Case Notes Session 8 Case 8

July 13, 2022

RECAP

- 61 yo female with class 1 obesity (BMI 33). Her obesity-related co-morbidities include well-controlled T2DM 5/2021, hyperlipidemia, and HTN on (3 agents)
- Experienced worsening DM control in setting of chronic pain, emotional and financial stress resulting from work injury causing disability.
- Clinical Question: How do you maximize weight loss and what is next step for lipid management for pt already on high intensity statin

Current Medication(s) (including dose frequency):

Medication	Dose	Frequency
Metformin SR	1000 mg	BID
Liraglutide	0.6 mg	Daily
Amlodipine	10 mg	Daily
Lisinopril	40 mg	Daily
Chlorthalidone (new)	12.5 mg	Daily
Atorvastatin	80mg	Daily

Individual Patient Characteristics

- BMI 33.6 (87.2kg)= so + insulin resistance
- GFR >60
- Age 61
- A1c improved on daily GLP-1 RA
- Sig DM distress and other life situation distress
- Limited mobility from arthritis and shoulder injury.
- Recent sig changes in lifestyle
- Regence insurance
- Hyperlipidemia (159, 49, 101)
- Hypertension on 3 agents (142/83)
- NASH- will be our next session discussion

First question:

Does this person produce insulin?

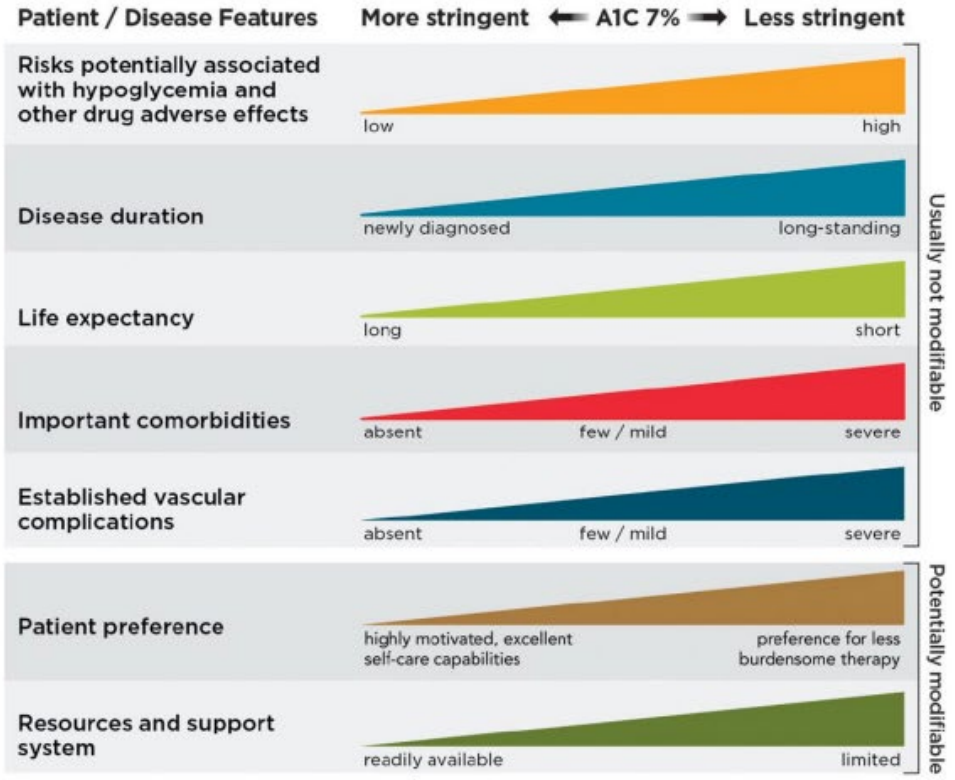
- Type 1 or Type 2?
- Insulinopenic or Insulin resistant ?

Type 2- most likely

Second Question:

- **What is her A1c Goal?**
- <7.0% (<6.5 if possible, without hypoglycemia))

Individualizing Glycemic Targets



American Diabetes Association.

Figure 6.1—Depicted are patient and disease factors used to determine optimal A1C targets. Characteristics and predicaments toward the left justify more stringent efforts to lower A1C; those toward the right suggest less stringent efforts. A1C 7% = 53 mmol/mol. Adapted with permission from Inzucchi et al. (40).

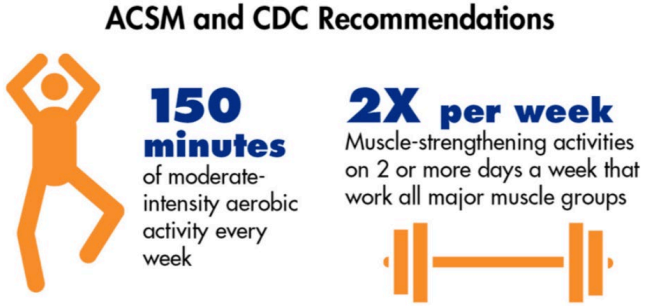
Clarifying questions

From a weight management perspective:

- Sleep
  - Any concerns?
  - Sleep apnea?
  - STOPBANG screening?
- Behavioral health
  - Currently connected
  - Results of phq-9?
  - Any history of disordered eating?
  - Previously on any medications for mental health?

Non-Pharm Intervention

- BEHAVIORAL HEALTH
  - Referral to social work
- SLEEP
  - Critical for weight loss
  - Practice good sleep hygiene
  - Avoid staying up too late
  - Must wear cpap if needed
  - Ideally 7-8 hours of sleep per night
    - St-Onge et al. Sleep-obesity relation: underlying mechanisms and consequences for treatment. Obesity Reviews 18 (suppl. 1), 34-39, February 2017
- EXERCISE



Non-Pharm Intervention

- Nutrition
  - ”The best nutritional intervention is a plan that is evidence-based, quantitatively sound, qualitatively appropriate and **one the patient prefers and is therefore most likely to adhere to over a lifetime”** – 2021 Obesity algorithm

