to multiply your daily insulin dose by seven in order to get the right dose of the weekly insulin. If you are intent upon changing by, let us say five units, that would translate into an insulin dose adjustment of about 35 units per week.

Then again, because of the long half-life, you do not want to change it every two or three days. You want to have plenty of time for the dose to accumulate. That translates into dosing adjustments at a minimum of every week, but preferably generally every two weeks, in some cases every four weeks.

Okay. Great discussion, great questions. We are a little bit behind.

Dr. Isaacs:
Sorry. I just wanted to add one more thing in there. Just that with the icodec pen, it is actually going to go in 10 unit increments. In that case, you would round to 30 or 40. We do not know yet what the efsitora will look like, but just taking that into consideration too.

Dr. Pratley:
Yes. Really important points. Thanks, Diana.

Rising Above Barriers: Effective Implementation of New and Emerging Glycemic Therapies

It is now my pleasure to turn the podium over to Mara Fiorio. She is going to talk about barriers to effective implementation in these new and exciting emerging glycemic therapies. Mara?

Dr. Fiorio:
Perfect. Thanks, Dr. Pratley and Diana. Some of what I am going to talk about to, you guys touched upon. So it will be elaborating and making sure we really hone in on those points. I will shift us into what this actually looks like in practice because as we all know, having therapy is one thing and then getting it to work for patients in real life is another story. Let us talk about some of the barriers.

Barriers Occur at the Patient, HCP, and Health System Level

Before we get too much into how we are going to implement these therapies, we do have to acknowledge that, usually it is not the medication that is the problem, right? It is everything surrounding it. What we see in practice is that these barriers are not just living in one place, they are happening at multiple levels.

Yes, the patients have their barriers, which you can see there. Some of the ones that we see, but we have barriers as well as providers. Then the system itself adds a completely another layer on top of that. If we do not recognize all three, it becomes really easy to default to the thinking of, “Hey, this patient is just not adherent, when in reality there is a lot more going on.”

We will look at each of these barriers on the next slide again and break them down further.

Common Barriers to Implementing Emerging Glycemic Therapies

When we do that, you can see these barriers are common and a lot of times with education and support, they can be mitigated. At the patient level, what that looks like and what we are hearing is I do not want to mess this up. I do not have time for this. This does not fit into my schedule. Then, of course, for many patients, just that fear of injections is still a really big barrier.

We will talk about on the next slide how to overcome these. At the provider level, you guys know it. We have limited time, a lot of times and visits or patients come late. We are waiting too long to initiate or adjust the therapy. Then sometimes making that assumption that patients will follow through without really checking. Then at the system level, having those limited access to education gaps and follow-up. Those are all issues.

The big key takeaway here is these are not new barriers. These are all things that we have seen before with insulin with the GLP-1s. They are just showing up again in a new form.

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Knowing all of that, this is really where our role shifts from educating to implementing. This becomes even more important when we think about something like once-weekly insulin, because obviously Dr. Pratley has touched on it. Diana has touched on it. Yes, it will reduce the injection burden, but it also requires a different level of planning, consistency and just overall understanding. That is the gap that we are filling at CDCES.

We will be bridging that gap between what is recommended and then what is actually doable for the patient. We are the ones helping to translate that treatment plan into something they can realistically follow, anticipate where things might fall apart and then problem solve before it becomes a barrier. Ultimately, that is what is going to drive the optimized patient outcomes.

Making sure it works in the context of their day to day routine. Then going back to what, both the other presenters said, instead of asking them, do you understand this? Make sure we are asking them, can you actually do this consistently in their real life and come up with that plan? That is the key takeaway here is, it is not just about choosing the once-weekly insulin. It is about making sure the patient can actually implement it consistently.

Strategies to Overcome Barriers to Emerging Glycemic Therapies

How do we actually address that? A few things I have found that really matter in practice. First, normalizing the concern. Dr. Pratley mentioned he does this, and I agree it totally matters. Just saying something simple like a lot of people feel this way when starting insulin. It goes a long way to normalize how they are feeling and not feel brushed off or unheard.

