ADA Standards of Medical Care in Diabetes recommends all patients be assessed and referred for:

**NUTRITION**
Registered dietitian for medical nutrition therapy

**EDUCATION**
Diabetes self-management education and support

**EMOTIONAL HEALTH**
Mental health professional if needed

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FOUR CRITICAL TIMES TO ASSESS, PROVIDE, AND ADJUST DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

<table>
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<tr>
<th>1</th>
<th>AT DIAGNOSIS</th>
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<tbody>
<tr>
<td>2</td>
<td>ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS</td>
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<tr>
<td>3</td>
<td>WHEN NEW COMPlicating FACTORS Influence SELF-MANAGEMENT</td>
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<td>4</td>
<td>WHEN TRANSITIONS IN CARE OCCUR</td>
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</table>

WHEN PRIMARY CARE PROVIDER OR SPECIALIST SHOULD CONSIDER REFERRAL:

- Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S
- Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals
- Needs review of knowledge, skills, and behaviors
- Long-standing diabetes with limited prior education
- Change in medication, activity, or nutritional intake
- HbA1c out of target
- Maintain positive health outcomes
- Unexplained hypoglycemia or hyperglycemia
- Planning pregnancy or pregnant
- For support to attain or sustain behavior change(s)
- Weight or other nutrition concerns
- New life situations and competing demands
- Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen
- Physical limitations such as visual impairment, dexterity issues, movement restrictions
- Emotional factors such as anxiety and clinical depression
- Basic living needs such as access to food, financial limitations
- Living situation such as inpatient or outpatient rehabilitation or now living alone
- Medical care team
- Insurance coverage that results in treatment change
- Age-related changes affecting cognition, self-care, etc.

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### Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes:

#### ALGORITHM ACTION STEPS

**Four critical times to assess, provide, and adjust diabetes self-management education and support**

<table>
<thead>
<tr>
<th>AT DIAGNOSIS</th>
<th>ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS</th>
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<tbody>
<tr>
<td>□ Answer questions and provide emotional support regarding diagnosis</td>
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<td>□ Provide overview of treatment and treatment goals</td>
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<td>□ Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines)</td>
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<tr>
<td>□ Identify and discuss resources for education and ongoing support</td>
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<tr>
<td>□ Make referral for DSME/S and medical nutrition therapy (MNT)</td>
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<tr>
<td>□ Assess all areas of self-management</td>
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<tr>
<td>□ Review problem-solving skills</td>
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<tr>
<td>□ Identify strengths and challenges of living with diabetes</td>
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<tr>
<td>□ Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals</td>
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<td>□ Discuss impact of complications and successes with treatment and self-management</td>
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<td>□ Develop diabetes transition plan</td>
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<td>□ Communicate transition plan to new health care team members</td>
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<tr>
<td>□ Establish DSME/S regular follow-up care</td>
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#### PRIMARY CARE PROVIDER/ENDOCRINOLOGIST/CLINICAL CARE TEAM: AREAS OF FOCUS AND ACTION STEPS

**Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how:**

- Medication – choices, action, titration, side effects
- Monitoring blood glucose – when to test, interpreting and using glucose pattern management for feedback
- Physical activity – safety, short-term vs. long-term goals/recommendations
- Preventing, detecting, and treating acute and chronic complications
- Nutrition – food plan, planning meals, purchasing food, preparing meals, portioning food
- Risk reduction – smoking cessation, foot care
- Developing personal strategies to address psychosocial issues and concerns
- Developing personal strategies to promote health and behavior change
- Review and reinforce treatment goals and self-management needs
- Emphasize preventing complications and promoting quality of life
- Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands
- Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes
- Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications
- Provide/refer for emotional support for diabetes-related distress and depression
- Develop and support personal strategies for behavior change and healthy coping
- Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change
- Identify needed adaptations in diabetes self-management
- Provide support for independent self-management skills and self-efficacy
- Identify level of significant other involvement and facilitate education and support
- Assist with facing challenges affecting usual level of activity, ability to function, health benefits and feelings of well-being
- Maximize quality of life and emotional support for the patient (and family members)
- Provide education for others now involved in care
- Establish communication and follow-up plans with the provider, family, and others

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