MAKING THE CONNECTION
BETWEEN PATIENTS AND PROVIDERS

Improving Clinical Care with Modern Treatment Strategies for Type 1 and Type 2 Diabetes

October 3, 2020 · VIRTUAL

TCOYD TAKING CONTROL OF YOUR DIABETES | UC San Diego School of Medicine | global EDUCATION GROUP | UMA A DIVISION OF ULTIMATE MEDICAL ACADEMY

Taking Control Of Your Diabetes

990 Highland Drive, Suite 312
Solana Beach, CA 92075
Phone: 800.998.2693 or
858.755.5683
tcoyd.org/cme

UC San Diego School of Medicine

Continuing Medical Education
9500 Gilman Drive MC 0947
La Jolla, CA 92093-0947
Phone: 858.534.3940
cme.ucsd.edu

Global Education Group

5575 South Sycamore Street, Suite 200
Littleton, CO 80120
Phone: 303.395.1782
Fax: 303.648.5311
www.globaleducationgroup.com

This activity is jointly presented by UC San Diego School of Medicine & Taking Control Of Your Diabetes

This activity is jointly presented by Global Education Group & Taking Control Of Your Diabetes for ACPE credit

ACKNOWLEDGEMENTS

This activity is supported by educational grants from:

Amarin Pharma Inc., AstraZeneca, Lilly USA LLC,

Medtronic Diabetes, Merck Sharp & Dohme Corp.,
NovoNordisk, Inc., and Xeris Pharmaceuticals, Inc.

TABLE OF CONTENTS

General information

Appendix

For questions or comments about this activity, please contact Taking Control Of Your Diabetes:
Taking Control Of Your Diabetes
Attn: Continuing Medical Education
990 Highland Drive, Suite 312
Solana Beach, CA 92075
858.792.4741 ext. 117
robyn@tcoyd.org

HOW TO RECEIVE CREDIT AND EVALUATE THIS PROGRAM

Evaluations for this course are available online. To claim credit and evaluate this course:

Please visit cpd.ucsd.edu/evaluation to complete the evaluation for this course.

Sign in with your username and password. If you do not have an account with cmecalifornia.com, simply create an account.

Choose "TCOYD Making the Connection 2020 Evaluation – 10.03.20 Virtual" from the selection of courses and use the access code below when prompted:

TCOYD4VIR

Once you complete and submit your evaluation,
your certificate will be available immediately for download.

CREDIT DEADLINE:
The last day to submit your evaluation and receive a certificate
for the course is November 7, 2020

Pharmacists: You have 50 days to claim your credit online
so that it can be submitted to the NABP

Need help? Please contact UC San Diego Continuing Medical Education
Phone: 888.229.6263 or 858.534.3940
Email: ocme@health.ucsd.edu
(Email is recommended for fastest response, as phone staffing is limited at this time.)

OVERVIEW & STATEMENT OF NEED

Current clinician practice habits are not designed to evolve with the ever-changing standards of care for people with diabetes. One of the major barriers to changing practice habits in the area of diabetes is that physicians and other diabetes professionals do not always understand the physical and emotional issues that people living with diabetes and their family members face on a day-to-day basis; moreover, patients often experience guilt and embarrassment surrounding difficulties with treatment adherence, and may not admit these shortcomings to healthcare providers. The unique *Making the Connection Between Patients and Providers: Improving Clinical Care with Modern Treatment Strategies for Type 1 and Type 2 Diabetes* (MTC) series, which is in its 15th year, is specifically designed to bring together the educational needs of both the clinician and the patient in an effort to break down these barriers by improving communication and understanding between providers and their patients, ultimately improving long-term patient outcomes.

TARGET AUDIENCE

This course is designed for diabetes healthcare providers including endocrinologists, primary care physicians, nurse practitioners, physician assistants, nurses, certified diabetes educators, pharmacists, and other healthcare providers wanting to expand their knowledge of diabetes management.

CULTURAL AND LINGUISTIC COMPETENCY

Cultural and Linguistic Competency: This activity is in compliance with California Assembly Bill 1195 which requires continuing medical education activities with patient care components to include curriculum in the subjects of cultural and linguistic competency. Cultural competency is defined as a set of integrated attitudes, knowledge, and skills that enables health care professionals or organizations to care effectively for patients from diverse cultures, groups, and communities. Linguistic competency is defined as the ability of a physician or surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language. Cultural and linguistic competency was incorporated into the planning of this activity. Additional resources can be found on the UC San Diego CME website (cme.ucsd.edu).

PROGRAM AGENDA – ALL TIMES ARE CDT

9:15am	Program Overview & Introduction
9:30am	Understanding and Addressing Problematic Adherence to Oral and Injectable Cardiometabolic Medications *William Polonsky, PhD, CDE*
10:30am	A Focus on Time in Range, Unmet Needs and Modern Management of Type 1 Diabetes *Jeremy H. Pettus, MD*
11:45am - Break	
12:15pm	Effective Use of Oral Medications for Type 2 Diabetes: Lowering Cardiovascular Risk While Improving Glycemic Control *Tricia Santos Cavaiola, MD*
1:45pm - Break	
2:15pm	Practical Application of Injectable Agents and Their Cardiovascular Effects: Individualized Treatment Strategies *Steven V. Edelman, MD*
3:30pm	Combined Patient-Provider Workshop: Doctors Are From Mars, Patients Are From Venus *William Polonsky, PhD, CDE, and Steven V. Edelman, MD*
4:00pm	Wrap Up: How to Bring Today's Learning Into Tomorrow's Practice *William Polonsky, PhD, CDE, and Steven V. Edelman, MD*
4:15pm	Adjourn – Additional Q&A and Networking

EDUCATIONAL OBJECTIVES

Upon completion of this course, participants should be able to:

1. Identify the different pathophysiologic defects associated with type 2 diabetes and how all the pharmacologic agents (oral and injectable) address these specific abnormalities.

