4th International Geriatric Diabetes Society Workshop
Boston, MA
May 18-19, 2023

Overarching principles presented as "4 Ss of deprescribing"

***S**creening for comorbidities and frailty*
- Goals are established based on the comorbidities
- Identify comorbidities that impact self-care

***S**et appropriate and realistic goals*
- A1C may not be the right choice esp as individual gets frailer
- Using CGM to develop goals for TIR and time below hypo

***S**afer medication use*
- Avoid sulfonylurea and meal-time insulin to reduce hypoglycemia
- Avoid SGLT-2, GLP-1RA to reduce risk of excessive weight loss, dehydration or anorexia etc
- Avoid metformin with renal insufficiency

***S**implify*
- Understand barriers affecting individual patient and their caregivers
- Adapt treatment strategy to overcome / accommodate barriers

May 18, 202

8.00- 8.10: Welcome

8.10 – 10.00:

Session 1: General concepts of Deprescribing: idenfitying "name" that implies "optimization and appropriate prescribing" instead of "deprescribing"
(presentation: 30 mins, group discussion: 1.20 mins)
Presenting team: Alan Sinclair, Sei Lee, Grady Meneilly,

- **Current literature**
  - Defining deprescribing, literature supporting it, outcomes from deprescribing for other classes of meds such as opioids or antipsychotics)
  - Why consider DE prescribing in older people with diabetes? Primarily safety: (heterogeneity in targets, AE of drugs, narrow therapeutic range in hypoglycemic agents)
- **Knowledge gaps**
  - Why hyperglycemic medications can not follow the same steps of deprescribing as the other classes
  - Lack of data on outcomes with deprescribing
  - Heterogeneity of diabetes
- **Vision**
  - Do we need to call it something different than deprescribing?

- Prefer a different name. Deprescribing implies "giving up" and providing less than optimal care – not the message we want. We are really proposing simplifying and modifying therapy to improve patient safety
- What would be the vision for implementation / scaling?
    - **Playbook**
- Perhaps table depicting why diabetes and hyperglycemic meds are different than other classes of drugs in context of deprescribing
- How to identify older individuals for whom DE prescribing should be considered

10.00-10.10: Coffee break

10.10-12.00: Session 2: Role of glycemic pattern in deprescribing in diabetes: CGM vs BGM. what are the goals and outcomes?
(presentation 30 mins, group discussion: 1.20 mins**)**

Presenting team: Ruth Weinstock, Elena Toschi, Rich Pratley, Anna Kahkoshka

- **Current literature**
- Deprescribing done following A1c without consideration of glycemic excursions
- Some observations studies use functionality
    - **Knowledge gaps**
- CGM /BGM based outcomes to eliminate unrecognized hypoglycemia
- Glucose levels fluctuate in older adults with any changes in their overall health e.g. hyperglycemia occurs with acute medical events including infection or stress. Hypoglycemia occurs with acute events that may result in changes in appetite and eating pattern.
- Patient-Reported Outcomes
- Hard outcomes – ED/hospitalization, need to go to long term care, need for help at home, falls, decline in cognitive/functional status, DKA, severe hypoglycemia, hyperosmolar state
- Different classes of anti-hyperglycemic medications including different insulin formulations lower glucose levels at different times of the day depending on when they are administered. Knowledge of glycemic patterns is essential for mitigating risk of hypoglycemia while avoiding severe hyperglycemia.
- Role of / training of caregivers?
    - **Vision**
- How do we develop BGM and CGM criteria for optimizing/ deprescribing? (avoid A1C based cirteria)
- Professional vs iCGM vs rtCGm? We need criteria for all 2?
    - **Playbook**
- Table /figure / algorithm for CGM/BGM numbers and how to deprescribe based on numbers
- Figure on type & number of glucose measurements (number of BGM, or CGM) required according to patient characteristic's

12.00-1.00: Lunch Break

1.00-2.50: Session 3: Use of anti-hyperglycemic medications for deprescribing

(presentation 30 mins, group discussion: 1.20 mins)

Presenting team: Joshua Neumiller, Lisa McCarthy, Stef Alexopoulos, Leocardio Rodriguez-manas

- **Current literature**
  - Primarily discussing lowering doses of insulin/SU or stopping them
  - Use of SGLT2, GLP-1 RA & DPP4 inhibitors for glucose lowering in order to minimize hypoglycemia
- **Knowledge gaps**
  - Newer classes of anti-hyperglycemic agents are beneficial and well tolerated but have many contraindications for older population esp those with renal failure, weight loss and other severe comorbidities
- **Vision**
  - Need to develop algorithm and decision tree based on patient characteristics with safe strategies to use basal insulin and basal mixed with other safer classes - based on glucose data
- **Playbook**
  - Decision tree /algorithm using 4Ss : Screening for comorbidities, Setting appropriate goals for CGM parameters, Safer medication use, and Simplifying regimen

2.50-3.00: coffee break

3.00-4.50: Session 4: Issues pertaining to PA-LTC and end-of-life care

(presentation 30 mins, group discussion: 1.20 mins)

Presenting team: Naushira Pandya, Sarah Sy, Kasia Lipska (Sei Lee)

- **Current literature**
  - Current literature
- **Knowledge gaps**
  - What are the goals?
  - What are the strategies?
- **Vision**
  - Patient characterizes based deprescribing with technology that is minimally invasive
  - Can monitoring with CGM be consider deprescribing due to lack of fingerstick?
- **Playbook**
  - Decision tree/algorithm

4:50 PM- 5:30 PM : individual teams to gather their thoughts and plan summary for Day 2.

6 PM: Depart for Dinner

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8.00 – 9.50: Session 5: Future directions: novel insulin? Novel agents? Novel technology?
Presenting Team: Tally Cuckierman-yaffee, Nancy Allen, Elbert Huang

- **Current literature**
  - Once a week insulin, hybrid closed loop system without patient input
- **Knowledge gaps**
  - How they are used in older adults
- **Vision**
  - Integrating technology into daily care of older people with diabetes in order to optimize care
- **Playbook**
  - Figure of how we envision optimal care of older people with diabetes using multi-domain technology

9.50- 10.00: Coffee Break

10.00-12.00: Summary presentation for sessions 1-4 by team members (30 mins each)

12.00-1.00 : Lunch Break

1.00-3.00: developing education moduls for dissminations
Succinct messaging and platforms for messaging.
Lead: Nuha El-Sayed, Moderator: Medha Munshi

3.00.3.10: coffee break

3.10-4.10: next steps

4.10: Adjourn