It is more than just "high sugar": Comprehensive Medical Evaluation and Assessment of Comorbidities

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## Disclosures:

- Speaker Bureau- Abbott, Novo Nordisk, Xeris
- Advisory Board- Corcept, Xeris

## Learning Objectives:

Discuss	<ul> <li>Discuss taking a person-centered approach managing those with type 2 diabetes</li> </ul>
Review	<ul> <li>Review a comprehensive medical evaluation for those with diabetes</li> </ul>
Assess	<ul> <li>Assess comorbidities that are common in people with diabetes</li> </ul>

## **Chronic Care Model**



Delivery system design (move from reactive to proactive care where planned visits are coordinated through a teambased approach)



Self-management support



Decision support at point of care/clinical encounter (evidence-based, effective care guidelines)



Clinical information systems (Registries that can provide person-specific and population-based support to care team)



Community resources and policies (identifying or developing resources to support health lifestyles)



Health systems (to create a quality-oriented culture)

American Diabetes Association Professional Practice Committee; 1. Improving Care and Promoting Health in Populations: *Standards of Care in Diabetes*—2024. *Diabetes Care* 1 January 2024; 47 (Supplement\_1): S11–S19. <u>https://doi.org/10.2337/dc24-S001</u>

## **Person-Centered Approach**

#### Recommendations

- 4.1 A person-centered communication style that uses person-centered, culturally sensitive, and strength-based language and active listening; elicits individual preferences and beliefs; and assesses literacy, numeracy, and potential barriers to care should be used to optimize health outcomes and health-related quality of life. B
- 4.2 People with diabetes can benefit from a coordinated interprofessional team that may include and is not limited to diabetes care and education specialists, primary care and subspecialty clinicians, nurses, registered dietitian nutritionists, exercise specialists, pharmacists, dentists, podiatrists, and behavioral health professionals. E

## Person-Centered Approach and Shared **Decision Making**

#### **DECISION CYCLE FOR PERSON-CENTERED GLYCEMIC MANAGEMENT IN TYPE 2 DIABETES**

#### ASSESS KEY PERSON CHARACTERISTICS **REVIEW AND AGREE ON MANAGEMENT PLAN** The individual's priorities Current lifestyle and health behaviors Review management plan Comorbidities (i.e., CVD, CKD, HF) • Mutually agree on changes Clinical characteristics (i.e., age, A1C, weight) Ensure agreed modification of therapy is implemented • Issues such as motivation, depression, cognition in a timely fashion to avoid therapeutic inertia Social determinants of health • Undertake decision cycle regularly (at least once/twice a year) Operate in an integrated system of care **CONSIDER SPECIFIC FACTORS THAT IMPACT CHOICE** GOALS **OF TREATMENT PROVIDE ONGOING SUPPORT AND OF CARE** Individualized glycemic and weight goals **MONITORING OF:** Impact on weight, hypoglycemia, and cardiorenal protection • Emotional well-being Underlying physiological factors Prevent complications Lifestyle and health behaviors Side effect profiles of medications • Optimize quality of life Tolerability of medications Complexity of regimen (i.e., frequency, mode of administration) Biofeedback including BGM/CGM, Regimen choice to optimize medication use weight, step count, A1C, BP, lipids and reduce treatment discontinuation Access, cost, availability of medication, and lifestyle choices **IMPLEMENT MANAGEMENT PLAN** UTILIZE SHARED DECISION-MAKING TO CREATE A MANAGEMENT PLAN Ensure there is regular review: **Ensure access to DSMES** more frequent contact initially is often desirable for DSMES Involve an educated and informed person AGREE ON MANAGEMENT PLAN

- Specify SMART goals:
- **S**pecific
- Measurable
- Achievable
- Realistic
- Time limited

- (and the individual's family/caregiver)
- Explore personal preferences
- Language matters (include person-first, strengths-based, empowering language)
- Include motivational interviewing, goal setting, and shared decision-making

## The Use of Language in Diabetes Care and Education

#### Neutral, non judgemental, based on fact

#### Free of stigma

# Strength-based, respectful, inclusive

Fosters collaboration between people with diabetes and health care professional Person-Centered (person with diabetes versus diabetic)