2. Develop individualized treatment strategies based on the living standards of care and patient characteristics.

3. Discuss the recently published cardiovascular-renal outcome trials on oral and injectable type 2 medications.

4. Summarize the most up-to-date clinical information on GLP-1 RA and SGLT-2 inhibitors.

5. Evaluate the use of SGLT-2 and GLP-1 RA in patients who have cardiovascular risk factors and are at risk or have a history of atherosclerotic cardiovascular disease (ASCVD).

6. Discuss approaches to combination therapy with the currently available oral agents, as well as physician and patient-directed insulin titration strategies and the basal-bolus approach.

7. Design a treatment plan for multiple daily injection regimens and insulin pump therapy.

8. Explain how to interpret continuous glucose monitoring (CGM) data.

9. Demonstrate the ability to select effective therapeutic adjustments based on CGM trending or rate of change arrows, time in range, and standard deviation.

10. Recognize the physical and emotional barriers that prevent patients with diabetes from being persistent and adherent to their therapeutic regimen(s).

11. Employ innovative and dynamic strategies for communication with patients to strengthen provider-patient relations and improve patient outcomes.

ACCREDITATION

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the University of California San Diego School of Medicine and Taking Control Of Your Diabetes. The University of California San Diego School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

AMA: The University of California San Diego School of Medicine designates this live activity for a maximum of **6.0** *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Nurses: For the purposes of recertification, the American Nurses Credentialing Center accepts *AMA PRA Category 1 credits*™ issued by organizations accredited by the ACCME. For the purpose of re-licensure, the California Board of Registered Nursing accepts *AMA PRA Category 1 Credits* ™ (report up to **6.0** hours of credit and list "CME Category 1" as the provider number).

Physician Assistants: The AAPA accepts certificates of participation for educational activities certified for *AMA PRA Category 1 Credit*s™ from organizations accredited by ACCME or a recognized state medical society. Physician assistants may receive a maximum of **6.0** hours of Category 1 credit for completing this program.

Certified Diabetes Educators: The University of California San Diego School of Medicine is accredited by the ACCME, which is on the NCBDE list of approved providers.

Pharmacists: Global Education Group is accredited by the Accreditation Counsel for Pharmacy Education as a provider of continuing pharmacy education.

Credit Designation - Global Education Group designated this continuing education activity for **6.0** contact hour(s). (.6 CEUs) of the Accreditation Council for Pharmacy Education (Universal Activity Number – 0530-9999-20-092-L01-P)

This is a knowledge-based activity. A current list of commercial supporters is available at tcoyd.org/cme

Global Contact Information – For information about the ACPE accreditation of this program, please contact Global at 303.395.1782 or CME@globaleducationgroup.com

COURSE DIRECTOR

Steven V. Edelman, MD

Clinical Professor of Medicine
University of California San Diego School of Medicine;
Director, Diabetes Care Clinical, San Diego VA Medical Center;
Founder and Director, Taking Control Of Your Diabetes (TCOYD)

FACULTY GUEST SPEAKERS

William Polonsky, PhD, CDE

President, Behavioral Diabetes Institute
Associate Clinical Professor, Department of Psychiatry
University of California, San Diego

Jeremy H. Pettus, MD

Associate Clinical Professor of Medicine
Division of Endocrinology, Diabetes and Metabolism
University of California San Diego School of Medicine

Tricia Santos Cavaiola, MD

Associate Clinical Professor of Medicine
Division of Endocrinology, Diabetes and Metabolism
University of California San Diego School of Medicine

DISCLOSURE SUMMARY

Making the Connection Between Patients and Providers
Improving Clinical Care with Modern Treatment Strategies for Type 1 and Type 2 Diabetes

It is the policy of the University of California San Diego School of Medicine and Global Education Group (Global) to ensure balance, independence, objectivity and scientific rigor. All persons involved in the selection, development and presentation of content are required to disclose any real or apparent conflicts of interest. All conflicts of interest will be resolved prior to an educational activity being delivered to learners through one of the following mechanisms 1) altering the financial relationship with the commercial interest, 2) altering the individual's control over CME content about the products or services of the commercial interest, and/or 3) validating the activity content through independent peer review. All persons are also required to disclose any discussions of off label/unapproved uses of drugs or devices. Persons who refuse or fail to disclose are disqualified from participating in the CME activity. Participants will be asked to evaluate whether the speaker's outside interests reflect a possible bias in the planning or presentation of the activity. This information is used to plan future activities.

The faculty reported the following financial relationships or relationships to products or devices they or their spouse/life partner have with commercial interested related to the content of this CME activity:

Steven V. Edelman, MD

Board Member: Senseonics, TeamType1

Medical Advisory Board: AstraZeneca, BrightSight, Companion Medical, Lilly USA, LLC, Merck, Sanofi-aventis U.S. Inc.

Speaker's Bureau: AstraZeneca, Lilly USA, LLC, MannKind Corporation, Merck, Sanofi-aventis U.S. Inc.

Jeremy H. Pettus, MD

Consultant: Eversense, Insulet, Lexicon Pharmaceuticals, Lilly USA, LLC, MannKind Corporation, Novo Nordisk, Sanofi-aventis U.S. Inc.

