Personalized Diabetes Care Plans that Work

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SinfoniaRx, A TRHC Solution

Nay Linn Aung, MD
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We learned that we must require either a hardwired internet connect or calling in via a land line in the future – live and learn. I think that internet in general is having more issues due to so much use.

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About Today’s Presenters

**Sandra Leal, PharmD, MPH, FAPhA, CDCES** is the Executive Vice President for SinfoniaRx, A Tabula Rasa HealthCare Solution. She is responsible for oversight and expansion of progressive pharmacists’ services that focus on outcomes, access, and quality. Her work has been published broadly and she currently serves as President-elect for the American Pharmacists Association for the 2020-2022 term.

**Nay Linn Aung, MD** is a fellowship-trained primary care diabetologist at Mohawk Valley Health System (MVHS). He also works as a hospitalist and leads an inpatient glycemic QI team. He teaches diabetes in a family medicine residency and affiliated medical school as a faculty/assistant clinical professor. Dr. Aung created a diabetes sub-track in his family medicine residency program and virtual inpatient glucose management team at MVHS.
Learning Objectives

1. Increase understanding of the role personalized diabetes care plans can play in overcoming therapeutic inertia.

2. Review the essential components of high-quality personalized diabetes care and management plan.

3. Improve understanding of the medical, social, emotional, and patient-preference factors to be considered in developing an effective personalized diabetes care plan.

4. Improve confidence in creating effective personalized diabetes care plan with a person with diabetes.
Disclosures

Sandra Leal, PharmD, MPH, FAPhA, CDCES
Sandra has no relevant financial items to disclose related to this presentation.

Nay Linn Aung, MD
Nay Linn has no relevant financial items to disclose related to this presentation.
Therapeutic Inertia is, in part, responsible for failure to meet goals.

THERAPEUTIC INERTIA: The failure to initiate or intensify (or sometimes de-intensify) the therapy regimen when a patient’s therapeutic goals are not met.

CLINICAL INERTIA: Includes underuse of therapies and interventions known to prevent or delay negative outcomes including DSMES, lack of screening, risk assessment, preventive measures, and referrals.
Overcoming TI Strategic Drivers

A. Timely Therapy Optimization
- Notice who is at risk
- Do something at every visit when not at target
- Assumes shared target and timeframe set

B. Improved Care Plan Adherence
- Continuously assess and barriers
- Actively monitor need for plan change

Both are critical...

But neither is sufficient!

All Strategies Aim to **Drive** Either...

- Increase Clinician...
- Urgency
- Awareness
- Knowledge/Efficacy

- Improve Patient...
- Engagement
- Understanding
- Self-Efficacy
1. There is a lot you can control in diabetes care, and a lot you can’t…so focus on what is in your sphere of control or influence.

2. Do something to optimize therapy at every visit when a patient is above goal.

3. Ask every patient about challenges they may be having with managing their diabetes at every visit.

4. Make sure that therapeutic inertia can never traced back to you.
Key Concepts Overview

1. A high-quality and personalized diabetes care plan is an essential tool in overcoming therapeutic inertia in diabetes care.

2. Not everybody is the same! Personalization of target and treatment plan is important to treat diabetes safely and effectively.

3. The patient is the most important member of a diabetes care team! Shared decision making with a patient-centered approach is the way to achieve goal.

4. To be successful a care plan MUST both optimize therapy in a timely fashion and address care plan adherence barriers.
Defining a Personalized Diabetes Care Plan

Critical Factors for Success:

1. Created in collaboration with patient using shared decision-making discussions
2. Patient is educated enough to make informed decisions
3. Therapy plan has a realistic chance of success – rooted in evidence
4. Patient has community/family support system to help

Core Components of an Effective Plan:

1. Considers patient characteristics along with current health status and comorbidities
2. Includes targets and **timeframes**
3. Identifies barriers to care plan adherence and provides support resources (i.e. DSMES, copay assistance, emotional support)
4. Includes realistic therapy and adherence support plan aimed at goal achievement within **6 months**

“The diabetes care plan is a realistic and comprehensive roadmap for how you reach the agreed upon target within the identified timeframe.”
Case Comparison:

**Case 1:** 45 years old successful businesswoman who was diagnosed with diabetes 3 months ago during her annual physical exam.

Her A1C today is 8.5%.

**Case 2:** 70 years old with alcohol use disorder who has been diagnosed with diabetes for 30 years.

His A1C today is 8.5%.
Diabetes Care Plan as a Road Map

A high-quality and personalized diabetes care plan is the road map to overcome therapeutic inertia!