- Encourage foods that result in a negative caloric balance to achieve and maintain a healthy weight
- Consider the following:
  - Eating behaviors, and meal patterns
  - Cultural background, traditions, and food availability
  - Time constraints and financial issues
  - Nutritional knowledge and cooking skills
  - Medical conditions potentially affected by the nutrition plan
- Nutritional approaches for weight loss typically focus on the caloric manipulation of the three macronutrients: carbohydrate, fat, or protein
- Very low-calorie diets contain less than 800 kcal/day and require close medical supervision for safety reasons
- Low calorie diets range from 1,200-1,800 kcal/day (1,200-1,500 for women, 1,500-1,800 for men)
- Restricting dietary fat leads to a greater reduction in total and LDL cholesterol, whereas restricting dietary carbohydrate leads to a greater reduction in serum triglycerides and an increase in HDL-cholesterol
- Reduction of carbohydrates can lead to a greater reduction in serum glucose and hemoglobin A1C

Limit:

- **Unhealthful ultra-processed foods of minimum nutritional value such as:** “sweets”, “junk foods,” cakes, cookies, candy, pies, chips, and ultra-processed meats such as bacon, sausage, hot dogs, pastrami
- Energy-dense foods high in calories
- **Energy-dense beverages:** sugar-sweetened beverages, juice, cream
- Avoid trans fats and excessive sodium
- Among sweeteners, sucrose and saccharin may increase body weight compared to aspartame, rebaudioside A, and sucralose

Encourage:

- Consumption of healthful proteins and fats, vegetables, leafy greens, fruits, berries, nuts, legumes, whole grains
- Complex carbohydrates over simple sugars: Low glycemic index over high glycemic index foods
- High-fiber foods over low-fiber foods
- Many dairy products (while being mindful of caloric content)
- Reading labels rather than marketing claims

Obesity Algorithm 2021

Depression and Diabetes

- **1 in 4 individuals with diabetes has elevated symptoms of depression or depressive disorders**

  T1D: 21.3%

  T2D: 27%

- **History of depression and current depressive symptomatology are risk factors for the development of T2D**

Associated with sub-optimal diabetes management (e.g., self-care behaviors, glycemic levels), higher complication rates, increased health care use and cost, diminished quality of life, increased disability with lost productivity, and increased risk of death

Anderson, R. J., Freedland, K. E., Clouse, R. E., & Lustman, P. J. (2001). The Prevalence of Comorbid Depression in Adults with Diabetes: A Meta-Analysis. *Diabetes Care, 24*, 1069-1078.

De Groot, M., Golden, S. H., & Wagner, J. (2016). Psychological conditions in adults with diabetes. *American Psychologist*, *71*(7), 552.

American Diabetes Association. (2022). 5. Facilitating behavior change and well-being to improve health outcomes: standards of medical care in diabetes—2022. *Diabetes Care*, *44*(Supplement_1), S60-S82.

Bidirectional Relationship

Having T2D increases the risk for depression or a recurrence of depression

- Symptom burden
- Diabetes complications
- Physical limits from diabetes
- Impairments in quality of life
- Vascular changes in brain function

Having a history of depression increases risk for T2D

- Smoking
- Obesity
- Lack of exercise
- Elevated cortisol levels
- Elevated inflammatory markers
- Insulin resistance

The comorbidity can impact memory, energy levels, and cognitive function

Park M, Reynolds CF 3rd. Depression among older adults with diabetes mellitus. Clin Geriatr Med. 2015 Feb;31(1):117-37,ix. doi:cger.2014.08.022.

Diabetes and Anxiety

Psychiatric Disorders

- Generalized Anxiety Disorder

  T1D or T2D: 19.5%

  - Six times higher than the prevalence rate in general US population
  - Higher prevalence rates found in Latinx and young adults

- Specific Phobia, PTSD, OCD
- **Body Dysmorphic Disorder**

Diabetes-Related Anxiety

Associated with sub-optimal diabetes management, higher complication rates, increased health care use, diminished quality of life, increased depression, increased body-mass index, and increased disability

Smith, K. J., Béland, M., Clyde, M., Gariépy, G., Pagé, V., Badawi, G., ... & Schmitz, N. (2013). Association of diabetes with anxiety: a systematic review and meta-analysis. *Journal of psychosomatic research*, *74*(2), 89-99.
Li, C., Barker, L., Ford, E. S., Zhang, X., Strine, T. W., & Mokdad, A. H. (2008). Diabetes and anxiety in US adults: findings from the 2006 Behavioral Risk Factor Surveillance System. *Diabetic Medicine*, *25*(7), 878-881.

Diabetes Distress

- Negative reactions to the demands and challenges of living with diabetes, including the constant, complicated demands of self-care and the potential or actuality of disease progression