Speaker's Bureau: MannKind Corporation

Research Funding: Novo Nordisk

Advisory Board: Diasome

William Polonsky, PhD, CDE

Consultant: Abbott Laboratories, Ascensia, Dexcom, Eli Lilly, Insulet, Lifescan, Livongo, MannKind Corporation, Novo Nordisk, Onduo, Roche, Sanofi-aventis U.S. Inc., Servier, Xeris

Tricia Santos Cavaiola, MD

No financial relationships to disclose.

DISCLOSURE SUMMARY CONTINUED

TCOYD, UC San Diego School of Medicine, Global Education Group:

The CME staff, meeting planners, planning committee and CME committee or peer reviewers other than previously listed do not have any relevant financial relationships to disclose.

DISCLOSURE OF UNLABLED USE: This educational activity may contain discussion of unlabeled and/or investigational uses of agents that are not approved by the FDA. Please consult the prescribing information for each product. The views and opinions expressed in this activity are those of the faculty and do not necessarily reflect the views of the University of California San Diego, Global Education Group, or Taking Control Of Your Diabetes.

DISCLAIMER: Participants have an implied responsibly to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed in the activity should not be used by clinicians without evaluation of patient conditions and possible contraindications on dangers in use, review of any applicable manufacture's product information, and comparison with recommendations of other authorities.

APPENDIX

CHOOSING GLUCOSE-LOWERING MEDICATION IN THOSE WITH ESTABLISHED ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD) OR CHRONIC KIDNEY DISEASE (CKD)

Use metformin unless contraindicated or not tolerated

If not at HbA1c target:

- Continue metformin unless contraindicated (remember to adjust dose/stop metformin with declining eGFR)
- Add SGLT2i or GLP-1 RA with proven cardiovascular benefit[1] (see below)

If at HbA1c target:

- If already on dual therapy, or multiple glucose-lowering therapies and not on an SGLT2i or GLP-1 RA, consider switching to one of these agents with proven cardiovascular benefit[1] (see below)

OR reconsider/lower individualized target and introduce SGLT2i or GLP-1 RA

OR reassess HbA1c at 3-month intervals and add SGLT2i or GLP-1 RA if HbA1c goes above target

ASCVD PREDOMINATES

GLP-1 RA with proven CVD benefit[1]

EITHER/ OR

SGLT2i with proven CVD benefit[1], if eGFR adequate[2]

If HbA1c above target

If further intensification is required or patient is now unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:

- Consider adding the other class (GLP-1 RA or SGLT2i) with proven CVD benefit[1]
- DPP-4i if not on GLP- RA
- Basal insulin[5]
- TZD[6]
- SU[7]

HF OR CKD PREDOMINATES

PREFERABLY

SGLT2i with evidence of reducing HF and/or CKD progression in CVOTs if eGFR adequate[3]

-------- OR --------

If SGLT2i not tolerated or contraindicated of if eGFR less than adequate[2] add GLP-1 RA with proven CVD benefit [1,4]