Current Status  | Goal/Target
--- | ---

**Barrier**

- Diabetes Care Plan

**YOUR QUESTION:** Have you done everything in your control to optimize therapy and support adherence at every visit? And between visits?

- Lifestyle (diet/exercise)
- Medications
- Monitoring
- Diabetes Education
- Social/Emotional/Cost Challenges
Any plan formulated without patient’s involvement is set to be a failure!
Decision Cycle for Patient-Centered Glycemic Management in Type 2 Diabetes

- Review AND Agree ON Management Plan
  - Review management plan
  - Mutual agreement on changes
  - Ensure agreed modification of therapy is implemented in a timely fashion to avoid clinical inertia
  - Decision cycle undertaken regularly (at least once/twice a year)

- Ongoing Monitoring and Support Including:
  - Emotional well-being
  - Check tolerability of medication
  - Monitor glycemic status
  - Biofeedback including SMBG, weight, step count, HbA1c, BP, lipids

- Assess Key Patient Characteristics
  - Current lifestyle
  - Comorbidities i.e. ASCVD, CKD, HF
  - Clinical characteristics i.e. age, HbA1c, weight
  - Issues such as motivation and depression
  - Cultural and socio-economic context

- Consider Specific Factors Which Impact Choice of Treatment
  - Individualized HbA1c target
  - Impact on weight and hypoglycemia
  - Side effect profile of medication
  - Complexity of regimen i.e. frequency, mode of administration
  - Choose regimen to optimize adherence and persistence
  - Access, cost, and availability of medication

- GOALS OF CARE
  - Prevent complications
  - Optimize quality of life

- Implement Management Plan
  - Patients not meeting goals generally should be seen at least every 3 months as long as progress is being made; more frequent contact initially is often desirable for DSMES

- Agree On Management Plan
  - Specify SMART goals:
    - Specific
    - Measurable
    - Achievable
    - Realistic
    - Time limited

- Shared Decision-Making To Create A Management Plan
  - Involves an educated and informed patient (and their family/caregiver)
  - Seeks patient preferences
  - Effective consultation includes motivational interviewing, goal setting and shared decision-making
  - Empowers the patient
  - Ensures access to DSMES

American Diabetes Association
Overcoming Therapeutic Inertia
Personalization Factors to Consider

**Social, emotional, preference factors:**
- Health beliefs (personal, cultural, familial)
- Health literacy
- Food and housing security
- Transportation
- Support system
- Emotional health / psychological status
- Economic issues
- Quality of life (QoL)
- Social determinants of health (SDoH) screening tools

**Clinical characteristics:**
- Patient age and life expectancy
- Diabetes duration
- Glycemic control history
- Comorbid conditions, including obesity
- Vascular complications
- Risk of hypoglycemia
Poll Question 1

In your practice, about what percentage of people with diabetes have a personalized care plan?
Components of a Diabetes Care and Management Plan

• Managing Blood Glucose
• Protecting Heart Health
• Protecting Kidney Health
• Medication Understanding
• Addressing Key Complications/Comorbidities and Barriers
  Eye               Smoking
  Feet              Immunizations
  Dental            Psychosocial barriers
  Weight/activity   Other
# Your Diabetes Care and Management Plan Summary

**YOUR NAME:**

---

## Your Diabetes Tests and Targets

Work with your diabetes care team to set targets together, based on your health care needs.

<table>
<thead>
<tr>
<th>Test</th>
<th>How Often</th>
<th>Target Value</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C Target</td>
<td>Every 3 to 6 months</td>
<td>6.0</td>
<td>6.0 6.0</td>
<td>6.0 6.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose – Fasting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose – 2 hours after eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time in Range (TIR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Every clinic visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol (lipid profile)</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Exam</td>
<td>Every clinic visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Shot</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nerve Function (ACR or eGFR)</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Exam</td>
<td>Every 6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**NOTES:**
# Your Current Medications

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Date Prescribed</th>
<th>Dosage</th>
<th>Days of Week Taken</th>
<th>Time of Day Taken</th>
<th>Reason</th>
<th>New or Changed Medication?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example Medication 1</td>
<td>10/03/2020</td>
<td>500 mg</td>
<td>twice daily all day</td>
<td>AM and PM doses</td>
<td>Manage blood glucose</td>
<td>New</td>
</tr>
</tbody>
</table>

- New
- Changed

**Lifestyle Change Goals:**

- Weight loss goal: 
- Eating and nutritional changes: 
- Physical activity—resistance training: 
- Physical activity—aerobic training: 
- Stop smoking

