What’s New in the Standards of Medical Care in Diabetes?

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Learning Objectives

By the end of this presentation, participants should be able to:

• Discuss updates and changes in ADA Standards of Medical Care in Diabetes.
• Summarize the comprehensive medical evaluation and referral for people with diabetes.
• Discuss the importance of utilizing inclusive language in the care for people with diabetes.
# Evidence Grading System

<table>
<thead>
<tr>
<th>Grade</th>
<th>Evidence Description</th>
</tr>
</thead>
</table>
| A     | Clear evidence from well-conducted, generalizable RCTs, that are adequately powered, including:  
- Evidence from a well-conducted multicenter trial or meta-analysis that incorporated quality ratings in the analysis;  
- Compelling nonexperimental evidence;  
- Supportive evidence from well-conducted RCTs that are adequately powered |
| B     | Supportive evidence from a well-conducted cohort studies  
- Supportive evidence from a well-conducted case-control study |
| C     | Supportive evidence from poorly controlled or uncontrolled studies  
- Conflicting evidence with the weight of evidence supporting the recommendation |
| E     | Expert consensus or clinical experience |
Improving Care and Promoting Health in Populations
Diabetes and Population Health

• Ensure treatment decisions are:
  – timely
  – rely on evidence-based guidelines, and
  – made collaboratively with patients based on individual preferences, prognoses, and comorbidities. B

• Align approaches to management with the Chronic Care Model. A
• Care systems should facilitate team-based care, patient registries, decision support tools, and community involvement. B

• Efforts to assess the quality of diabetes care and create quality improvement strategies should incorporate reliable data metrics, to promote improved processes of care and health outcomes, with simultaneous emphasis on costs. E
Care Delivery Systems

- 33-49% of patients still do not meet targets for A1C, blood pressure, or lipids.
- Only 14% of patients meet targets for all A1C, BP, lipids, and nonsmoking status.
- Progress in CVD risk factor control is slowing.
- Substantial system-level improvements are needed.
- Delivery system is fragmented, lacks clinical information capabilities, duplicates services & is poorly designed.
Chronic Care Model (CCM)

The CCM includes Six Core Elements to optimize the care of patients with chronic disease:

1. Delivery system design
2. Self-management support
3. Decision support
4. Clinical information systems
5. Community resources & policies
6. Health systems
The National Diabetes Education Program (NDEP) maintains an online resource to help health care professionals design and implement more effective health care delivery systems for those with diabetes:

Strategies for System-Level Improvement

- Strategies for intensification:
  - Explicit and collaborative goal setting with patients
  - Identifying and addressing language, numeracy, and/or cultural barriers to care
  - Integrating evidence-based guidelines and clinical information tools into the process of care
  - Soliciting performance feedback, setting reminders, and providing structured care
  - Incorporating care management teams
Support Patient Self-Management

• Implement a systematic approach to support patient behavior change efforts, including:
  – High-quality diabetes self-management education and support (DSMES)
    • Clinical content & skills
    • Behavioral strategies (goal setting, problem solving, etc.)
    • Engagement with psychosocial concerns
  – Addressing barriers to medication taking
Tailoring Treatment for Social Context

Key Recommendations:

• Providers should assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions. A

• Refer patients to local community resources when available. B

• Provide patients with self-management support from lay health coaches, navigators, or community health workers when available. A
Health Inequities

• Health inequities related to diabetes and its complications are well documented and are heavily influenced by social determinants of health

• Social determinants of health are defined as:
  – The economic, environmental, political, and social conditions in which people live
  – Responsible for a major part of health inequality worldwide
Health Inequities

- Social determinants of health unrecognized and often go undiscussed in the clinical encounter.
- Creating systems-level mechanisms to screen for social determinants of health may help overcome structural barriers and communication gaps between patients and providers.
- Validated screening tools for some social determinants of health exist for clinical use.
Comprehensive Medical Evaluation and Assessment of Comorbidities
Patient-Centered Collaborative Care

A patient-centered communication style should be used to optimize health outcomes and quality of life:

- Person-centered and strength-based language
- Active listening
- Elicits patient preferences and beliefs, and
- Assesses literacy, numeracy, and potential barriers to care

Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S28-S37
## Components of the Comprehensive Diabetes Evaluation

<table>
<thead>
<tr>
<th>Past Medical and Family History</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes history</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Characteristics at onset (e.g., age, symptoms)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Review of previous treatment regimens and response</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>- Assess frequency/cause/severity of past hospitalizations</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Family history</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family history of diabetes in a first-degree relative</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Family history of autoimmune disorder</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal history of complications and common comorbidities</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Macrovascular and microvascular</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Common comorbidities</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Presence of hemoglobinopathies or anemias</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- High blood pressure or abnormal lipids</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Last dental visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Last dilated eye exam</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Visits to specialists</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Interval history</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>- Changes in medical/family history since last visit</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comprehensive Medical Evaluation and Assessment of Comorbidities:**

*Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S28-S37*
# Components of the Comprehensive Diabetes Evaluation

<table>
<thead>
<tr>
<th>SOCIAL HISTORY</th>
<th>INITIAL VISIT</th>
<th>EVERY FOLLOW-UP VISIT</th>
<th>ANNUAL VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eating patterns and weight history</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Sleep behaviors and physical activity</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Familiarity with carbohydrate counting in type 1 diabetes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Tobacco, alcohol, and substance use</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Identify existing social supports</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MEDICATIONS AND VACCINATIONS</th>
<th>INITIAL VISIT</th>
<th>EVERY FOLLOW-UP VISIT</th>
<th>ANNUAL VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication-taking behavior</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Medication intolerance or side effects</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Complementary and alternative medicine use</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Vaccination history and needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
### Components of the Comprehensive Diabetes Evaluation

#### Technology Use
- Assess use of health apps, online education, patient portals, etc.
- Glucose monitoring (meter/CGM): results and data use
- Review insulin pump settings

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
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<tbody>
<tr>
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</tbody>
</table>

#### Screening
- Psychosocial conditions
  - Screen for depression, anxiety, and disordered eating; refer for further assessment or intervention if warranted
  - Consider assessment for cognitive impairment*

<table>
<thead>
<tr>
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<th>Annual Visit</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
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</tbody>
</table>

- Diabetes self-management education and support
  - History of dietitian/diabetes educator visits
  - Screen for barriers to diabetes self-management
  - Refer or offer local resources and support as needed

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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</tbody>
</table>

- Hypoglycemia
  - Timing of episodes, awareness, frequency and causes

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
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</tbody>
</table>

- Pregnancy planning
  - For women with childbearing capacity, review contraceptive needs and preconception planning

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Visit</th>
<th>Every Follow-Up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Components of the Comprehensive Diabetes Evaluation

### PHYSICAL EXAMINATION

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Visit</th>
<th>Every Follow-up Visit</th>
<th>Annual Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height, weight, and BMI; growth/pubertal development in children and adolescents</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Blood pressure determination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Orthostatic blood pressure measures (when indicated)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fundoscopic examination (refer to eye specialist)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Thyroid palpation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Skin examination (e.g., acanthosis nigricans, insulin injection or insertion sites, lipodystrophy)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Comprehensive foot examination</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>* Visual inspection (e.g., skin integrity, callous formation, foot deformity or ulcer, toenails)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>* Screen for PAD (pedal pulses; refer for ABI if diminished)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>* Determination of temperature, vibration or pinprick sensation, and 10-g monofilament exam</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>LABORATORY EVALUATION</td>
<td>INITIAL VISIT</td>
<td>EVERY FOLLOW-UP VISIT</td>
<td>ANNUAL VISIT</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------------</td>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>A1C, if the results are not available within the past 3 months</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>If not performed/available within the past year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lipid profile, including total, LDL, and HDL cholesterol and triglycerides#</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Liver function tests#</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Spot urinary albumin-to-creatinine ratio</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Serum creatinine and estimated glomerular filtration rate†</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Thyroid-stimulating hormone in patients with type 1 diabetes#</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Vitamin B12 if on metformin (when indicated)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>• Serum potassium levels in patients on ACE inhibitors, ARBs, or diuretics†</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

† May be needed more frequently in patients with known chronic kidney disease or with changes in medications that affect kidney function and serum potassium.