Second, that shared decision-making, and as Diana mentioned earlier, that person-centered care is the standard of care. So not telling patients what to do, but bringing them into the conversation. So instead of this is what you should do, asking them what feels realistic for

you right now.

Then third, start the conversations early. Do not wait until the A1C is already well above the target. Introducing the idea before it becomes an urgent problem. Ultimately, that is where we are going to have the most impact. So how we guide the conversations, build the readiness and support patients in taking that next step.

I am sure, as CDCES, as you guys have heard this a thousand times, but the takeaway here is meeting patients where they are and focusing on what they can do. That is what is really going to drive the behavior change.

Real-world Sustainability: Supporting Long-term Success

This real-world sustainability, this is the part where things either work or they do not. Because even if a plan looks great on paper, if it does not hold up over time, it is not going to be successful. What actually makes that difference in real life? It is things like setting those clear expectations up front with them. What this is going to look like in their day to day life.

Keeping their routines simple and realistic. Diana mentioned it, but anchoring that once-weekly insulin to something in their life so that there is more consistency. Using tools like the CGM to build awareness and confidence. Then most importantly, just early follow-up. That follow-up is where we are going to be able to catch issues, build the confidence, and then prevent drop off.

In the follow-up, that is where we are going to catch things. The key takeaway here is follow-up is where the success happens.

Elevate and Empower: Clinical Case Study Discussion

With that in mind, we are going to go back to Maria. Diana had presented on Maria. We are going to go back to her and see how this plays out in the real-world scenario.

Patient Case Continued: Follow-up With Maria

I am not going to read this to you again, but just to recap quickly with where she stands. You have that 56-year-old with type 2 diabetes, A1C of 8.6, the fasting glucose in that 160/180 range, already on multiple therapies for her diabetes. Also managing other comorbidities like hypertension and dyslipidemia.

Then when we layer in what she is experiencing at the bottom, that patient-reported concerns. We will see that on the next slide. Just keeping those in mind.

Patient Case: Follow-up With Maria

Based on what she is experiencing, she is telling you she feels overwhelmed by the day to day demands of diabetes. She is anxious about starting the insulin and occasionally missing her oral medication. Now she is asking us about once-weekly insulin.

This is where things do get a little interesting, because we have to balance what we see clinically with what the patient is telling us about their experience and concerns. The question becomes, how do we approach this conversation? Which is what you guys are going to tell us in the next poll question, right?

Poll 5

Here is your poll question. How should emerging once-weekly basal insulin therapies be discussed with Maria?

A. As alternatives to daily basal insulin endorsed by guidelines;
B. As approved options for patients missing daily insulin doses;
C. As emerging therapies that may reduce burden but require education and follow-up; or
D. As replacements for GIP/GLP-1 receptor agonist therapies.

I will give you guys a couple seconds and then we will show the results. Okay. Let us see. You guys are rock stars.

Yes. The correct answer is C. Just to tell you the rationale that it does really come about how we are framing these therapies with the patient. Yes, the once-weekly basal insulins are still emerging. They are not yet a part of the ADA treatment algorithms. Our role is just to position them as an option that, yes, we will reduce treatment burden, but also being really clear that they do still require education.

Poll 6

Which will bring us to one more question. Which factor is most likely to influence Maria's acceptance of once-weekly basal insulin?

A. Concerns about long-term cardiovascular benefit;

B. Fear of making dosing mistakes and worsening glucose;
C. Preference for injectable therapies over oral agents; or
D. Severity of dyslipidemia and hypertension.

Take a few seconds and then we will close the polls.

Perfect. Let us see what you guys said. Yes. 76% of you got that right. The answer is B, fear of making dosing mistakes and worsening glucose. As you guys saw, Maria already told us she is worried about messing things up. That is her psychological insulin resistance. This really is not about the therapy. It is about her confidence.