**Referrals Recommended:**

- Diabetes self-management education and support (DMEQES)
- Behavioral health specialist
- Medical nutrition therapy (MNT)
- Social worker/therapist (emotional health)
- Eye doctor (ophthalmologist or contact lens specialist)
- Cardiologist (heart health)
- Foot doctor (podiatrist)
- Kidney doctor (nephrologist)

- Endocrinologist (additional diabetes health support)
- Dentist
- Exercise specialist/physical therapist
- Pharmacist
- Vaccines/immunizations
  - Pneumonia
  - Hepatitis B
  - Tetanus
  - Zoster
  - Other

**Notes:**

<table>
<thead>
<tr>
<th>NOTES:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NOTES:</th>
</tr>
</thead>
</table>
Poll Question 2

How are diabetes care plans implemented in your clinic?
Managing Blood Glucose
Historical “Treat to Failure” Approach

“Treat to Target” Approach

Set Individualized A1C Targets

Approach to the Management of Hyperglycemia

<table>
<thead>
<tr>
<th>Patient / Disease Features</th>
<th>More stringent</th>
<th>A1C 7%</th>
<th>Less stringent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risks potentially associated with hypoglycemia and other drug adverse effects</td>
<td>low</td>
<td>high</td>
<td></td>
</tr>
<tr>
<td>Disease duration</td>
<td>newly diagnosed</td>
<td>long-standing</td>
<td></td>
</tr>
<tr>
<td>Life expectancy</td>
<td>long</td>
<td>short</td>
<td></td>
</tr>
<tr>
<td>Important comorbidities</td>
<td>absent</td>
<td>few/mild</td>
<td>severe</td>
</tr>
<tr>
<td>Established vascular complications</td>
<td>absent</td>
<td>few/mild</td>
<td>severe</td>
</tr>
<tr>
<td>Patient attitude and expected treatment efforts</td>
<td>highly motivated, excellent self-care capabilities</td>
<td>less motivated, poor self-care capabilities</td>
<td></td>
</tr>
<tr>
<td>Resources and support system</td>
<td>readily available</td>
<td>limited</td>
<td></td>
</tr>
</tbody>
</table>

A1C
- Frequency - every 3-6 month
- Target for most patient - 7%

Individualized target based on multiple factors including, but not limited to
- Risk potential associated with hypoglycemia and other drug adverse effects
- Disease duration
- Life expectancy
- Important comorbidities
- Established vascular complications
- Patient preference
- Resources and support system
Blood Glucose Monitoring is the Foundation for Optimizing Care

- Blood glucose meters and continuous glucose monitors (CGM)
- Frequency depends on:
  1. Type of medications
  2. Glycemic pattern
  3. Risk of hypoglycemia
- Target for most patients
  - Fasting/premeal - 80 – 130 mg/dl
  - 2 hours after meal - <180 mg/dl
- Hypoglycemia
Protecting Heart Health
Lipids

- ASCVD Risk Assessment
- Lifestyle Modifications
- Cost Considerations
- Shared Decision Making
- Reassess
**Blood Pressure**

**Target for most people:**

Higher CV risk (ASCVD score >15%) - **<130/80 mmHg**

Lower CV risk (ASCVD score < 15%) - **<140/90 mmHg**

Individualized goal and treatment plan that includes lifestyle and medication is important.
In addition to Blood Pressure and Lipid Control…

1. Quit smoking

2. Low dose aspirin (over age 50 and have risk factors)

3. Other cardioprotective medications
   - Sodium–glucose cotransporter 2 inhibitor (SGLT2) or glucagon-like peptide 1 (GLP1) receptor agonist with demonstrated cardiovascular disease benefit
   - ACE inhibitor or angiotensin receptor blocker therapy
   - Patients with prior myocardial infarction, β-blockers should be continued for at least 2 years after the event
Protecting Kidney Health
# Kidney Health Tests

## Suitable Albumin Creatinine Ratio (ACR)

- **Below 30 - normal**
- **Between 30 - 299 - Microalbuminuria**
- **Above 300 - Macroalbuminuria**

## Glomerular Filtration Rate (GFR)

**Frequency**
- At least once a year
- Twice annually if urinary albumin >30 mg/g creatinine and/or an eGFR <60 mL/min/1.73 m²