# May also need to be checked after initiation or dose changes of medications that affect these laboratory values (i.e., diabetes medications, blood pressure medications, cholesterol medications, or thyroid medications).

^ In people without dyslipidemia and not on cholesterol-lowering therapy, testing may be less frequent.
<table>
<thead>
<tr>
<th>Component</th>
<th>Initial</th>
<th>Every Follow-Up</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal setting</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Set A1C/blood glucose target and monitoring frequency</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>If hypertension diagnosed, establish blood pressure goal</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Incorporate new members to the care team as needed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Diabetes education and self-management support needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Cardiovascular risk assessment and staging of CKD</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>History of ASCVD</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Presence of ASCVD risk factors (see Table 9.2)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Staging of CKD (see Table 10.1)†</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Therapeutic treatment plan</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Lifestyle management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pharmacologic therapy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Referrals to specialists (including dietitian and diabetes educator) as needed</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Use of glucose monitoring and insulin delivery devices</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

† May be needed more frequently in patients with known chronic kidney disease or with changes in medications that affect kidney function and serum potassium.
### Referrals for Initial Care Management

- Eye care professional for annual dilated eye exam
- Family planning for women of reproductive age
- Registered dietitian for MNT
- DSMES
- Dentist for comprehensive dental and periodontal examination
- Mental health professional, if indicated
Anxiety Disorders: When to Refer

• Screening in people exhibiting anxiety or worries B:
  – diabetes complications
  – insulin injections or infusion
  – taking medications, and/or
  – hypoglycemia
  that interfere with self-management behaviors

• And those who express:
  – Fear
  – dread, or
  – irrational thoughts

• And/or show anxiety symptoms such as:
  – avoidance behaviors
  – excessive repetitive behaviors, or
  – social withdrawal.

Comprehensive Medical Evaluation and Assessment of Comorbidities:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S28-S37
Referral for Psychosocial Care

**Table 4.2—Situations that warrant referral of a person with diabetes to a mental health provider for evaluation and treatment**

- If self-care remains impaired in a person with DD after tailored diabetes education
- If a person has a positive screen on a validated screening tool for depressive symptoms
- In the presence of symptoms or suspicions of disordered eating behavior, an eating disorder, or disrupted patterns of eating
- If intentional omission of insulin or oral medication to cause weight loss is identified
- If a person has a positive screen for anxiety or fear of hypoglycemia
- If a serious mental illness is suspected
- In youth and families with behavioral self-care difficulties, repeated hospitalizations for diabetic ketoacidosis, or significant distress
- If a person screens positive for cognitive impairment
- Declining or impaired ability to perform diabetes self-care behaviors
- Before undergoing bariatric or metabolic surgery and after surgery if assessment reveals an ongoing need for adjustment support
Lifestyle Management
Diabetes Self-Management Education & Support (DSMES)

- Participation in DSME to facilitate the knowledge, skills, and ability necessary for diabetes self-care and in DSMS to assist with implementing and sustaining skills and behaviors needed for ongoing self-management. B

- Facilitating appropriate diabetes self-management and improving clinical outcomes, health status, and quality of life are key goals of DSMES to be measured and monitored as part of routine care. C
• Effective DSMES should be:
  – patient centered
  – Delivered in group or individualized settings, or using technology, and
  – should help guide clinical decisions. A

• DSMES can improve outcomes and reduce costs B → adequate reimbursement by third-party payers is recommended. E
DSMES Delivery

Four critical time points for DSMES delivery:

1. At diagnosis
2. Annually for assessment of education, nutrition, and emotional needs
3. When new complicating factors (health conditions, physical limitations, emotional factors, or basic living needs) arise that influence self-management; and
4. When transitions in care occur
### Table 4.1—MNT recommendations