If HbA1c above target

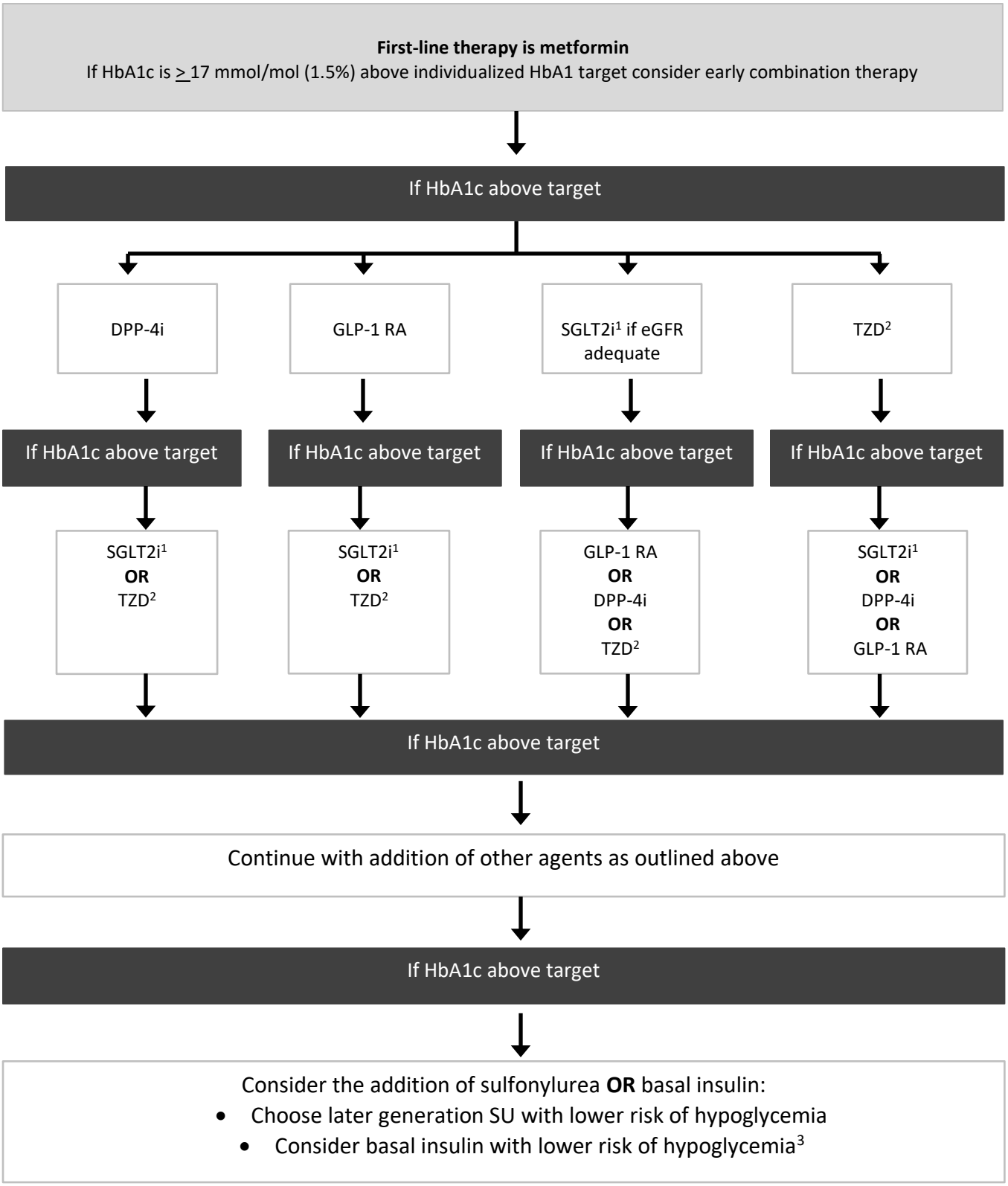
- Avoid TZD in the setting of HF

Choose agents demonstrating CV safety:

- Consider adding the other class with proven CVD benefit[1]
- DPP-4i (not saxagliptin) in the setting of HF (it not on GLP-1 RA)
- Basal insulin[5]
- SU[7]

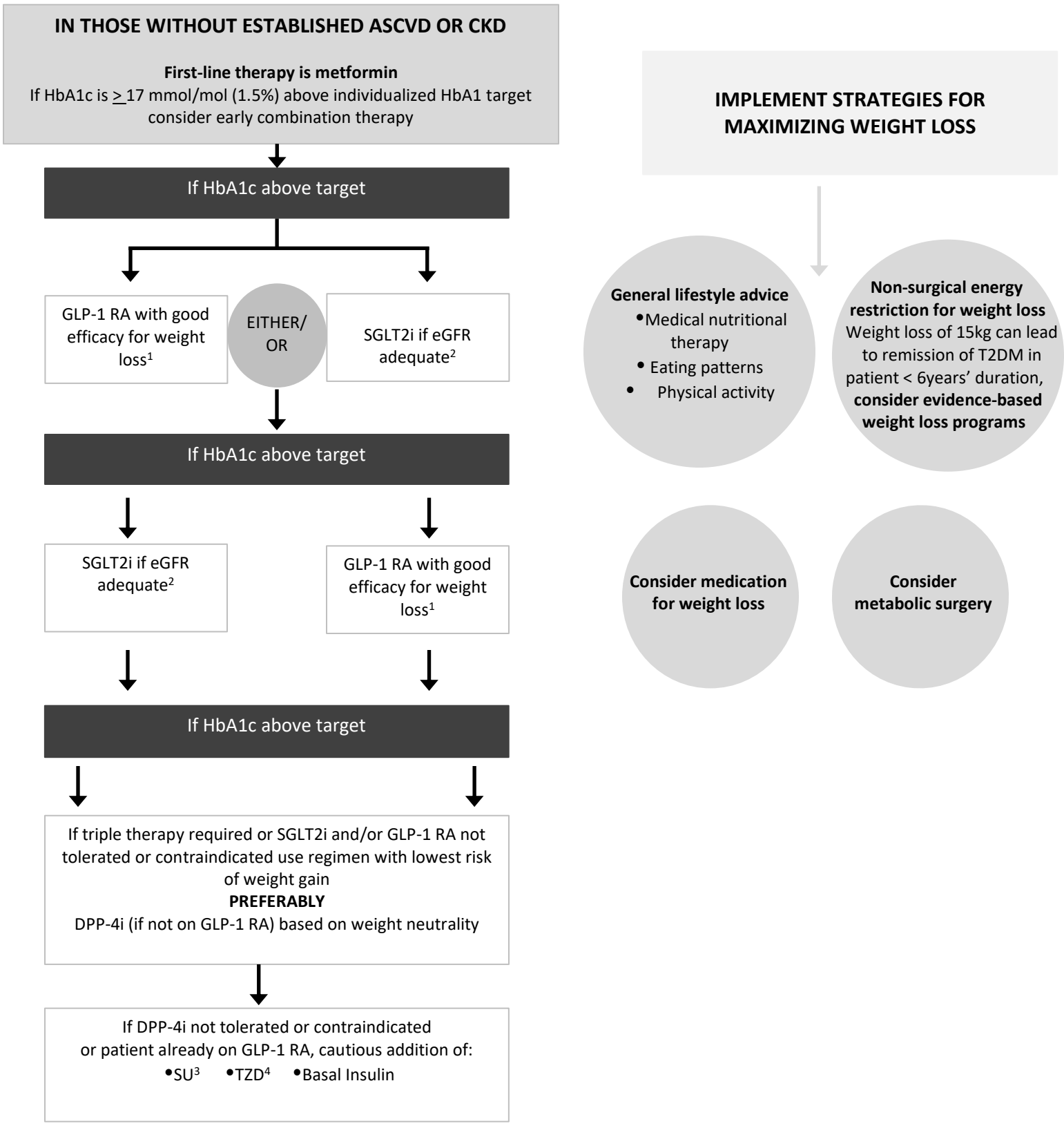
1. Proven CVD benefit means it has label indication of reducing CVD events. For GLP-1 RA strongest evidence for liraglutide > semaglutide > exenatide extended release. For SGLT2i evidence modestly stronger for empagliflozin > canagliflozin.
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use.
3. Both empagliflozin and canagliflozin have shown reduction in HF and to reduce CKD progression in CVOTs.
4. Caution with GLP-1 RA in ESRD.
5. Degludec or U100 glargine have demonstrated CVD safety.
6. Low dose may be better tolerated through less well studied for CVD effects.
7. Choose later generation SU to lower risk of hypoglycemia.