## Comprehensive Medical Evaluation

## 2024 ADA Standards of Care

- Recommendations
- **4.3** A complete medical evaluation should be performed at the initial visit to:
  - Confirm the diagnosis and classify diabetes. A
  - Evaluate for diabetes complications, potential comorbid conditions, and overall health status. **A**
  - Identify care partners and support system. E
  - Assess social determinants of health and structural barriers to optimal health and health care. A
  - Review previous treatment and risk factor management in people with established diabetes. A
  - Begin engagement with the person with diabetes in the formulation of a care management plan including initial goals of care. **A**
  - Develop a plan for continuing care. A

## **Past Medical and Family History**

componenta or the comprehensive diabetes medical evaluation at initial, tollow-up, and annual visits

	VISIT	FOLLOW- UP VISIT	ANNUAL VISIT
Diabetes history		() ()	
<ul> <li>Characteristics at onset (e.g., age, symptoms)</li> </ul>	~		
<ul> <li>Review of previous treatment plans and response</li> </ul>	1		
<ul> <li>Assess frequency/cause/severity of past hospitalizations</li> </ul>	-		
Family history			
<ul> <li>Family history of diabetes in a first-degree relative</li> </ul>	× .		
<ul> <li>Family history of autoimmune disorder</li> </ul>	~		
Personal history of complications and common comorbidities			
<ul> <li>Common comorbidities (e.g., obesity, OSA, NAFLD)</li> </ul>	1		
<ul> <li>High blood pressure or abnormal lipids</li> </ul>	1		~
<ul> <li>Macrovascular and microvascular complications</li> </ul>	×		~
<ul> <li>Hypoglycemia: awareness/frequency/causes/timing of episodes</li> </ul>	~	~	~
<ul> <li>Presence of hemoglobinopathies or anemias</li> </ul>	1		~
Last dental visit	1		~
<ul> <li>Last dilated eye exam</li> </ul>			~
Visits to specialists			~
<ul> <li>Disability assessment and use of assistive devices (e.g., physical, cognitive, vision and auditory, history of fractures, podiatry)</li> </ul>	~	~	~
<ul> <li>Personal history of autoimmune disease</li> </ul>	~		
Interval history			
<ul> <li>Changes in medical/family history since last visit</li> </ul>		~	×.
	Diabetes history         • Characteristics at onset (e.g., age, symptoms)         • Review of previous treatment plans and response         • Assess frequency/cause/severity of past hospitalizations         Family history         • Family history of diabetes in a first-degree relative         • Family history of autoimmune disorder         Personal history of complications and common comorbidities         • Common comorbidities (e.g., obesity, OSA, NAFLD)         • High blood pressure or abnormal lipids         • Macrovascular and microvascular complications         • Hypoglycemia: awareness/frequency/causes/timing of episodes         • Presence of hemoglobinopathies or anemias         • Last dental visit         • Last dilated eye exam         • Visits to specialists         • Disability assessment and use of assistive devices (e.g., physical, cognitive, vision and auditory, history of fractures, podiatry)         • Personal history of autoimmune disease         Interval history         • Changes in medical/family history since last visit	INITIAL           Diabetes history            • Characteristics at onset (e.g., age, symptoms)            • Review of previous treatment plans and response            • Assess frequency/cause/severity of past hospitalizations            Family history            • Family history of diabetes in a first-degree relative            • Family history of autoimmune disorder            Personal history of complications and common comorbidities            • Common comorbidities (e.g., obesity, OSA, NAFLD)            • High blood pressure or abnormal lipids            • Hypoglycemia: awareness/frequency/causes/timing of episodes            • Presence of hemoglobinopathies or anemias            • Last dental visit            • Usits to specialists            • Disability assessment and use of assistive devices (e.g., physical, cognitive, vision and auditory, history of fractures, podiatry)            • Presonal history of autoimmune disease	Diabetes historyCharacteristics at onset (e.g., age, symptoms)·• Characteristics at onset (e.g., age, symptoms)·• Review of previous treatment plans and response·• Assess frequency/cause/severity of past hospitalizations·Family history·• Family history of diabetes in a first-degree relative·• Family history of diabetes in a first-degree relative·• Family history of autoimmune disorder·Personal history of complications and common comorbidities·• Common comorbidities (e.g., obesity, OSA, NAFLD)·• High blood pressure or abnormal lipids·• Hypoglycemia: awareness/frequency/causes/timing of episodes·• Last dental visit·• Last dental visit·• Disability assessment and use of assistive devices (e.g., physical, cognitive, vision and auditory, history of fractures, podiatry)• Personal history of autoimmune disease·• Changes in medical/family history since last visit·

