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Session Date: 8/20/2026

Thank you for presenting your patient at ECHO Idaho –Diabetes and Metabolic Conditions session.

Summary: 56-year-old female with T2DM (dx 2016) and HTN presents with persistent poor glycemic control, with a recent A1c of 10.4% and historical A1c values ranging from 9.1% to 11.6%. She is currently managed with basal-bolus insulin (glargine 40 units daily and aspart 15-20 units TID with meals), metformin 1,000 mg BID, CGM, and atorvastatin 40 mg daily. CGM data showed an average glucose of 199 mg/dL, and she reports no history of DKA, severe hypoglycemia, or HHS. Contributing factors include medication nonadherence related to cost and diabetes burnout, as well as challenges associated with being away from home during the workday. She prioritizes family meals and regularly consumes traditional Hispanic foods. Renal and hepatic function are normal, and BP is well controlled.

Question: What are some ways we can simplify medications and care for this patient?

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Recommendations:

- **Review CGM/Libre data in detail before making major treatment changes**, with particular attention to glucose variability, patterns of hyperglycemia, and whether the elevated A1c is driven by persistent hyperglycemia versus significant glucose fluctuations. Assessment of the coefficient of variation could help identify excessive glycemic variability.
- **Evaluate insulin sensitivity and overall diabetes phenotype** by reviewing CGM trends, family history, and clinical characteristics. Given her BMI, consider whether she may have a more insulin-sensitive phenotype that could influence treatment decisions.
- **Consider addition of a GLP-1 receptor agonist, if accessible and affordable**, as this could provide significant glycemic benefit.
- **Consider initiation of an SGLT2 inhibitor if cost is not prohibitive**, as this medication class may be affordable through some FQHC pharmacy programs and could provide additional metabolic and renal benefits.
- **Assess adequacy of basal insulin coverage over the full 24-hour period**. Evaluate whether insulin glargine may be wearing off before the next dose and whether split dosing of basal insulin could improve glycemic control if fasting hyperglycemia or gaps in coverage are identified.
- **Explore culturally appropriate nutrition modifications rather than eliminating culturally important foods**, such as reducing portions of refined carbohydrates, substituting whole grains when feasible, increasing non-starchy vegetables, and making incremental, sustainable dietary changes while preserving preferred family and cultural meals.
- **Use a patient-centered approach when discussing nutrition and diabetes self-management**. Given her prior experience with diabetes education and current reluctance to re-engage, meet the patient where she is and focus on achievable goals rather than rigid dietary expectations.

- **Assess barriers to prandial insulin administration during the workday.** Barriers may include administering injections while working, carrying insulin and supplies, needle disposal, lack of privacy, concerns about cleanliness, and temperature exposure of insulin while working outdoors or away from home.
- **Discuss practical strategies for insulin storage and transport while working,** including carrying insulin in a lunchbox or insulated container and ensuring insulin is protected from excessive heat while avoiding direct contact with ice packs that could freeze or crystallize the medication, such as using a pencil case for storage.
- **Determine whether fear of hypoglycemia is contributing to missed mealtime insulin doses.** The CGM review may help identify episodes of hypoglycemia and clarify whether this is affecting adherence.
- **Assess psychosocial barriers to diabetes self-management,** including whether the patient is concealing her diabetes from coworkers or others, as this may create additional obstacles to insulin administration and routine diabetes care during the workday.
- **Build on existing successes and strengths.** Acknowledge positive clinical outcomes already achieved, including well-controlled blood pressure and favorable lipid parameters, as a foundation for further discussions about diabetes management and behavior change.