CHOOSING GLUCOSE-LOWERING MEDICATION IF COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA IN THOSE WITHOUT ESTABLISHED ASCVD OR CKD



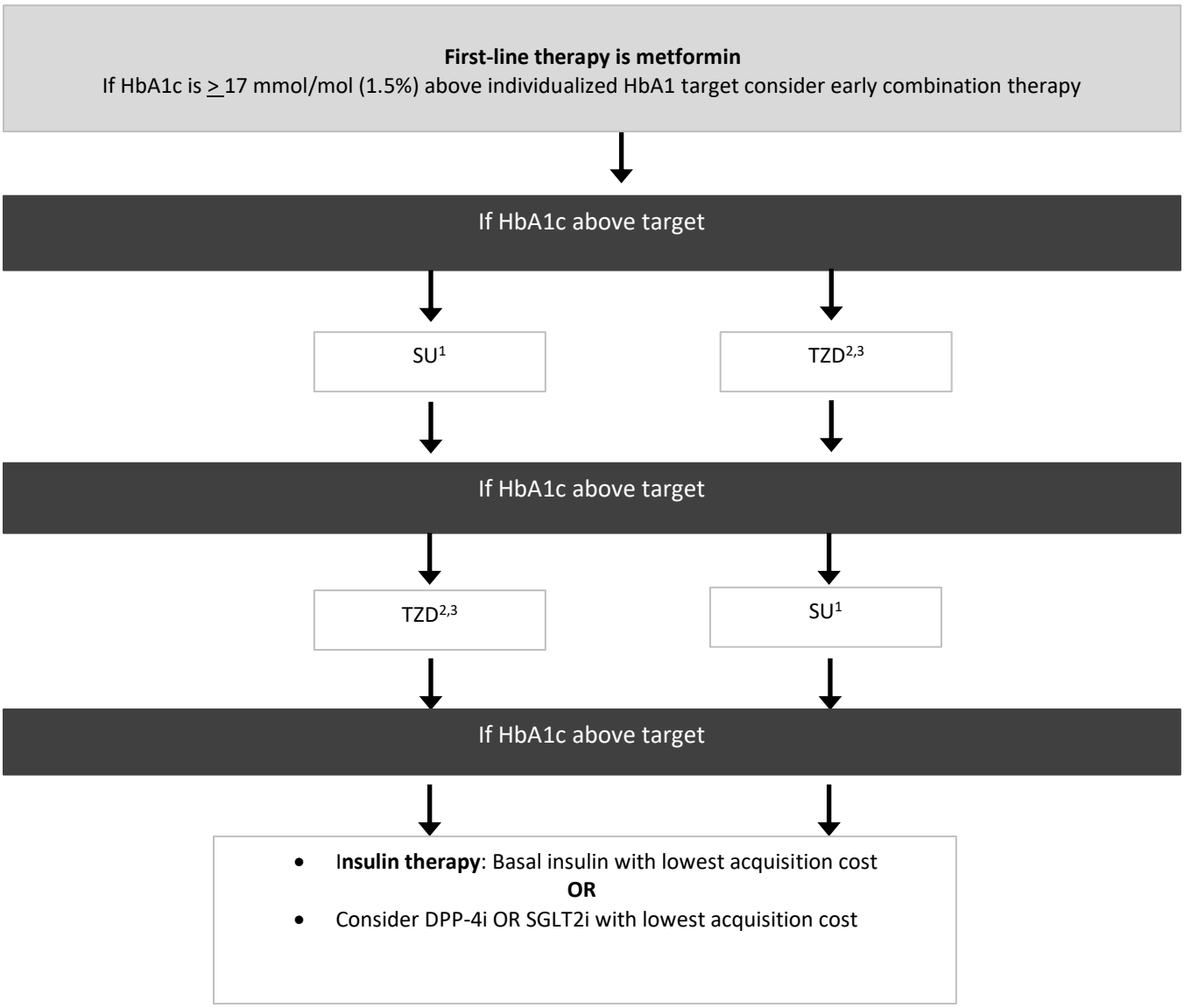
1. Be aware that SGLT2i vary by region and individual agent with regard to indicated level of eGFR for initiation and continued use.
2. Low dose TZDs are better tolerated.
3. Degludec/ glargine U300 < glargine u100 / detemir < NPH insulin .