- **Distinct from and more prevalent than depression**

  18-45% prevalence rate

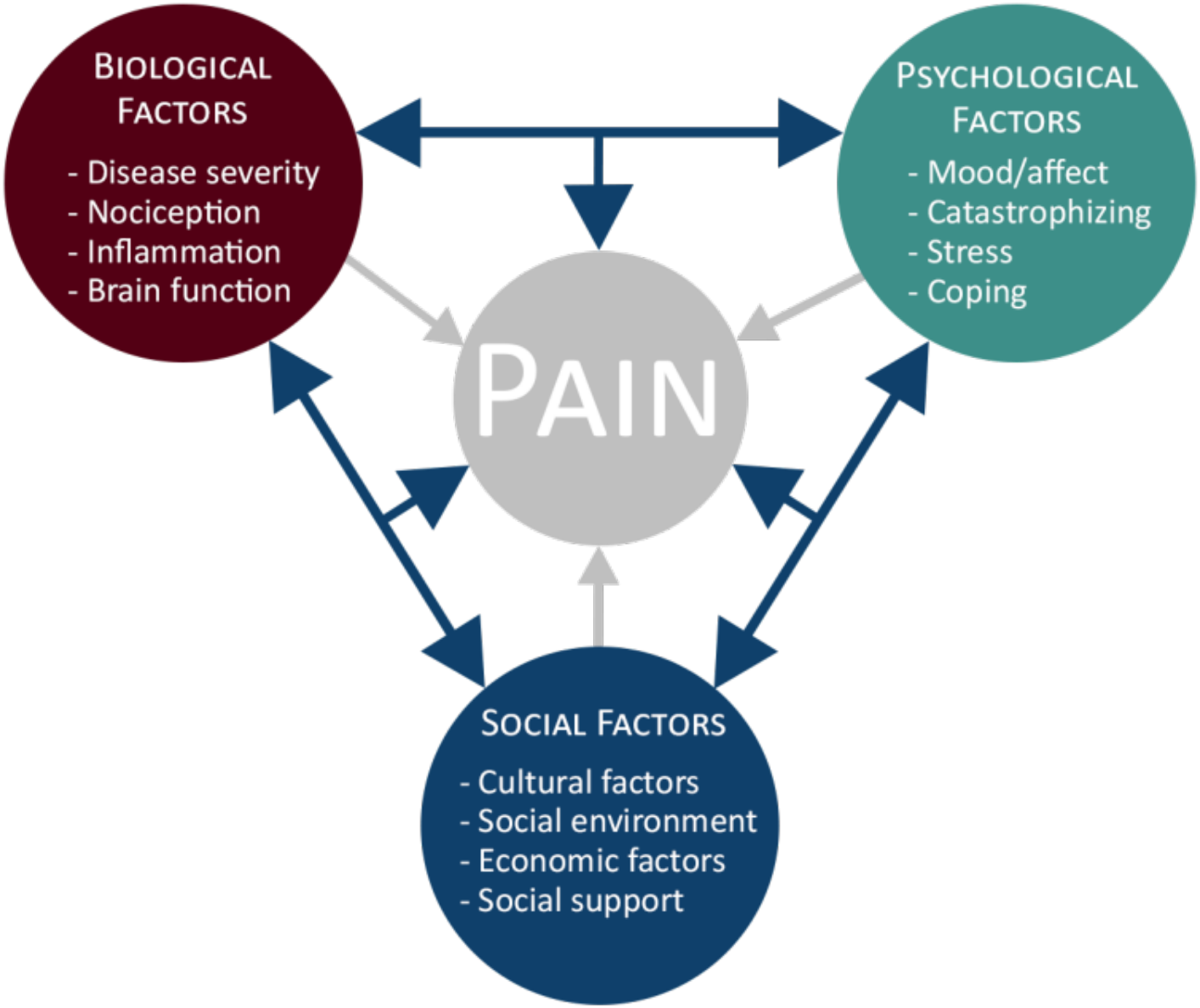
- Associated with higher A1c, lower diabetes self-efficacy, and poorer self-care behaviours (e.g., limited physical activity, unhealthful food choices)

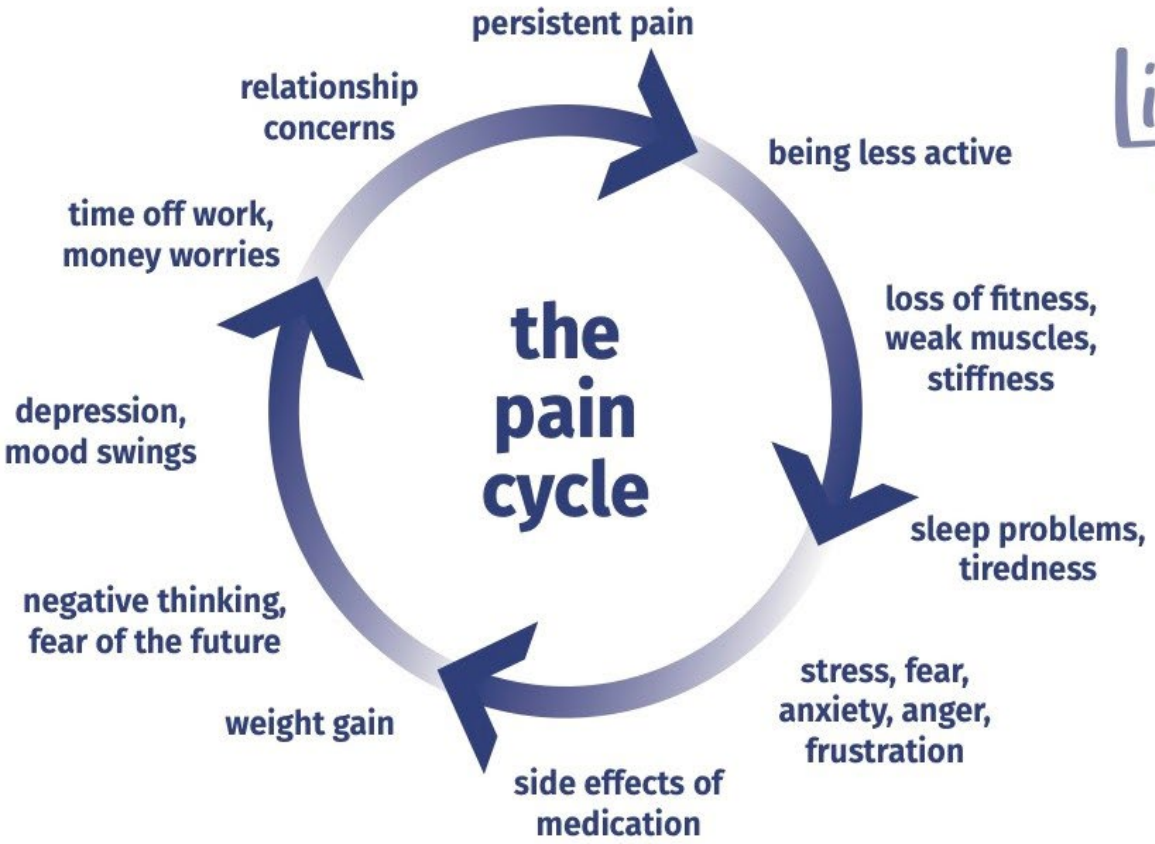
- **Even at low levels, Diabetes Distress deserves to be a focus of clinical attention**

American Diabetes Association. (2022). 5. Facilitating behavior change and well-being to improve health outcomes: standards of medical care in diabetes—2022. *Diabetes Care*, *44*(Supplement_1), S60-S82

Fisher, L., Polonsky, W. H., & Hessler, D. (2019). Addressing Diabetes Distress in Clinical Care: A Practical Guide. *Diabetic Medicine, 36*, 803-812.

Fisher, L., Polonsky, W. H., Hessler, D. H., Masharani, U., Blumer, I., Peters, A. L. et al. (2015). Understanding the Sources of Diabetes Distress in Adults with Type 1 Diabetes. *Journal of Diabetes Complications, 29*, 572–577.





my Live Well with pain

Things to Consider

What are patient's goals for her healthcare? What are her priorities?

Where is patient at in terms of rehabilitation from injury and return to work?