#### Behavioral Factors, Medications, Vaccines, Technology Use, Social Life

					-
BEHAVIORAL FACTORS	Eating patterns and weight history	~	~	-	
	<ul> <li>Assess familiarity with carbohydrate counting (e.g., type 1 diabetes,</li> </ul>	~		~	
	type 2 diabetes treated with MDI)			5.2	L
	<ul> <li>Physical activity and sleep behaviors; screen for obstructive sleep apnea</li> </ul>	~	~	1	
	<ul> <li>Tobacco, alcohol, and substance use</li> </ul>	~		-	
MEDICATIONS AND VACCINATIONS	Current medication plan	~	~	~	
	<ul> <li>Medication-taking behavior, including rationing of medications and/or medical equipment</li> </ul>	~	~	-	
	<ul> <li>Medication intolerance or side effects</li> </ul>	~	~	~	
	<ul> <li>Complementary and alternative medicine use</li> </ul>	~	~	1	
	Vaccination history and needs	1		1	
TECHNOLOGY USE	<ul> <li>Assess use of health apps, online education, patient portals, etc.</li> </ul>	~		-	
	<ul> <li>Glucose monitoring (meter/CGM): results and data use</li> </ul>	~	~	~	
	<ul> <li>Review insulin pump settings and use, connected pen and glucose data</li> </ul>	~	~	1	
SOCIAL LIFE ASSESSMENT	Social network				
	Identify existing social supports	~		1	
	<ul> <li>Identify surrogate decision maker, advanced care plan</li> </ul>	~		1	
	<ul> <li>Identify social determinants of health (e.g., food security, housing stability &amp; homelessness, transportation access, financial security, community safety)</li> </ul>	~		~	
	<ul> <li>Assess daily routine and environment, including school/work schedules and ability to engage in diabetes self-management</li> </ul>	~	~	~	

## **Physical Exam**

		INITIAL VISIT	FOLLOW- UP VISIT	ANNUAL VISIT
	<ul> <li>Height, weight, and BMI; growth/pubertal development in children and adolescents</li> </ul>	1	~	× .
	Blood pressure determination	1	1	×
	<ul> <li>Orthostatic blood pressure measures (when indicated)</li> </ul>	1		
	<ul> <li>Fundoscopic examination (refer to eye specialist)</li> </ul>	1		~
PHYSICAL EXAMINATION	Thyroid palpation	1		~
	<ul> <li>Skin examination (e.g., acanthosis nigricans, insulin injection or insertion sites, lipodystrophy)</li> </ul>	1	~	~
	Comprehensive foot examination	× -		~
	<ul> <li>Visual inspection (e.g., skin integrity, callous formation, foot deformity or ulcer, toenails)**</li> </ul>	1	~	~
	<ul> <li>Screen for PAD (pedal pulses—refer for ABI if diminished)</li> </ul>	1		~
	<ul> <li>Determination of temperature, vibration or pinprick sensation, and 10-g monofilament exam</li> </ul>	~		~
	<ul> <li>Screen for depression, anxiety, diabetes distress, fear of hypoglycemia, and disordered eating</li> </ul>	~		~
	Consider assessment for cognitive performance*	1		~
	<ul> <li>Consider assessment for functional performance*</li> </ul>	1		~
	Consider assessment for bone pain	1		~

## Laboratory Evaluation

LABORATORY EVALUATION	<ul> <li>A1C, if the results are not available within the past 3 months.</li> </ul>	1	~	~
	If not performed/available within the past year	1		1
	<ul> <li>Lipid profile, including total, LDL, and HDL cholesterol and triglycerides*</li> </ul>	~		~
	Liver function tests*	~		1
	Spot urinary albumin-to-creatinine ratio	~		×
	Serum creatinine and estimated glomerular filtration rate*	~		~
	<ul> <li>Thyroid-stimulating hormone in people with type 1 diabetes*</li> </ul>	~		1
	Vitamin B12 if on metformin	1		1
	Complete blood count (CBC) with platelets	~		~
	<ul> <li>Serum potassium levels in people with diabetes on ACE inhibitors, ARBs, or diuretics*</li> </ul>	~		1
	Calcium, vitamin D, and phosphorous for appropriate people with diabetes	~		1

