Question & Answer
Recorded November 4, 2020 from the live webinar:
Personalized Diabetes Care Plans that Work

**Question:**
When should you be referring to diabetes self-management education and support and to dietitians?

**Answer:**
Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association recommend the following:

1. At diagnosis
2. Annually and/or when not meeting treatment targets
3. When complicating factors develop
4. When transitions in life or care occur

https://care.diabetesjournals.org/content/43/7/1636

-Sandra Leal, PharmD, MPH, FAPhA, CDCES

**Question:**
Can you share your thoughts on interventions and approaches to better engage a disengaged patient?

**Answer:**
Work on understanding patients where they are at. Work on building trust with them so that they know you are on their side. Personalize their care to include them in all decisions. Establish timelines and goals that they help to identify collaboratively with you. Work to identify and remove barriers that might prevent people from being successful.

A great resource that address this exact topic can be found here:


-Sandra Leal, PharmD, MPH, FAPhA, CDCES
Question:
What is the ADA doing to work with major EHR companies (EPIC, Athena) to embed diabetes care plans?

Answer:
The American Diabetes Association is currently working with the EHR Association (EHRA) to create a working group around how EHRs can support more timely and effective care. Part of this will include discussions about embedding customizable care plans into the EHR.

-Paul Scribner, Director, Therapeutic Inertia Initiative.

Question:
In my practice I experience what I would call physician inertia. Can you share some ways that non-physician staff might help to encourage and support the use new meds and tools?

Answer:
Consider engaging the care team to support the team in advancing therapy. A great strategy that we have utilized effectively is to become preceptors for students and residents to create a training environment where all of us work together to keep up with the latest guidelines, journal clubs, information which tends to bust inertia because we hold each other accountable. Additionally, we leverage things like point-of-care testing, screenings to be able to act faster rather than delay care. Additionally, as this education program pointed out, establishing a patient care plan helps to direct both patients and providers to assess and keep on top of the recommended frequency for interventions, referrals, etc. to bust inertia!

-Sandra Leal, PharmD, MPH, FAPhA, CDCES

Question:
How do you make sure that there is continuity with the development and use of a care plan? Does the care plan travel with the patient?

Answer: Based on my personal experience, I always make sure I have the care plan which is formulated via shared decision making process at the end of each visit and documented in my EHR system. Most of my patients do not sign up for “MyChart” so I always printed out the plan for them (even for those who have MyChart account) and go over it with them again using that document before checking out. That copy travels with the patient. Having good communication with other care team helps a lot with continuity of care plan as well. In my experience, DSMES specialists and pharmacists within the system are very helpful to fill in the gaps in the care plan which is not completed during patient encounter.

- Nay Linn Aung, MD
**Question:**
Should non-alcoholic fatty liver diseases (NALFD) and nonalcoholic steatohepatitis (NASH) be part of a diabetes care plan?

**Answer:** NASH and NALFD are important associated conditions with diabetes and should be part of diabetes care plan. The ADA has recommends having a liver function test every year and also assessing inflammation and fibrosis in certain high risk patients. Although the extent of assessment vary depending on patient condition, availability of resource etc., possibility of NAFLD and NASH should be considered in choosing medication options for diabetes management.

[https://care.diabetesjournals.org/content/43/Supplement_1/S37](https://care.diabetesjournals.org/content/43/Supplement_1/S37)

- Nay Linn Aung, MD

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**Question:**
I am a community nurse who works with people that are homeless. Can you provide suggestions and tips for how to best engage and support the homeless with managing diabetes?

**Answer:** In my opinion, the most important step is to engage individuals and bring them on board to formulate a diabetes care plan. One of the ways to engage a patient might be via motivational interviewing which has been used often in any patients with diabetes. Homeless people with diabetes have unique challenges and barriers to implement a care plan such as food security, timing of food, storage of medication and supplies, etc. Those need to be considered in developing a care plan. The care team may need to include a local food bank, community support program, and shelter resources to overcome therapeutic inertia in this specific population.

MI- [https://spectrum.diabetesjournals.org/content/19/1/5](https://spectrum.diabetesjournals.org/content/19/1/5)

Psychosocial issue - [https://care.diabetesjournals.org/content/43/Supplement_1/S48](https://care.diabetesjournals.org/content/43/Supplement_1/S48)

- Nay Linn Aung, MD