What are patient's beliefs about pain, physical functioning, and return to work?

What is her history of weight loss and management? What worked? What didn't work?

How is her relationship to how her body has changed over time, including with recent weight gain and weight loss? What negative thoughts might be there for her?

Is patient aware about the possibility of weight gain if liraglutide is discontinued? If it is discontinued, wait to do so until she is actively engaged in health behaviours for weight loss/management.

Things to Consider

From a physical activity/exercise perspective, what are things that she do that are fulfilling to her? Is she engaging in fulfilling activities, is she getting out of the house, is she seeing friends?

What is her history with diabetes self-care? What worked? What didn't work?

What is her history with diabetes self-care? What worked? What didn't work?

What support does she have in place that could help her meet and maintain her goals?

Screen for psychosocial concerns and refer to behavioural health accordingly

Provide education on acute versus chronic pain. Discuss activity pacing

Recommend use of stress management techniques (including self-regulatory strategies for pain management)

Use SMART to increase her use and ability to maintain health promotion behaviours

Screening Measures

Depression	PHQ-9
Anxiety	GAD-7
Diabetes Distress	Diabetes Distress Scale (DDS)
Pain Catastrophizing	Pain Catastrophizing Scale (PSC)

Pharmacological Therapy for Depression and Chronic pain

- **Serotonin and norepinephrine reuptake inhibitors:** Some SNRIs may help relieve chronic pain
- Venlafaxine (Effexor XR), duloxetine (Cymbalta, Drizalma Sprinkle)
- Milnacipran (Savella) and desvenlafaxine (Pristiq)
- Venlafaxine and duloxetine offer the advantage of being effective for depression and anxiety at the same dosages useful for treating pain

- **Tricyclic antidepressants:** one most common type of antidepressant used for pain. Side-effect weight gain
- Amitriptyline
- Nortriptyline (Pamelor)

Marks DM, Shah MJ, Patkar AA, Masand PS, Park GY, Pae CU. Serotonin-norepinephrine reuptake inhibitors for pain control: premise and promise. Curr Neuropharmacol. 2009 Dec;7(4):331-6

CASE Question?

- Maximizing Weight loss while maintaining glycemic control?

GLP-1 RA and Headed to Head Studies

- SUSTAIN-7 trial :Semaglutide (1.0mg) compared with dulaglutide(1.5mg) −6.5 kg *versus* −3.0 kg, $p < 0.0001$
- The SUSTAIN-10: Semaglutide 1.0 mg with liraglutide 1.2 mg and more people lost >5% body weight in Semaglutide
- The PIONEER-4 trial: Oral semaglutide vs liraglutide

−4.4 kg *versus* −3.1 kg, $p = 0.0003$

Trujillo JM, Nuffer W, Smith BA. GLP-1 receptor agonists: an updated review of head-to-head clinical studies. Ther Adv Endocrinol Metab. 2021

Other Anti-Obesity Medication options

- Due to uncontrolled hypertension right now would avoid contrave (bupropion/naltrexone) or phentermine or Qsymia
- If she has chronic pain or need for opioids contrave should be avoided also since naltrexone would block opioid effect
  - The highest percentage of weight loss will be with semaglutide vs other options

Metabolic Surgery

Metabolic Surgery vs. Medical Therapy

- Randomized clinical trials have demonstrated that metabolic surgery is more effective than medical and/or lifestyle interventions including pharmacological therapy in producing diabetes remission, glycemic control, and weight loss
  - Final five-year results of the Surgical Treatment and Medications Potentially Eradicate Diabetes Efficiency (STAMPEDE) Study show in patients with uncontrolled type 2 diabetes (mean BMI 37), metabolic surgery plus intensive medical therapy was more effective than intensive medical therapy alone for achieving and maintaining glycemic control, weight reduction, medication reduction, and improvements in lipid levels (NEJM, 2017)[13,14,15]
    - Diabetes remission rates at years one, three and five with metabolic surgery were about 40% (42% gastric bypass; 37% sleeve gastrectomy), 31% (38% gastric bypass; 24% sleeve gastrectomy), and 26% (29% gastric bypass; 23% sleeve gastrectomy), respectively; compared to 12%, 5% and 5% for medical therapy
  - Diabetes remained in remission for up to two years in 85% of patients with a BMI of 35 or greater randomized to metabolic surgery compared to no medical therapy patients (NEJM, 2012)[16] – 50% remission rates for metabolic surgery at 5 years and zero for medical therapy[17]

CASE Question?

- Improving lipid control once on max statin therapy

ACC/AHA CV Risk Calculator

On
Lisinopril, Amlodipine, Chlorthalidone (new)

[ACC/AHA CV Risk Calculator (2013) (medscape.com)]

Hyperlipidemia

- LDL at 159
- First assess if barrier to taking

Consider

- rosuvastatin 40mg and adding ezetimibe

Table 3
Dose ranges and efficacy of statins, ezetimibe, and bile acid sequestrants

Drug	Dose Range	Effect on LDL-C (% Decrease)	Effect on HDL-C (% Increase)	Effect on Triglycerides (% Decrease)
Statins				
Fluvastatin	20–80 mg	22–35	3–11	17–21
Pravastatin	10–80 mg	22–37	2–12	15–24
Lovastatin	10–80 mg	21–42	2–8	6–21
Simvastatin	5–80 mg	26–47	10–16	12–33
Atorvastatin	10–80 mg	39–60	5–9	19–37
Rosuvastatin	5–40 mg	45–63	8–10	10–30
Ezetimibe	10 mg	14–25	1	7–9
Bile acid sequestrants				
Cholestyramine	4–24 g	9–26	2–8	Increase 10–28
Colestipol	5–30 g (powder) 2–16 g (tablet)	10–29	3–10	Increase 7–25
Colesevelam	3.75–4.38 g (6–7 tablets)	10–25	3–10	Increase 10–25