<table>
<thead>
<tr>
<th>GFR categories (mL/min/1.73m²)</th>
<th>Description and range</th>
<th>Albuminuria categories Description and range</th>
<th>A1 Normal to mildly increased</th>
<th>A2 Moderately increased</th>
<th>A3 Severely increased</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1 Normal or high</td>
<td>≥90</td>
<td>1 if CKD</td>
<td>Treat 1</td>
<td>Refer* 2</td>
<td></td>
</tr>
<tr>
<td>G2 Mildly decreased</td>
<td>60-89</td>
<td>1 if CKD</td>
<td>Treat 1</td>
<td>Treat 2</td>
<td>Refer* 3</td>
</tr>
<tr>
<td>G3a Mildly to moderately decreased</td>
<td>45-59</td>
<td>Treat 1</td>
<td>Treat 2</td>
<td>Refer 3</td>
<td></td>
</tr>
<tr>
<td>G3b Moderately to severely decreased</td>
<td>30-44</td>
<td>Treat 2</td>
<td>Treat 3</td>
<td>Refer 3</td>
<td></td>
</tr>
<tr>
<td>G4 Severely decreased</td>
<td>15-29</td>
<td>Refer* 3</td>
<td>Refer* 3</td>
<td>Refer 4+</td>
<td></td>
</tr>
<tr>
<td>G5 Kidney failure</td>
<td>&lt;15</td>
<td>Refer 4+</td>
<td>Refer 4+</td>
<td>Refer 4+</td>
<td></td>
</tr>
</tbody>
</table>
Minimize Complications: Address Comorbidities and Barriers to Adherence
Minimize Complications

- **Eye Exam** (every year)

- **Feet Exam** (at least once per year) but, with evidence of sensory loss or prior ulceration or amputation at every visit. Exam should include...
  1. Inspection of the skin
  2. Assessment of foot deformities
  3. Neurological assessment (10-g monofilament testing with at least one other assessment: pinprick, temperature, vibration)
  4. Vascular assessment including pulses in the legs and feet

- **Dental Checkup** (at least once or twice a year)

- **Obesity/Weight Management** (discuss at every visit) - Five to Seven percent reduction in weight improves blood glucose and reduces the need of medication. Set individualized goal, treatment plan, and time to reach the goal
Minimize Complications cont’d

**Immunizations**

- Annual vaccination against *influenza* is recommended for all people ≥6 months of age, *especially* those with diabetes.

- People with diabetes ages 2 through 64 years should also receive 23-valent *pneumococcal polysaccharide vaccine* (PPSV23). At age ≥65 years, regardless of vaccination history, additional PPSV23 vaccination is necessary.

- Administer a 2- or 3-dose series of *hepatitis B vaccine*, depending on the vaccine, to unvaccinated adults with diabetes ages 18 through 59 years and consider for unvaccinated adults with diabetes ≥60 years of age.
Psychosocial Barriers – Assess and Address

- Assess for symptoms of **diabetes distress, depression, anxiety, disordered eating, and cognitive capacities**. Perform at the initial visit, at periodic intervals, and when there is a change in disease, treatment, or life circumstance.

- Assess for **cognitive impairment** and depression in older adults (aged ≥65 years) with diabetes.

- Screen for SDoH like **food insecurity**, inconsistent access to **transportation**, **housing** instability. Other things to consider include loss of employment, birth of a child, or other family-based stresses.
Poll Question 3

What are the biggest barriers to developing and maintaining personalized diabetes care plans with every patient?
Some Common Barriers:

➔ Insufficient time

➔ Lack of patient engagement in implementing the plan

➔ Lack of continuity of care, different providers

➔ Patient not able to come in with enough frequency to keep the plan up to date

Possible Solutions:

- Schedule annual diabetes only visit
- Refer to DSMES
- Leverage team and tech to increase quantity and quality of touchpoints
- Integrate regular screening for social/emotional barriers and identify community support resources
- Other
Case Comparison:

Case 1: 45 years old successful businesswoman who was diagnosed with diabetes 3 months ago during her annual physical exam. She does not have any other comorbidities and complications except obesity. She is very enthusiastic about getting his diabetes and weight under control. Her A1C today is 8.5%.

Current medication – Metformin

Previous medication – None

Case 2: 70 years old with alcohol use disorder who has been diagnosed with diabetes for 30 years. He lives alone and he has been on disability since age of 50. He has coronary artery disease, stroke with residual right sided weakness, chronic kidney disease as well as hard of hearing. He has had frequent hypoglycemia and struggles with adherence to medication partly due to fear of hypoglycemia. His A1C today is 8.5%.