## Lifestyle Management and Behavioral Health

Cornerstone of Diabetes Management Refer for DSMES, MNT, and assessment of behavioral health Ο

## **Assessing Diabetes Complications**

ASCVD and heart failure history

ASCVD risk factors and 10-year ASCVD risk assessment

Staging of chronic kidney disease

Hypoglycemia risk

Assessment for retinopathy

Assessment for neuropathy

Assessment for NAFLD/NASH

## Goal Setting



## **Therapeutic Treatment Plans**

#### Lifestyle management

Pharmacologic therapy: glucose lowering Pharmacologic therapy: CV & Kidney Disease risk factors

Weight management with pharmacotherapy or metabolic surgery Use of glucose monitoring and insulin delivery devices Referral to diabetes education, behavioral health, and medical specialists

## Referrals for initial care management

Eye care professional for annual dilated eye exam	Family planning for individuals of childbearing potential	Registered dietitian nutritionist for MNT	DSMES
Dentist for comprehensive dental and periodontal examination	Behavioral Health Professional, if indicated	Audiology, if indicated	Social worker/community resources, if indicated
	Rehabilitation medicine or another relevant HCP for physical and cognitive disability evaluation, if indicated	Other appropriate HCPs	

## Immunizations

Vaccine	Recommended Ages	Schedule
COVID-19	All≥6 mos.	Current initial vaccination and boosters
Hepatitis B	Adults with DM <60 Adults ≥ 60 discretion of clinician	Depends on age refer to Updated Recommendations of Advisory Committee on Immunizations Practice- US
Influenza	All people with DM	Annual
Pneumonia (Pneumovax/PPSV23)	19-64 vaccinate with Pneumovax ≥65	Refer to CDC & Prevention, Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults using PPSV23
PCV20 or PCV15	19-64 yrs with immunocompromised 19-64 yrs immunocompetent ≥65 yrs immunocompetent	Use of 15-Valent Pneumococcal Conjugate Vaccine & 20-Valent Pneumococcal Conjugate Vaccine Among U.S. Adults. Update Immunization Practices 2022
RSV	≥ 60 with DM	Single Dose
Tetanus, (Tdap)	All adults; pregnancy should receive extra dose	Booster every 10 years
Zoster	≥ 50	Two-dose Shingrix, even if previously vaccinated

# Assessment of Comorbidities

- Conditions that affect people with diabetes more often than agematched people without diabetes
  - Autoimmune Diseases
  - Bone Health
  - Cancer
  - Cognitive Impairment/Dementia
  - Diabetes and COVID-19
  - Disability
  - Low Testosterone in Men
  - NAFLD & NASH



## Autoimmune Diseases

- Type 1 Diabetes are at increased risk for other autoimmune diseases
  - Most Common-
    - Thyroid Disease
    - Celiac Disease
    - Pernicious Anemia (Vitamin B12 deficiency)
  - Autoimmune Liver Disease
  - Primary Adrenal Insufficiency (Addison)
  - Collagen Vascular Diseases
  - Myasthenia Gravis



Most Common Autoimmune Diseases in T1DM

### Thyroid dysfunction

screen soon after diagnosis and periodically thereafter

### Vitamin B12 deficiency

• Measure in type 1 diabetes and peripheral neuropathy or unexplained anema

### Celiac Disease- Screen adults with DM +

- Symptoms
  - Diarrhea, malabsorption, abdominal pain
- Signs
  - Osteoporosis, vitamin deficiencies, iron deficiency anemia

## **Bone Health**

## Assess fracture risk in older adults with diabetes

Dexa Scan every 2-3 yrs for high-risk older adults with diabetes (>65) and younger individuals with DM and multiple risk factors

Prioritize glycemic lowering medications with proven safety of bones for those elevated fracture risk

Prioritize glycemic lowering medications to reduce risk of hypoglycemia that may increase fall and fracture risk

Advise on Calcium and Vitamin D for those with fracture risk through diet or supplements Antiresorptive meds & osteoanabolic agents use for T-score ≤ -2.0 or experienced fragility fractures