CHOOSING GLUCOSE-LOWERING MEDICATION IF COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS

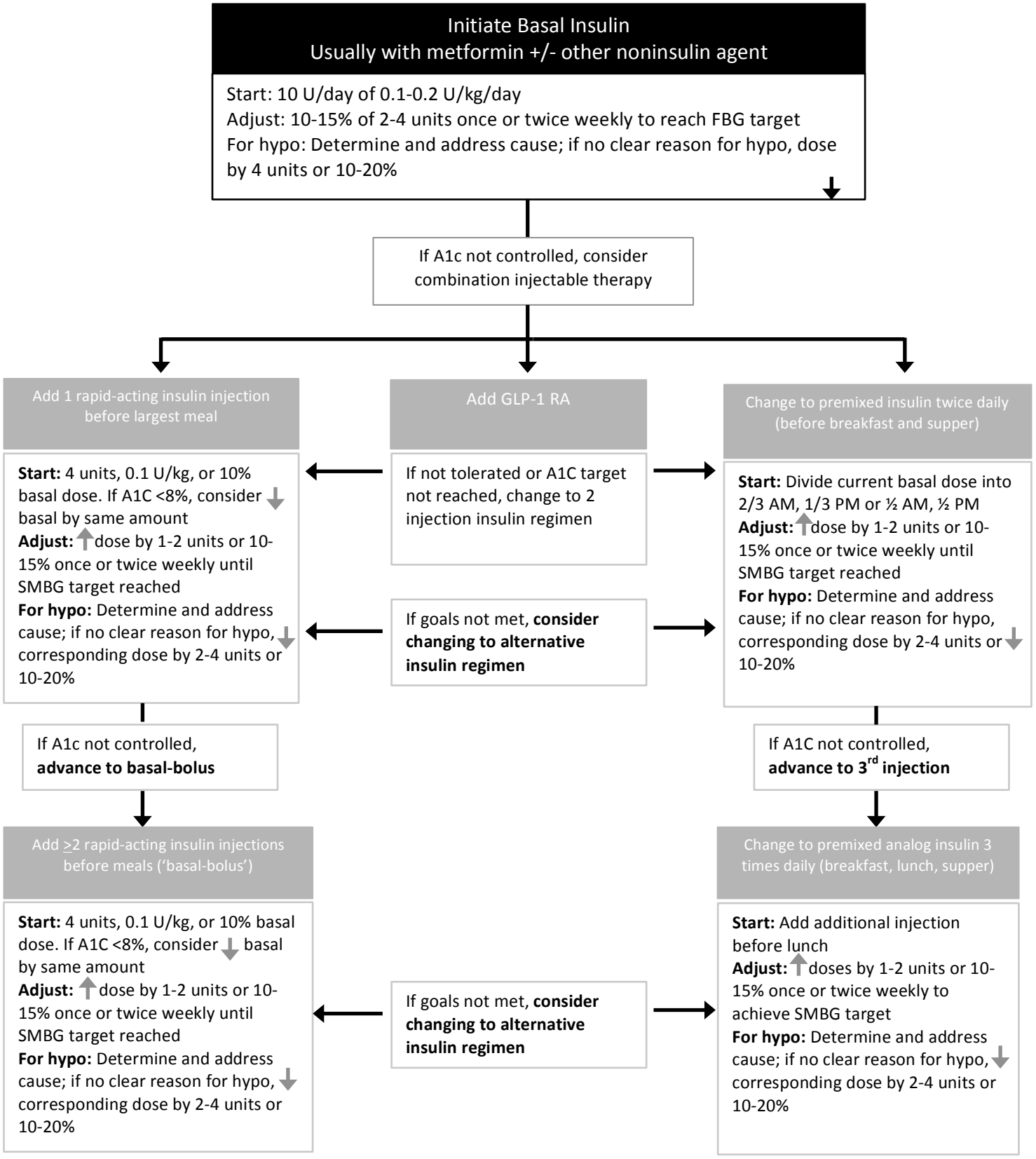


1. Semaglutide > liraglutide >dulaglutide > exenatide > lixisenatide
2. Be aware that SGLT2i vary by region and individual agent with regard to indicated level ofeGFR for initiation and continued use
3. Choose later generation SU with lower risk of hypoglycemia.
4. Low dose may be better tolerated though less well studied for CVD effects.

CHOOSING GLUCOSE-LOWERING MEDICATION IF COST IS A MAJOR ISSUE IN THOSE WITHOUT ESTABLISHED ASCVD OR CKD



1. Choose later generation SU to minimize risk of hypoglycemia.
2. Consider country- and region-specific cost of drugs. In some countries, TZD relatively more expensive and DPP-4i relatively cheaper.
3. Low-dose TZDs are better tolerated.



ADA. Standards of medical care in diabetes – 2018. Diabetes Care. 2018; 41(1)

Oral Agents - Drug Class	Oral Agents - Generic	Oral Agents - Trade
Alpha-Glucosidase Inhibitors	Acarbose Miglitol	Precose Glyset
Biguanide	Metformin	Glucophage Fortamet Glucophage XR Glumetza
Bile Acid Sequestrant	Colesevelam	Welchol
Dopamine Receptor Agonist	Bromocriptine mesylate	Cycloset
DPP-4 Inhibitors	Linagliptin Saxagliptin Sitagliptin Alogliptin	Tradjenta Onglyza Januvia Nesina
Glinides	Nateglinide Repaglinide	Starlix Prandin
Sulfonylureas	Glimepiride Glipizide Glipizide (extended release) Glyburide Micronized Glyburide	Amaryl Glucotrol Glucotrol XL DiaBeta, Micronase Glynase PressTab Glynase
Thiazolidinediones	Pioglitazone	Actos
SGLT-2 Inhibitors	Canagliflozin Dapagliflozin Empagliflozin Ertugliflozin	Invokana Farxiga Jardiance Steglatro
GLP-1 Receptor Agosnists	Semaglutide	Rybelsus