<table>
<thead>
<tr>
<th>Topic</th>
<th>Recommendations</th>
<th>Evidence rating</th>
</tr>
</thead>
</table>
| Effectiveness of nutrition therapy     | • An individualized MNT program, preferably provided by a registered dietitian, is recommended for all people with type 1 or type 2 diabetes or gestational diabetes mellitus.  
• A simple and effective approach to glycermia and weight management emphasizing portion control and healthy food choices may be considered for those with type 2 diabetes who are not taking insulin, who have limited health literacy or numeracy, or who are older and prone to hypoglycemia.  
• Because diabetes nutrition therapy can result in cost savings and improved outcomes (e.g., A1C reduction), MNT should be adequately reimbursed by insurance and other payers. |
|                                        | A, B, E                                                                                                                                       |                 |
| Energy balance                         | • Weight loss (>5%) achievable by the combination of reduction of calorie intake and lifestyle modification benefits overweight or obese adults with type 2 diabetes and also those with prediabetes. Intervention programs to facilitate weight loss are recommended. |
|                                        | A                                                                                                                                              |                 |
| Eating patterns and macronutrient distribution | • There is no single ideal dietary distribution of calories among carbohydrates, fats, and proteins for people with diabetes; therefore, macronutrient distribution should be individualized while keeping total calorie and metabolic goals in mind.  
• A variety of eating patterns are acceptable for the management of type 2 diabetes and prediabetes. |
|                                        | E, B                                                                                                                                            |                 |
Goals of Nutrition Therapy

1. To promote and support healthful eating patterns, emphasizing a variety of nutrient-dense foods in appropriate portion sizes, to improve overall health and to:
   – Achieve and maintain body weight goals
   – Attain individualized glycemic, blood pressure, and lipid goals
   – Delay or prevent the complications of diabetes

2. To address individual nutrition needs based on personal & cultural preferences, health literacy & numeracy, access to healthful foods, willingness and ability to make behavioral changes, & barriers to change

Lifestyle Management: Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S38-S50
3. To maintain the pleasure of eating by providing non-judgmental messages about food choices

4. To provide an individual with diabetes the practical tools for developing healthful eating patterns rather than focusing on individual macronutrients, micronutrients, or single foods
Physical Activity

- 150 min of moderate-to-vigorous intensity aerobic activity/week with no more than 2 consecutive days without activity.

- Shorter durations (min. 75 min/week) of vigorous-intensity or interval training may be sufficient for younger and more physically fit individuals.

- Adults should do 2-3 sessions/week of resistance exercise on nonconsecutive days.

- Interrupt sitting every 30 min for blood glucose benefits, particularly in adults with type 2 diabetes.

- Flexibility training and balance training are recommended 2–3 times/week for older adults with diabetes.
Smoking Cessation

• Advise all patients not to use cigarettes and other tobacco products A or e-cigarettes. E

• Include smoking cessation counseling and other forms of treatment as a routine component of diabetes care. B
Diabetes Distress

• Diabetes distress
  – Very common and distinct from other psychological disorders
  – Negative psychological reactions related to emotional burdens of managing a demanding chronic disease

• Recommendation:
  – Routinely monitor people with diabetes for diabetes distress, particularly when treatment targets are not met and/or at the onset of diabetes complications. B

Lifestyle Management:
Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S38-S50
Prevention or Delay of Type 2 Diabetes
Prevention or Delay of T2DM

- At least annual monitoring for the development of diabetes in those with prediabetes is suggested. E

- Patients with prediabetes should be referred to an intensive behavioral lifestyle intervention program modeled on the Diabetes Prevention Program to achieve and maintain 7% loss of initial body weight and increase moderate-intensity physical activity (such as brisk walking) to at least 150 min/week. A
Prevention or Delay of T2DM

- Technology-assisted tools including Internet-based social networks, distance learning, and mobile applications that incorporate bidirectional communication may be useful elements of effective lifestyle modification to prevent diabetes. B

- Given the cost-effectiveness of diabetes prevention, such intervention programs should be covered by third-party payers. B
Prevention of CVD in Prediabetes

- Screening for and treatment of modifiable risk factors for cardiovascular disease is suggested for those with prediabetes. B
• DSMES programs may be appropriate venues for people with prediabetes to receive education and support to develop and maintain behaviors that can prevent or delay the development of type 2 diabetes. B
Obesity Management Type 2 Diabetes
Benefits of Weight Loss

• Delay progression from prediabetes to type 2 diabetes

• Positive impact on glycemia in type 2 diabetes
  – Most likely to occur early in disease development
Assessment