## Cancer

## 01

Increased risk of cancers of the liver, pancreas, endometrium, colon/rectum, breast and bladder

## 02

Encourage age and sex appropriate cancer screenings 03

Encourage reducing modifiable cancer risk factors

• Obesity, Physical Inactivity, and Smoking

## **Cognitive Impairment/Dementia**

Significant increased risk and rate of cognitive decline and dementia In the presence of cognitive impairment, utilize treatment plans that minimize the risk of hypoglycemia

Meta-Analysis showing increased Dementia

- 122 literatures were included through researching PubMed in meta-analysis
- People living with diabetes
  - 43% higher risk of all types of dementia
  - 43% higher risk of Alzheimer dementia
  - 91% higher risk of vascular dementia
  - (compared to those without diabetes)

Xue M, Xu W, Ou YN, et al. Diabetes mellitus and risks of cognitive impairment and dementia: a systematic review and meta-analysis of 144 prospective studies. *Ageing Res Rev* 2019;55:100944

## Diabetes & COVID-19

#### Recommendations

- 4.16 Health care professionals should help people with diabetes aim to achieve individualized glycemic goals to reduce the risk of macrovascular and microvascular risk as well as reduce the risk of coronavirus disease 2019 (COVID-19) and its complications. B
- 4.17 As we move into the recovery phase, diabetes health care services and practitioners should address the impact of the COVID-19 pandemic in higher-risk groups, including minority, socioeconomically deprived, and older populations. B
- **4.18** People with diabetes who have been infected with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) should be followed up in the longer term to assess complications and symptoms of long COVID-19. **E**
- 4.19 New-onset diabetes cases should receive routine clinic follow-up to determine if the condition is transient. B
- **4.20** There is no clear indication to change prescribing of glucose-lowering therapies in people with diabetes infected by SARS-CoV-2. **B**
- 4.21 People with diabetes should be prioritized and offered SARS-CoV-2 vaccines and vaccine boosters. B

## Disability

 4.22 An assessment of disability should be performed at each visit for people with diabetes. If a disability is impacting functional ability or capacity to manage their diabetes, a referral should be made to an appropriate health care professional specializing in disability (e.g., physical medicine and rehabilitation specialist, physical therapist, occupational therapist, speech-language pathologist). E



# Statistics on Disability & Diabetes

- 50-80% increased risk for disability with DM vs. without DM
- Most prevalent- Lower-body functional limitation (47-84%)
- Diabetic peripheral neuropathy is most common complication of both type 1 and type 2 DM
  - Impairment of postural balance and gait kinematics
  - Can lead to nontraumatic lower-limb amputation

## Hepatitis C

- Infection with HCV associated with higher prevalence of T2DM
- 1/3 individuals with chronic HCV have T2DM
- Meta-analysis of observational studies revealed after eradication of HCV infection
  - 0.45% mean reduction in A1C
  - Reduced requirement for glucose-lowering medication

## Low Testosterone in Men

#### Recommendation

**4.23** In men with diabetes who have symptoms or signs of hypogonadism, such as decreased sexual desire (libido) or activity or erectile dysfunction, consider screening with a morning serum testosterone level. **B** 

## Low Testosterone in Men

- Mean levels of testosterone are lower in men with diabetes
- Obesity is a major confounder
- Morning Total Testosterone should be measured
- If total testosterone level is close to lower limit, free testosterone levels can be measured
- LH and FSH may be needed to further evaluate
- Testosterone replacement in older men has been associated with increased coronary artery plaque volume with no conclusive evidence that testosterone supplementation is associated with increased CV risk

## NAFLD/NASH

- Screening
- Recommendations
- 4.24a Adults with type 2 diabetes or prediabetes, particularly those with obesity or cardiometabolic risk factors or established cardiovascular disease, should be screened/risk stratified for clinically significant liver fibrosis (defined as moderate fibrosis to cirrhosis) using a calculated fibrosis-4 index (FIB-4) (derived from age, ALT, AST, and platelets [mdcalc.com/calc/2200/fibrosis4-fib-4-index-liver-fibrosis]), even if they have normal liver enzymes. B
- 4.24b Adults with diabetes or prediabetes with persistently elevated plasma aminotransferase levels for >6 months and low FIB-4 should be evaluated for other causes of liver disease. B
- 4.25 Adults with type 2 diabetes or prediabetes with an indeterminate or high FIB-4 should have additional risk stratification by liver stiffness measurement with transient elastography or the blood biomarker enhanced liver fibrosis (ELF). B
- 4.26 Adults with type 2 diabetes or prediabetes with indeterminate results or at high risk for significant liver fibrosis (i.e., by FIB-4, liver stiffness measurement, or ELF) should be referred to a gastroenterologist or hepatologist for further workup. Interprofessional care is recommended for long-term management. B