Injectable Agents - Drug Class	Injectable Agents – Generic	Injectable Agents – Trade
Fast-Acting Insulins	Regular U-500 Regular Aspart Aspart Glulisine Lispro Lispro Lispro-aabc Inhaled Insulin	Humulin R, Novalin R Humulin R U-500 Novolog Fiasp Apidra Humalog Admelog Lyumjev Afrezza
Basal Insulins	Intermediate-Acting: NPH Long-Acting: Detemir Glargine (U-100) Glargine (U-300) Degludec (U-100/U-200) Follow-On Biologic Glargine (U-100) Glargine (U-100)	 NPH Levemir Lantus Toujeo Tresiba Basaglar Semglee
GLP-1 Receptor Agonists	Exenatide: Once-weekly Twice-daily Liraglutide: Once-daily Lixisenatide Once-daily Dulaglutide: Once-weekly Semaglutide: Once-weekly Oral Semaglutide: Once-daily	 Bydureon Byetta Victoza, Saxenda Adlyxin Trulicity Ozempic Rybelsus
Basal Insulin/GLP-1 Receptor Agonist Fixed Combinations	Glargine/Lixisenatide Degludec/Liraglutide	Soliqua, iGlarLixi Xultrophy, iDegLira
Amylin Analog	Pramlintide	Symlin

Combination Pills – Generic Name	Combination Pills – Trade Name	Daily Dose Range (mg)
Pioglitazone & metformin	Actoplus Met	15/500 to 45/2250
Glyburide & metformin	Glucovance	1.25/250 to 20/2000
Glipizide & metformin	Metaglip	2.5/250, 2.5/500, 5/500
Sitagliptin & metformin	Janumet Janumet XR	50/500, 50/1000 50/5001 50/1000, 100/1000
Saxagliptin & metformin	Kombiglyze XR	2.5/1000, 5/500, 5/1000
Repaglinide & metformin	Prandimet	1/500, 2/500
Linagliptin & metformin	Jentadueto	2.5/500, 2.5/850, 2.5/1000
Alogliptin & metformin	Kazano	12.5/500 to 12.5/1000
Pioglitazone & glimepiride	Duetact	30/2, 30/4
Linagliptin & empagliflozin	Glyxambi	5/10, 5/25
Alogliptin & pioglitazone	Oseni	25/15, 25/30, 25/45, 12.5/15, 12.5/30, 12.5/45
Dapagliflozin & saxagliptin	Qtern	5/10
Ertugliflozin & sitagliptin	Steglujan	5/100, 15/100
Canafliglozin & metformin	Invokamet	50/500, 50/100, 150/500, 150/1000
Ertugliflozin & metformin	Segluromet	2.5/500, 2.5/1000, 7.5/500, 7.5/1000
Empagliflozin & metformin	Synjardy Synjardy XR	5/500, 12.5/500, 5/1000, 12.5/1000 5/1000, 10/1000, 12.5/1000, 25/1000
Dapagliflozin & metformin	Xiguo XR	5/500, 10/500, 5/1000, 10/1000
Empagliflozin & linagliptin & metformin	Trijardy XR	5/2.5/1000, 10/5/1000, 12.5/2.5/1000, 25/5/1000

Improving Glucose Control Using Your Continuous Glucose Monitor (CGM)
Tips for Type 1 Diabetes

***#1*: Wear your CGM as much as possible**.
It will not help you if it is sitting in a drawer!

***#2*: Look at your receiver frequently.**
Use your CGM to learn what foods and/or insulin dose works best for you. Also, knowing the direction your glucose is heading and how fast it is moving helps avoid highs and lows.

***#3*: Maintain reasonable expectations for your CGM.**
It is a great device, but it is not perfect. Always confirm with your glucose meter before dosing insulin or if results seem abnormal. Also, twice daily calibrations are important to minimize false readings and alarms. These must be done when the glucose is between 40 and 400 mg/dl. For best results calibrate when the trend arrow is horizontal (meaning blood glucose is stable).

 ***= STABLE***

***#4*: Alerts and alarms should be your friend, not your enemy.**
When you get a high or low alert, think about what led to the alert and the actions you should take. Don't give up on your CGM if you are getting too many alerts. Instead, discuss diabetes management changes and/or your alert settings with your healthcare team.

- You can set alerts for high and low blood sugars. Typical high and low alerts would be 200 mg/dl and 80 mg/dl, but these should be individualized.
- There are also Repeat Low and Repeat High alerts. Consider turning these on so you are alerted if glucose remains too low or too high for a period of time.

***#5*: Reflect on your past decisions and actions.**
Many CGM users develop a habit of looking back at their 24-hour trend graph every morning or night. Others regularly download their CGM receivers to their computers to look at patterns that occur over time. Think about your decisions that worked well and what you could do differently to prevent high, low, or rapidly changing glucose.

***#6*: Know your personal glucose targets and take actions to reach them**.

My pre-meal target is ____ - ____
My post-meal target is < ____ mg/dl
(2 hours after start of meal).

- An alternative post-meal target is no more than 50-80 mg/dl above your pre-meal glucose.

***#7:* Have a plan for preventing or responding to low glucose.**

Don't panic or overreact. Eat some carbs (or drink something with sugar in it) then re-test in 15 minutes. It may take 15 minutes or more for the carbohydrates to reverse the falling glucose and you may not see the trend graph begin to rise for at least 15 minutes.

- Take action rather than waiting for the low glucose alert if your glucose is at target but falling rapidly.