Hou R, Goldberg AC.. Endocrinol Metab Clin North Am. 2009 Mar;38(1):79-97

Bempedoic Acid With Statin

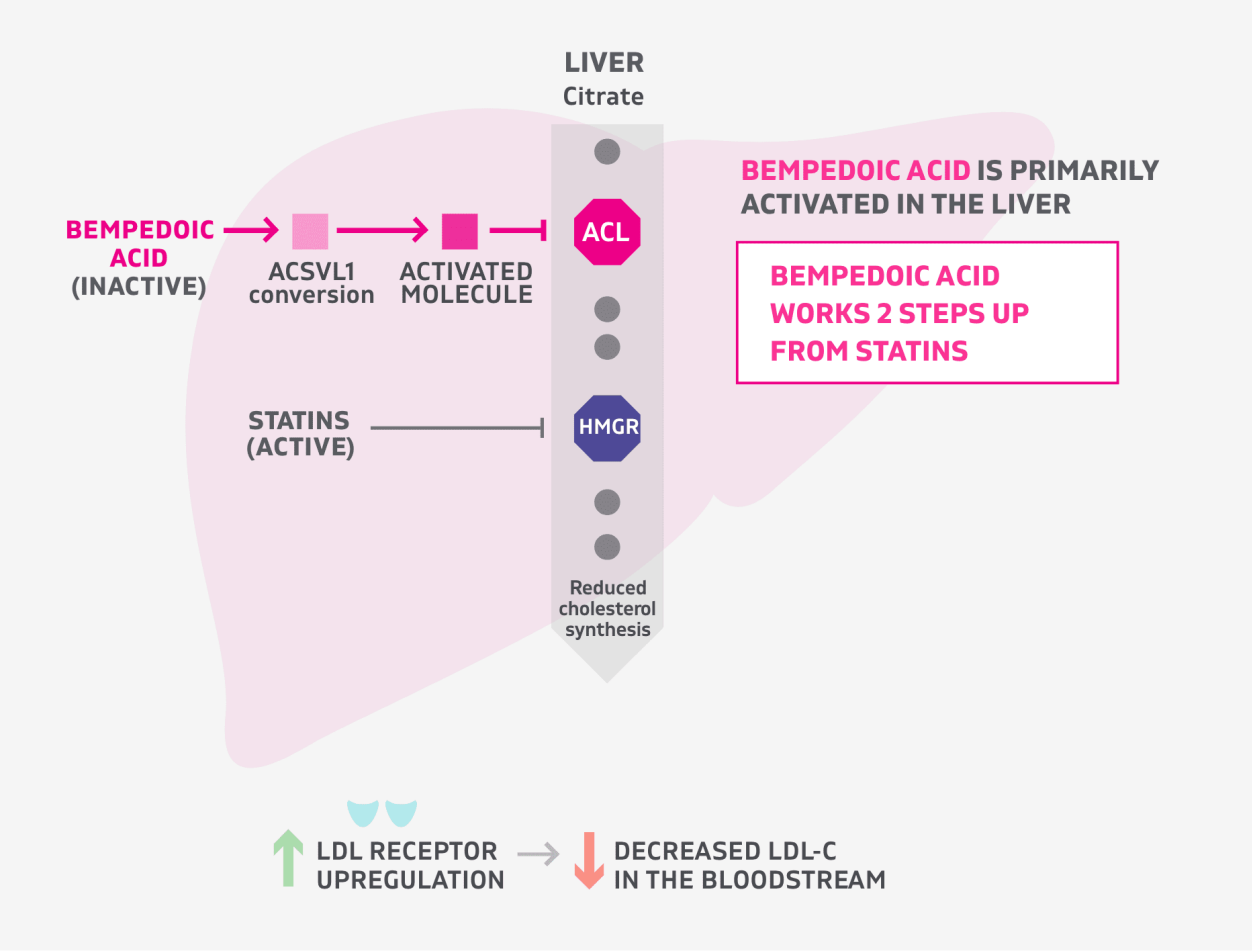
- Combination resulted in greater reductions in LDL-C level than monotherapies

- Bempedoic acid + statin vs. statin: LSM difference (%), – **18.37**, 95% CI, – 20.16 to – 16.57

- Muscle-related AEs was 1.29 (95% CI, 1.00 to 1.67, $I^2 = 0$) when compared with statin alone

Zhao, X., Ma, X., Luo, X. *et al.* Efficacy and safety of bempedoic acid alone or combining with other lipid-lowering therapies in hypercholesterolemic patients: a meta-analysis of randomized controlled trials. *BMC Pharmacol Toxicol* **21,** 86 (2020).