If she does not feel like she can do it safely, she is not going to and she is not going to move forward. Our role is really to address that through education, readiness assessment and building confidence.

I will pause here. You guys can put any thoughts or questions in the chat. I will hand it back to Dr. Pratley for the posttest.

POSTTEST ASSESSMENT

Posttest 1

Dr. Pratley:
I wanted to remind you, you do have the opportunity to work with Maria a little bit more in a virtual way. Let us go back to our posttest questions quickly, and then we might have a time for a couple of online questions.

Posttest question one. This is a 62-year-old gentleman who has the A1C of 9.1 despite metformin and daily basal insulin therapy. Which CDCES strategy would be most supportive of optimal glycemic management with a once-weekly insulin change? I want you to lock in your answers now. I would not go through them all to save a little bit of time.

Okay, let us take a look at the results. While we are pulling those up, I want to say I am just so delighted so many people are online. Do we have the results from posttest one?

Posttest 1: Rationale

Good. The answer, of course, is to collaborate to anchor dosing to a consistent routine using teach-back. I am sure that you all got that right.

Posttest 2

Posttest question two. After this program, how confident are you in your ability to analyze and apply recent evidence to once-weekly insulin therapies when considering options for patients with type 2 diabetes? Again, no right or wrong answer here. Remember that these are all new therapies and lots of questions in the chat. Clearly, there is a need for new information. Go ahead and lock your answers in while I am chatting.

Posttest 3

Dr. Pratley:
Okay. Posttest question three. The 58-year-old person with type 2 diabetes, considering a transition from daily to once-weekly basal insulin. Which action is most likely to optimize the patient outcomes? Again, I want you to at least think about this if we cannot lock in the answers.

A. Coordinating medication selection and insulin titration;
B. Educating the patient, using standard materials;
C. Monitoring laboratory results; or
D. Providing patient-specific education and supporting readiness for change.

I guess we are still having a little problem with the polling.

Posttest 3: Rationale

The right answer, as you all know, it is providing-patient specific education and supporting readiness for change, meeting the patients where they are.

Question and Answer Session

We do have an opportunity to answer a couple of questions.

Now It Is YOUR Turn!

First, I promised you that you would have the opportunity to interact with Maria some more. Scan this QR code. This will take you to an empowered AI simulation. This allows you to make choices. Go back and forth, ask questions about Maria. It is really fun. This will help you work with patients better and help you understand potentially the role of once-weekly insulin analogs.

Poll 7

Poll question seven. Do you plan to make any changes based upon your program today?

A. Yes;
B. No; or
C. Uncertain.

Poll 8

Poll eight. Take a moment to enter one key change you might want to make in your clinical practice based upon this education.

Go Online for More Coverage of T2D!

Go online to get more coverage of this. Here is a great website. Lots of resources, expert commentaries, the AI case simulation, additional CME/CE-certified slide set on type 2 diabetes.

Q&A

We have over 20 questions in the Q&A slots. We cannot get to all of those. I want to encourage you to join us for the coffee break, in which Diana and Mara will be going over a lot of these questions and reviewing some of the highlights.

There is one question I did want to highlight though. This is, are ultra-long-acting insulin therapies indicated for gestational diabetes and diabetes in pregnancy? Now I know what my answer is, but Diana and Mara, I am going to turn to you for what your opinions are.

Dr. Isaacs:
I am going to say no at this time, because it has not been studied in pregnancy yet. Also we tend to make changes much more frequently in pregnancy. That could potentially be a barrier also to using.

Dr. Pratley:
I agree with that. We do need to adapt to the changing insulin resistance and the insulin requirements as women progress through pregnancy. Probably not the optimal insulin in that clinical scenario.

Lots of questions about insurance coverage or costs. Do not have the answer to any of those. That will play out as soon as the insurance companies start getting these prescriptions online.

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