  ↓ *or* ↓↓ = ***FALLING RAPIDLY***
- If exercise contributed to your low glucose, ask yourself if an earlier snack or insulin reduction before exercising would have helped.
- If you "stacked" insulin (taking multiple doses of rapid-acting insulin over a short period of time), be more cautious the next time.

***#8:* Use your CGM trends to improve your meal insulin dosing decisions.**

Learn to adjust your insulin dose using both your blood glucose and the trend arrows. Consider the following mealtime insulin dosing scenarios and how you would react to the glucose trend.

Trend Arrow Scenarios:

Scenario 1 → = STABLE

- Do what you would normally do.
- Try to take your mealtime insulin dose about 15 minutes before eating.

Scenario 2 - ↗ *or* ↑ ↑ = RISING

- Consider increasing your mealtime insulin dose.
- Consider allowing more time between your insulin dose and meal.
- Think about starting your meal with proteins and fats rather than carbohydrates.
- Think back if you should have taken extra insulin for an earlier snack or if you over-treated an earlier low glucose.

Scenario 3 ↘ *or* ↓ *or* ↓ ↓ = FALLING

- Consider decreasing your mealtime insulin dose.
- Consider allowing less time between your insulin dose and your meal, or even taking your meal insulin after you eat.
- Think about starting your meal with carbohydrates.

***#9:* Respond to high glucose between meals but avoid "stacking" insulin. Don't overreact.**

Rapid-acting insulin can take up to 90-120 minutes to peak and may still be working 4 hours after your injection.

If it is 2+ hours or more since your last mealtime insulin injection and the trend arrow indicates that your glucose is still rising:

↗ *or* ↑ *or* ↑ ↑ = ***GLUCOSE RISING***

- Consider giving an extra dose of rapid-acting insulin.
- Think about what you would do differently next time with your meal timing and/or your mealtime insulin dose to avoid high and rising glucose.

We thank Dexcom® for allowing us to use and edit their
'Guidelines to Improve Glucose Control Using CGM' brochure.

Starting/Adjusting Long-Acting Basal Insulin

1. Give Glargine (U-300), Glargine (U-100), Degludec (U-100/U-200), or Detemir once a day at _____

2. Starting dose: _____ units

3. Every _____ day(s), adjust your dose based on your fasting blood sugar that morning before eating or drinking:

    a. If fasting blood sugar is over _____ then increase dose by _____

    b. If fasting blood sugar is under _____ then decrease dose by _____

    c. If fasting blood sugar is between _____ and _____ then keep the same dose

IMPORTANT:

The purpose of basal or long-acting insulin is to provide a background amount of insulin throughout the day and at night while you sleep. It is not meant to treat high blood sugars caused by eating food, so you should now change your dose based on blood sugar number during the day when you are eating food.

Check-In Questionnaire for Patients with TYPE 1 DIABETES

Name (First, Last):

Date (MM/DD/YY):

1. Age:

2. Year of diagnosis:

3. Are you currently using an insulin pump? (circle one) YES or NO

   If Yes:
   A. What are your basal rates set at?

   B. Do you disconnect your pump? If you do under what circumstances and for how long?

   If No:
   A. What type of basal insulin are you on, how much do you take daily, and at what time of day?

4. How much and what type of bolus or meal-time insulin do you approximately take in a day?

5. What is your insulin to carbohydrate ratio if you use one?

6. What is your correction factor or insulin sensitivity factor (how much will your BS drop with one unit of fast-acting insulin i.e. 1:50)?

7. What else, if anything, do you take for your diabetes?

8. When was your last diabetes eye exam?

9. Do you wear a CGM (Dexcom or Medtronic)? (circle one) YES or NO

If Yes:

A. What are your upper and lower alert settings?

B. What is your snooze alert set at? (This is under advanced alert settings on your Dexcom)

10. Are you currently having problems with: (please circle YES or NO)

Low blood sugars	YES	NO
Blurry vision	YES	NO
New neck lumps or swelling	YES	NO
New or unusual skin rashes or lesions	YES	NO
New urinary or yeast infections	YES	NO
Numbness, tingling, or pain in your feet	YES	NO

11. What is/are the BIGGEST issue(s) you want to discuss today?

12. Will you need a renewal prescription today for any medications you are currently taking and if so what is the name of the medication?

Check-In Questionnaire for Patients with TYPE 2 DIABETES

Name (First, Last):

Date (MM/DD/YY):

PLEASE REPORT YOUR BLOOD SUGAR READINGS AT CHECK-IN.

Year of diagnosis:

WHAT ARE YOUR DIABETES MEDICATIONS:

Name of Medication	Dose	Frequency	Need Refill Y/N

Approximate meal times:
Breakfast: _____
Lunch: _____
Dinner: _____
Which is your biggest meal? _____

What type of exercise do you do? _____

How many days per week? _____

How many minutes each time? _____

Associated Symptoms/ROS: Are you currently having problems with:

Low blood Sugars (<80mg/dl)? □ Yes □ No
If yes, How often? _____
Time of day: _____

Date of last diabetes eye exam? _____
Blurry vision? □ Yes □ No
If yes, How long? _____

New neck lumps or swelling? □ Yes □ No

New or unusual skin rashes or lesions? □ Yes □ No
If yes, Describe: _____
New urinary or yeast infections? □ Yes □ No

Numbness, tingling, or pain in your feet? □ Yes □ No
If yes, How long? _____

Any sexual or erectile dysfunction? □ Yes □ No

What issue (s) would you like to address today (is any)? _____