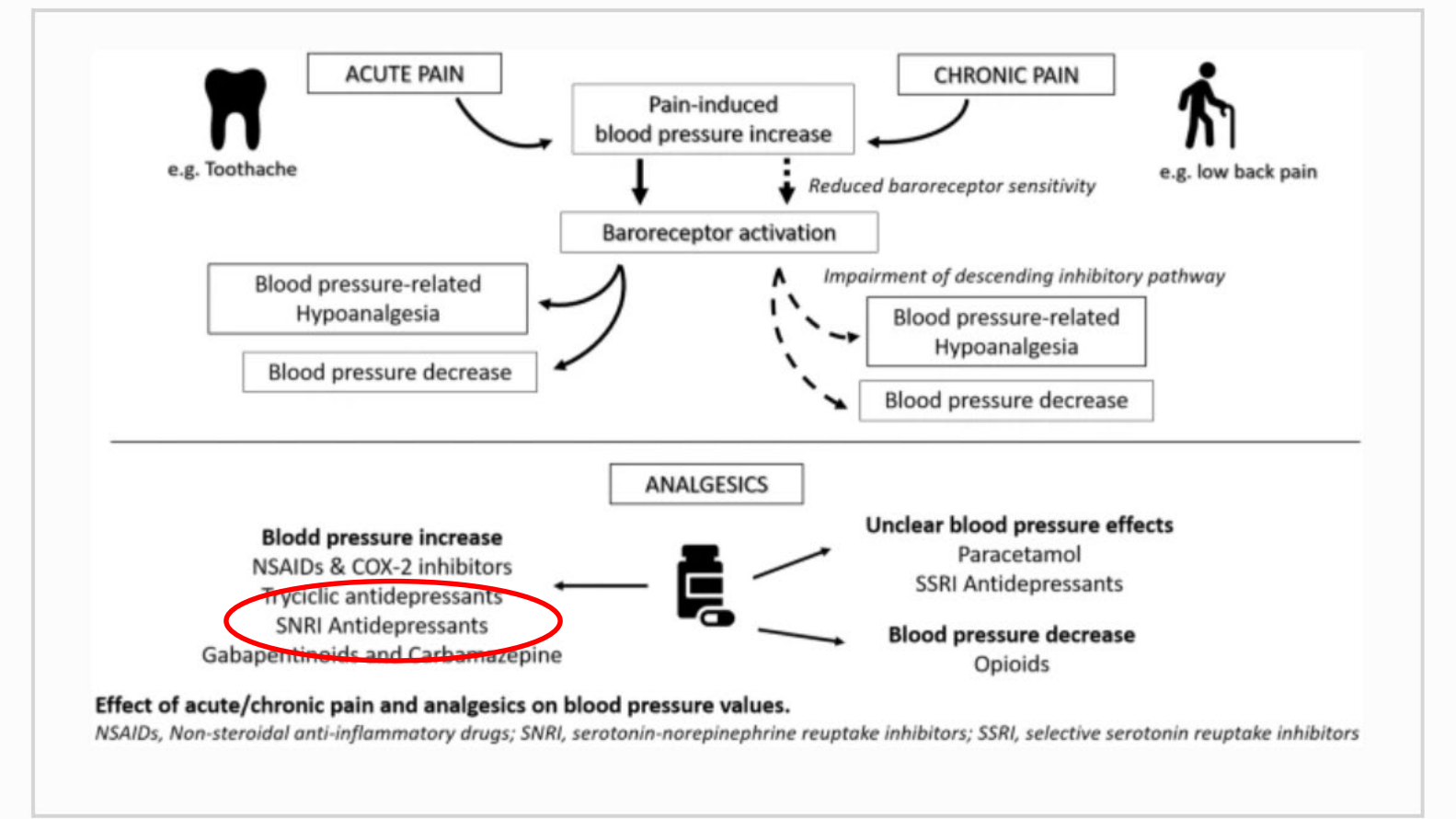
BEMPEDOIC ACID



May increase blood uric acid levels

Tendon Rupture: involved the rotator cuff, biceps tendon, or Achilles.

Pain and Blood Pressure

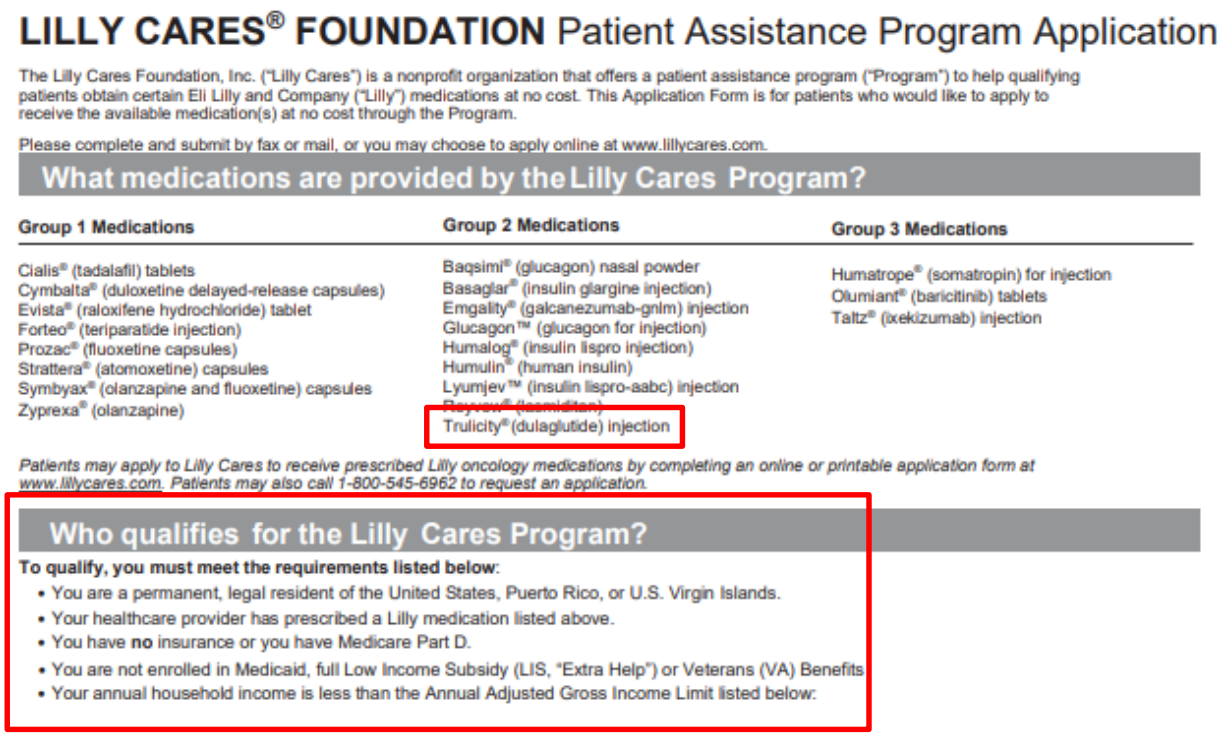


Chronic pain is associated with impaired regulation of cardiovascular and analgesia systems, which may predispose to persistent BP elevation.

Recs

- Consider Weekly GLP-1 RA like semaglutide
- Behavioral health
  - Referral to social work
- Practice good sleep hygiene
  - Refer for sleep study if needed
- Nutrition: Referral to dietician
  - ”The best nutritional intervention is a plan that is evidence-based, quantitatively sound, qualitatively appropriate and **one the patient prefers and is therefore most likely to adhere to over a lifetime”** – 2021 Obesity algorithm
- Exercise goal: 150 min per week of moderate to vigorous cardiovascular activity and/or 5000 steps per day
  - Pt should track activity

Manufacturer Patient Assistance Programs (PAP)



LILLY CARES® FOUNDATION Patient Assistance Program Application

The Lilly Cares Foundation, Inc. ("Lilly Cares") is a nonprofit organization that offers a patient assistance program ("Program") to help qualifying patients obtain certain Eli Lilly and Company ("Lilly") medications at no cost. This Application Form is for patients who would like to apply to receive the available medication(s) at no cost through the Program.

Please complete and submit by fax or mail, or you may choose to apply online at www.lillycares.com.

What medications are provided by the Lilly Cares Program?