From: 4. Comprehensive Medical Evaluation and Assessment of Comorbidities: Standards of Care in Diabetes—2024

Diabetes Care. 2023;47(Supplement\_1):S52-S76. doi:10.2337/dc24-S004



#### Figure Legend:

A proposed algorithm for risk stratification in individuals with nonalcoholic fatty liver disease or nonalcoholic steatohepatitis. ELF, enhanced liver fibrosis; FIB-4, fibrosis-4 index. Adapted from Kanwal et al. (174).

## NAFLD/NASH

- Management
- Recommendations
- 4.27 Adults with type 2 diabetes or prediabetes, particularly with overweight or obesity, with nonalcoholic fatty liver disease (NAFLD) should be recommended lifestyle changes that promote weight loss, ideally within a structured nutrition plan and physical activity program for cardiometabolic benefits B and histological improvement. C
- 4.28 For adults with type 2 diabetes, particularly with overweight or obesity, with NAFLD, consider using a glucagon-like peptide 1 (GLP-1) receptor agonist with demonstrated benefits in nonalcoholic steatohepatitis (NASH) as an adjunctive therapy to lifestyle interventions for weight loss. B
- **4.29** Pioglitazone or GLP-1 receptor agonists are the preferred agents for the treatment of hyperglycemia in adults with type 2 diabetes with biopsy-proven NASH or those at high risk with clinically significant liver fibrosis using noninvasive tests. **A**
- **4.30a** In adults with type 2 diabetes and NAFLD, use of glucose-lowering therapies other than pioglitazone or GLP-1 receptor agonists may be continued as clinically indicated, but these therapies lack evidence of benefit in NASH. **B**
- **4.30b** Insulin therapy is the preferred agent for the treatment of hyperglycemia in adults with type 2 diabetes with decompensated cirrhosis. **C**
- **4.31a** Adults with type 2 diabetes and NAFLD are at increased cardiovascular risk; therefore, comprehensive management of cardiovascular risk factors is recommended. **B**
- 4.31b Statin therapy is safe in adults with type 2 diabetes and compensated cirrhosis from NAFLD and should be initiated or continued for cardiovascular risk reduction as clinically indicated. B Statin therapy should be used with caution and close monitoring in people with decompensated cirrhosis, given limited safety and efficacy data. B
- **4.32a** Consider metabolic surgery in appropriate candidates as an option to treat NASH in adults with type 2 diabetes **B** and to improve cardiovascular outcomes. **B**
- **4.32b** Metabolic surgery should be used with caution in adults with type 2 diabetes with compensated cirrhosis from NAFLD **B** and is not recommended in decompensated cirrhosis. **B**

## **Obstructive Sleep Apnea**



Prevalence may be as high as 23% in people with T2DM

Participants with obesity in the Look AHEAD Trial there was a prevalence of 80%



Screen those with symptoms

Excessive daytime sleepiness Snoring Witnessed apnea

## Pancreatitis

People with diabetes has a two-fold higher risk of developing acute pancreatitis Prediabetes and diabetes has been found to develop in approximately 1/3 of individuals after an episode of acute pancreatitis

Could be either newonset disease or previously unrecognized disease

## Periodontal Disease



# Connected to higher A1Cs

## Sensory Impairment

- Hearing impairment increased in those with T2DM
- In the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications (DCCT/EDIC) cohort, increases in the time-weighted mean A1C was associated with increased risk of hearing impairment when tested after long-term (>20 years) follow-up, with every 10% increase in A1C leading to 19% high-frequency impairment
- Impairment in smell but not taste also has been reported

## Summary

- A person-centered approach should be used when managing diabetes
- A comprehensive medical evaluation is necessary for all people with diabetes including behavioral factors, social life assessment, previous treatments, and risk factor management
- Assessing and addressing comorbidities are important in a person living with diabetes