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Congratulations, Laura!

an interview with Laura Burke — our 15,000th member

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by David Hoffman, JD, FCPP

Diabetes care and monitoring—What works?

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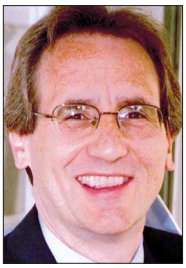
Years ago, I settled a case that involved, in part, the failure of a nursing home to provide adequate care to residents who had diabetes. A major cause of these failures stemmed from the lack of appropriate monitoring of blood sugars. I worked closely with an expert, Stanley M. Schwartz, MD, in developing a blood sugar monitoring tool to address hypo- and hyperglycemia. Recently, I was in a facility that was still using sliding scale insulin and the residents' blood sugar levels appeared to not be well controlled. This led me back to check in with Dr. Schwartz and he advised me that:



Hoffman

1. Significantly nursing homes were not monitoring fingerstick sugars in patients on sulfonylureas and glinides, and were insufficiently monitoring those taking insulin.
2. There is now much published data on the risk of sulfonylureas: increasing adverse cardiovascular outcomes and death after being on sulfonylureas for one year 1.8x, and 2.5x one year after starting insulin.
3. We know patients >65 years of age, in any setting, have more visits to ERs and admission to the hospital for hypoglycemia than hyperglycemia.
4. Regulatory commissions agree a "new sulfonylurea" agent would not pass current FDA or European Medicines Agency guidelines for cardiovascular safety if brought before them for approval.
5. Most importantly, we now have agents that can control sugar, in many cases at the same site sulfonylureas act, but without causing hypoglycemia. In addition, we have agents that work as quickly as insulin, preserving beta-cell function, but without its attendant weight gain and hypoglycemic risk.

> Thus, [he] advocates a "ban" on the use of sulfonylureas in everyone, but especially in the elderly.

Thus, Dr. Schwartz advocates a "ban" on the use of sulfonylureas in everyone, but especially in the elderly. He would use three or four non-insulin, non-hypoglycemic agents before considering insulin therapy and would continue them if there is a need to start basal insulin. This approach would obviate the need for meal time bolus insulin in most (which is often given as sliding scale), which would reduce the risk of hypoglycemia with insulin therapy by 85%.

In conclusion, it is apparent that monitoring of patients/residents with diabetes who require medication is essential from a quality-of-care perspective. Importantly, the compliance officer should take a proactive role in requesting that the medical director review the current medical management of patients with diabetes and whether your facility's approach constitutes "best practice." This clinical issue implicates compliance concerns around quality of care based on current medical literature.