Group 1 Medications

Cialis® (tadalafil) tablets
Cymbalta® (duloxetine delayed-release capsules)
Evista® (raloxifene hydrochloride) tablet
Forteo® (teriparatide injection)
Prozac® (fluoxetine capsules)
Strattera® (atomoxetine) capsules
Symbyax® (olanzapine and fluoxetine) capsules
Zyprexa® (olanzapine)

Group 2 Medications

Baqsimi® (glucagon) nasal powder
Basaglar® (insulin glargine injection)
Emgality® (galcanezumab-gnlm) injection
Glucagon™ (glucagon for injection)
Humalog® (insulin lispro injection)
Humulin® (human insulin)
Lyumjev™ (insulin lispro-aabc) injection
Reyvow® (lasmiditan)
Trulicity® (dulaglutide) injection

Group 3 Medications

Humatrope® (somatropin) for injection
Olumiant® (baricitinib) tablets
Taltz® (ixekizumab) injection

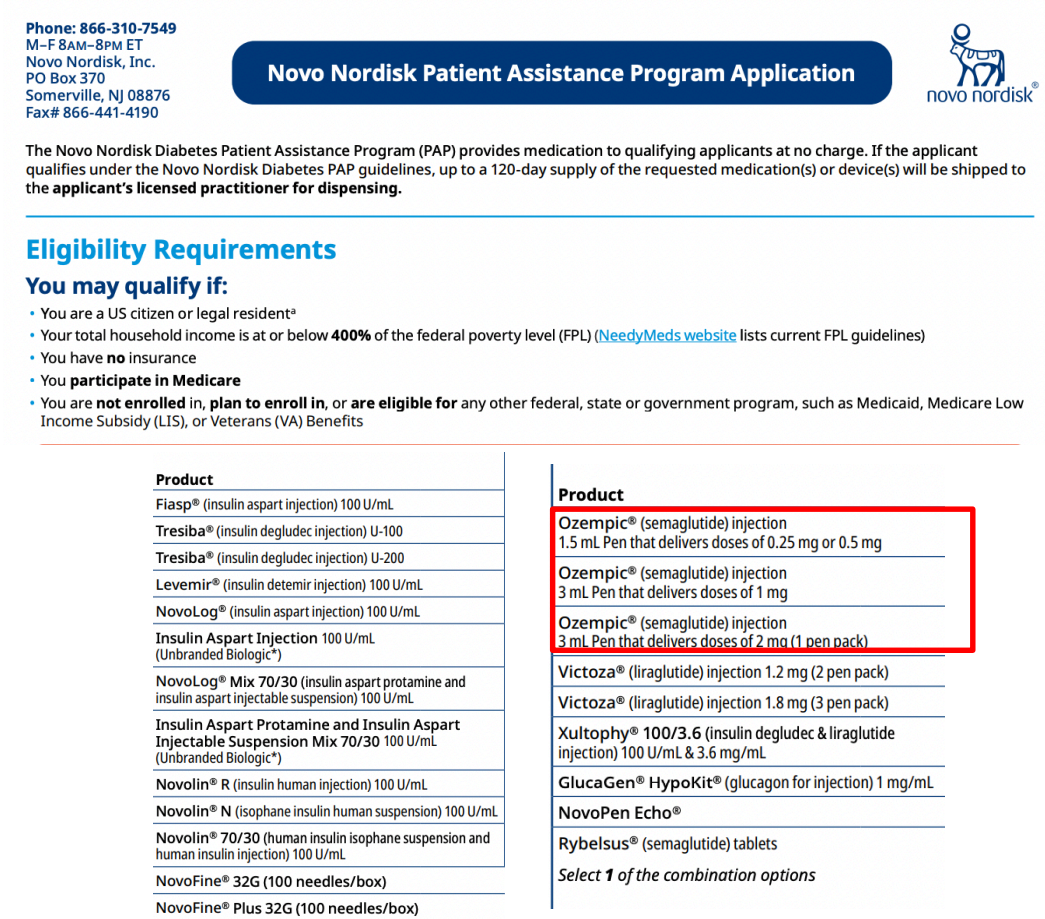
Patients may apply to Lilly Cares to receive prescribed Lilly oncology medications by completing an online or printable application form at www.lillycares.com. Patients may also call 1-800-545-6962 to request an application.

Who qualifies for the Lilly Cares Program?

To qualify, you must meet the requirements listed below:

- You are a permanent, legal resident of the United States, Puerto Rico, or U.S. Virgin Islands.
- Your healthcare provider has prescribed a Lilly medication listed above.
- You have **no** insurance or you have Medicare Part D.
- You are not enrolled in Medicaid, full Low Income Subsidy (LIS, "Extra Help") or Veterans (VA) Benefits
- Your annual household income is less than the Annual Adjusted Gross Income Limit listed below:

- **Website:** https://www.lillycares.com/how-to-apply
- **Application:** https://www.lillycares.com/assets/pdf/lilly_cares_application.pdf



Phone: 866-310-7549
M–F 8AM–8PM ET
Novo Nordisk, Inc.
PO Box 370
Somerville, NJ 08876
Fax# 866-441-4190

Novo Nordisk Patient Assistance Program Application

novo nordisk®

The Novo Nordisk Diabetes Patient Assistance Program (PAP) provides medication to qualifying applicants at no charge. If the applicant qualifies under the Novo Nordisk Diabetes PAP guidelines, up to a 120-day supply of the requested medication(s) or device(s) will be shipped to the **applicant's licensed practitioner for dispensing.**

Eligibility Requirements

You may qualify if:

- You are a US citizen or legal resident[a]
- Your total household income is at or below **400%** of the federal poverty level (FPL) (NeedyMeds website lists current FPL guidelines)
- You have **no** insurance
- You **participate in Medicare**
- You are **not enrolled** in, **plan to enroll in**, or **are eligible for** any other federal, state or government program, such as Medicaid, Medicare Low Income Subsidy (LIS), or Veterans (VA) Benefits

Product
Fiasp® (insulin aspart injection) 100 U/mL
Tresiba® (insulin degludec injection) U-100
Tresiba® (insulin degludec injection) U-200
Levemir® (insulin detemir injection) 100 U/mL
NovoLog® (insulin aspart injection) 100 U/mL
Insulin Aspart Injection 100 U/mL (Unbranded Biologic*)
NovoLog® Mix 70/30 (insulin aspart protamine and insulin aspart injectable suspension) 100 U/mL
Insulin Aspart Protamine and Insulin Aspart Injectable Suspension Mix 70/30 100 U/mL (Unbranded Biologic*)
Novolin® R (insulin human injection) 100 U/mL
Novolin® N (isophane insulin human suspension) 100 U/mL
Novolin® 70/30 (human insulin isophane suspension and human insulin injection) 100 U/mL
NovoFine® 32G (100 needles/box)
NovoFine® Plus 32G (100 needles/box)