• At each patient encounter, BMI should be calculated and documented in the medical record. B
  – BMI should be:
    • Classified to determine the presence of overweight or obesity
    • Discussed with the patient
    • Documented in the patient record
  – Remember that BMI cutpoints for Asian Americans are lower than in other populations

Obesity Management for the Treatment of Type 2 Diabetes: Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S65-S72
## Overweight/Obesity Treatment Options in T2DM

<table>
<thead>
<tr>
<th>Treatment</th>
<th>BMI Category (kg/m²)</th>
<th>25.0-26.9 (or 23.0-26.9*)</th>
<th>27.0-29.9 (or 27.5-32.4*)</th>
<th>30.0-34.9 (or 32.5-37.4*)</th>
<th>35.0-39.9 (or ≥37.5*)</th>
<th>≥40 (or ≥37.5*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet, physical activity &amp; behavioral therapy</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pharmacotherapy</td>
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<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Metabolic surgery</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

* Cutoff points for Asian-American individuals.

† Treatment may be indicated for selected, motivated patients.

Obesity Management for the Treatment of Type 2 Diabetes:
*Standards of Medical Care in Diabetes - 2018. Diabetes Care 2018; 41 (Suppl. 1): S65-S72*
Diet, physical activity and behavioral therapy designed to achieve >5% weight loss should be prescribed for overweight and obese patients with T2DM ready to achieve weight loss. Such interventions should be high-intensity (≥16 sessions in 6 months) and focus on diet, physical activity and behavioral strategies to achieve a 500 - 750 kcal/day energy deficit.
• Diets should be individualized, as those that provide the same caloric restriction but differ in protein, carbohydrate, and fat content are equally effective in achieving weight loss. A

• For patients who achieve short-term weight loss goals, long-term (≥1 year) comprehensive weight maintenance programs should be prescribed.
  – provide at least monthly contact
  – encourage ongoing monitoring of body weight (weekly or more frequently)
  – continued consumption of a reduced-calorie diet
  – participation in high levels of physical activity (200-300 min/week). A
To achieve weight loss of >5%, short-term (3-month) interventions that use very-low-calorie diets (≤800 kcal/day) and total meal replacements may be prescribed for carefully selected patients by trained practitioners in medical care settings with close medical monitoring. To maintain weight loss, such programs must incorporate long-term comprehensive weight maintenance counseling. B
Diabetes Advocacy
Advocacy Position Statements

• ADA publishes evidence-based advocacy statements on issues including:
  – Diabetes and employment
  – Diabetes and driving
  – Diabetes management in schools, child care programs, and correctional institutions.

• These are important tools in educating:
  – Schools
  – Employers
  – Licensing agencies
  – Policy makers
Diabetes Language
Language Principles

1. Diabetes is a complex and challenging disease

2. Every member of the health care team can serve people with diabetes more effectively through respectful, inclusive, and person-centered approach

3. Stigma that has historically been attached to a diagnosis of diabetes can contribute to stress and feelings of shame and judgment

Language Principles

4. Person-first, strengths-based, empowering language can improve communication and enhance motivation, health, and well-being of people with diabetes

Five Language Recommendations

1. Use neutral, non-judgmental language; based on facts, actions, or physiology/biology
2. Free of stigma
3. Strength-based, respectful, inclusive, and imparts hope
4. Fosters collaboration between patients and providers
5. Person-centered

Helpful Resources
2018 Standards of Care - Resources

- Full version available
- Abridged version for PCPs
- Free app (February 2018)
- Pocket cards with key figures
- Free webcast for continuing education credit

Professional.Diabetes.org/SOC
Professional Education

- Live programs
- Online self-assessment programs
- Online webcasts

Professional.Diabetes.org/CE
Diabetes Self-Management Education

- Find a recognized Diabetes Self-Management program
- Become a recognized DSME program
- Tools and resources for DSME programs
- Online education documentation tools

Professional.Diabetes.org/ERP
Professional Membership

- Journals
- Meeting, book and journal discounts
- Career center
- Quarterly member newsletter

Professional.Diabetes.org/membership
Thank you