Current medication – Metformin, Basal insulin, Glipizide
<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypoglycemia risk – Low</td>
<td>Hypoglycemia risk – High</td>
</tr>
<tr>
<td>Disease duration – Recent diagnosis</td>
<td>Disease duration – 30 years</td>
</tr>
<tr>
<td>Life expectancy – High</td>
<td>Life expectancy – Low</td>
</tr>
<tr>
<td>Important comorbidities – None</td>
<td>Important comorbidities – Many</td>
</tr>
<tr>
<td>Established vascular complications – None</td>
<td>Established vascular complications – Yes</td>
</tr>
<tr>
<td>Patient preference – Tight glycemic control</td>
<td>Patient preference – To avoid low blood glucose</td>
</tr>
<tr>
<td>Resources and support system – Plenty</td>
<td>Resources and support system – Limited</td>
</tr>
<tr>
<td>A1C Target – &lt;7%</td>
<td>A1C Target – 8% without hypoglycemia</td>
</tr>
</tbody>
</table>
# Treatment Plan - Edited

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical</strong> – No risk of hypoglycemia, obesity, recently diagnosed</td>
<td><strong>Clinical</strong> – High risk of hypoglycemia, multiple comorbidities, 30 years of diabetes</td>
</tr>
<tr>
<td><strong>Personal</strong> – Willing to try any medication that will help, able to learn skills, technology</td>
<td><strong>Personal</strong> – Fear of hypoglycemia (which is interfering with adherence to meds)</td>
</tr>
<tr>
<td><strong>SDOH</strong> – Good health insurance and support system</td>
<td><strong>SDOH</strong> – Food insecurity, poor social support</td>
</tr>
</tbody>
</table>

**Current Meds:** Metformin

- Add GLP1a injection
- Referral to DSMES
- Smart glucose meter

**Current Meds:** Metformin, Basal Insulin, Glipizide

- Discontinue Glipizide
- Decrease basal insulin (weight based)
- Add Actos or DPP4i if insurance covers with no or affordable copay
- Professional CGM to look for glycemic pattern
- Referral to social service to help with social support, food bank
- Referral to DSMES
## Follow Up Visit/Communication

<table>
<thead>
<tr>
<th>Case 1</th>
<th>Case 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical – No immediate risk such as DKA/HHS or hypoglycemia</td>
<td>Clinical – High risk of hypoglycemia as well as hyperglycemia, hard of hearing which prevents him to effectively use telephone</td>
</tr>
<tr>
<td>Personal – Don’t have time for frequent inpatient visit due to busy schedule</td>
<td>Personal – Low literacy</td>
</tr>
<tr>
<td>SDoH – Has access to technology</td>
<td>SDoH – Limited access to transportation</td>
</tr>
</tbody>
</table>

- Cloud transfer of blood glucose readings to clinic EHR
- Video remote visit in 6 weeks
- In-patient visit in 3 months

- Arrange Medicaid cab service
- 2 weeks in-person follow up for CGM download and further adjustment of medication
Conclusion

● A high-quality personalized diabetes care plan creates a road map to reduce therapeutic inertia in diabetes management.

● Comprehensive evaluation and consideration of multiple factors (such as medical, social, emotional, preference, cost) is essential in developing a thorough diabetes care plan that is effective.

● Shared decision making with a patient centered approach is essential in collaborative development of a successful care plan.
Questions?
Your Action Assignment - Should you choose to accept it!

1. **Download** “Your Diabetes Care and Management Plan” to share with your patients

2. **Download** a customizable “Diabetes Care and Management Plan Summary”

3. **Share** the “Getting to Goal: Overcoming Therapeutic Inertia in Diabetes Care” fact sheet to share with all your clinic staff

4. Take the post-webinar survey – in your email box

Learn more at… [TherapeuticInertia.Diabetes.org](http://TherapeuticInertia.Diabetes.org)
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- 1/27/2021  Engaging Your Community as an Inertia Buster
- 3/10/2021  Optimize the Patient Journey: A Case-Based Approach

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Overcoming Therapeutic Inertia
Summary of Diabetes Care Plan

**Medications**
- Diabetic medication
- Antihypertensive
- Lipid lowering medication
- Others: Aspirin, antidepressant, weight lost medication, etc.

**Lifestyle Modification/Risk Reduction**
- Exercise
- Weight management – calorie count, activity
- Blood glucose measurement
- Immunization

**Referral**
- Diabetes Self-Management Education and Support (DSMES)
- Dietician/MNT
- Social service/counselling
- Other medical subspecialties – cardiologist, nephrologist, pharmacist etc.

**Follow up visit/Communication**
- When to follow up
- When to contact the provider (for example: frequent or severe hypoglycemia)