Product
Ozempic® (semaglutide) injection 1.5 mL Pen that delivers doses of 0.25 mg or 0.5 mg
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 1 mg
Ozempic® (semaglutide) injection 3 mL Pen that delivers doses of 2 mg (1 pen pack)
Victoza® (liraglutide) injection 1.2 mg (2 pen pack)
Victoza® (liraglutide) injection 1.8 mg (3 pen pack)
Xultophy® 100/3.6 (insulin degludec & liraglutide injection) 100 U/mL & 3.6 mg/mL
GlucaGen® HypoKit® (glucagon for injection) 1 mg/mL
NovoPen Echo®
Rybelsus® (semaglutide) tablets
*Select **1** of the combination options*

- **Website:** https://www.novocare.com/diabetes-overview/let-us-help/pap.html
- **Application:** https://www.novocare.com/content/dam/diabetes-patient/novocare/redesign/General/PAP-Application-EN.pdf

Manufacturer Savings cards

- Only for patients with commercial/private insurance
- Ineligible if you have government programs (Medicaid, Medicare, Medicare Part D, Medigap, DoD, VA, TRICARE®/CHAMPUS)

https://www.novocare.com/ozempic/savings-card.html
https://www.trulicity.com/savings-resources

Cardiometabolic teleECHO™ Clinic

Patient Recommendation Form

Presentation Date: July 13, 2022 **Presenter name:** Gabriela Siegel, MD

Presenter Facility: Sea Mar CHC

Recap: 61 yo with well-controlled T2DM 5/2022 but complicated by hyperlipidemia (on 80 of atorvastatin), BMI 33.6 and HTN on (3 agents)

- Experienced worsening DM control in setting of chronic pain, emotional and financial stress resulting from work injury causing disability.
- Clinical Question: How do you maximizing weight loss and next step for lipid management for pt already on high intensity statin

Case Recommendations:

1. Further explore small change goals and support her already strong lifestyle changes. Consider asking her to monitor step count as a positive re-enforcement of her daily walking and also as a tool to increase over time
2. Refer to Sleep Medicine, as previously determined
3. Consider nutrition referral to monitor overall intake and ensure has nutrients needed
4. Consider on-going screening for depression, anxiety, and diabetes distress and intervene accordingly
5. Consider referral to Behavioural Health services for supportive counseling and/or recommend participation in a stress management program
6. Follow up on status of her worker's compensation and/or disability claim and the stressors associated with it
7. Start a conversation about her perception of chronic pain and her expectations about prognosis and pain management. Provide education as needed.
8. Consider medication therapy such as duloxetine that support both chronic pain and mood, if indicated
9. Consider transition to weekly semaglutide for ease of use and weight loss potential. Start at low dose 0.25mg weekly and increase monthly as needed for weight loss plateau if well tolerated
10. Monitor blood pressure and consider goal <120/80 and escalation of chlorthalidone if needed. Next step would be to consider spironolactone.
11. Evaluate if any barriers to taking atorvastatin 80mg. Consider use of rosuvastatin 40 and ezetimibe 10 in combination if LDL is not at goal <100.

Nicole Ehrhardt, MD

Physician Signature: *Nicole Ehrhasrdt*
Please Re-present case: sept 2022

Cardiometabolic teleECHO™ Clinic

Patient Recommendation Form

Mental Health Recommendations from Dr. Alison Ward:
"Small ways to support DM care when patients are feeling overwhelmed with other medical and/or psychosocial stress"

Normalize and validate her feelings of being stressed out and overwhelmed. They are understandable and expected.

Learn more about her history with T2D, what were her reactions to the diagnosis, what has been her treatment history for T2D, and what has her adjustment to living with and managing T2D been life for her.

Explore with her why she feels shame about herself and her approach to diabetes self-care over the past year (what contributed to this shame?). For what is she blaming herself? What consequences, if any, have there been because of her shame? For example, is she not checking her BGs, not eating as healthfully as she did before, has she lost confidence in herself (e.g., are her negative emotions driving her behaviours as a result)? Also, can she have self-compassion given the number of challenges and stress she has experienced over the past year that has made it more difficult for her to optimally manage T2D?

Learn more about what changed for her from a self-care or behavioural perspective that contributed to difficulties in managing T2D. Or, again, is she not feeling confident in her abilities to get back on track and sustain what she is doing?

Learn more about what are her fears about what occurred over the last year, does she have concerns about long-term complications? Provide education as needed.

Learn more about what she has been successful at re diabetes self-care. In what can she feel pride? What are the positive things that she is doing for herself in general? What is she doing now that she feels good about? Highlight and reinforce what she's doing now.

And then, explore with her what things that she could be focusing on/doing more of re diabetes self-care. Or, is she doing enough for now and does it just make sense for her to continue as is? Keep in mind that expectations and goals of both the patient and yourself are realistic given the number of stressors she is experiencing. This goes for diabetes self-care and weight management goals.

Consider using SMART format to create goals. ***See below for additional information:***

Getting the Most Out of Your Appointment

- Review patient's progress in safe diabetes self -management since last appointment.
- Identify challenges patient has had with safe diabetes self -management since last appointment
- Identify goals the patient can work towards to improve self-management

SMART Goals	
Specific	Set a concrete, clearly defined goal with specific points of success
Measurable	Define the evidence that will be used to show progress. Goals should have a quantifiable outcome or "success metric" so you and the patient know, with certainty, if the goal has been achieved
Achievable	Determine whether the goal can be reasonably accomplished within a defined time frame
Relevant	Identify how the goal aligns with patient's values and long-term objectives
Time Based	Set a realistic end date for the goal

Getting the Most Out of Your Appointment

- Rate importance of and patient's confidence in working on goal ("From 0 to 100, how important is this goal to you?", "From 0 to 100, how confident are you in meeting this goal?"). If low, modify goal chosen to increase rate.
- Connect goals to patient's personal values, values about health ("Why is this goal important to you?")
- Identify barriers to meeting goal
  - Problem solving
- Provide support
- Try, try again