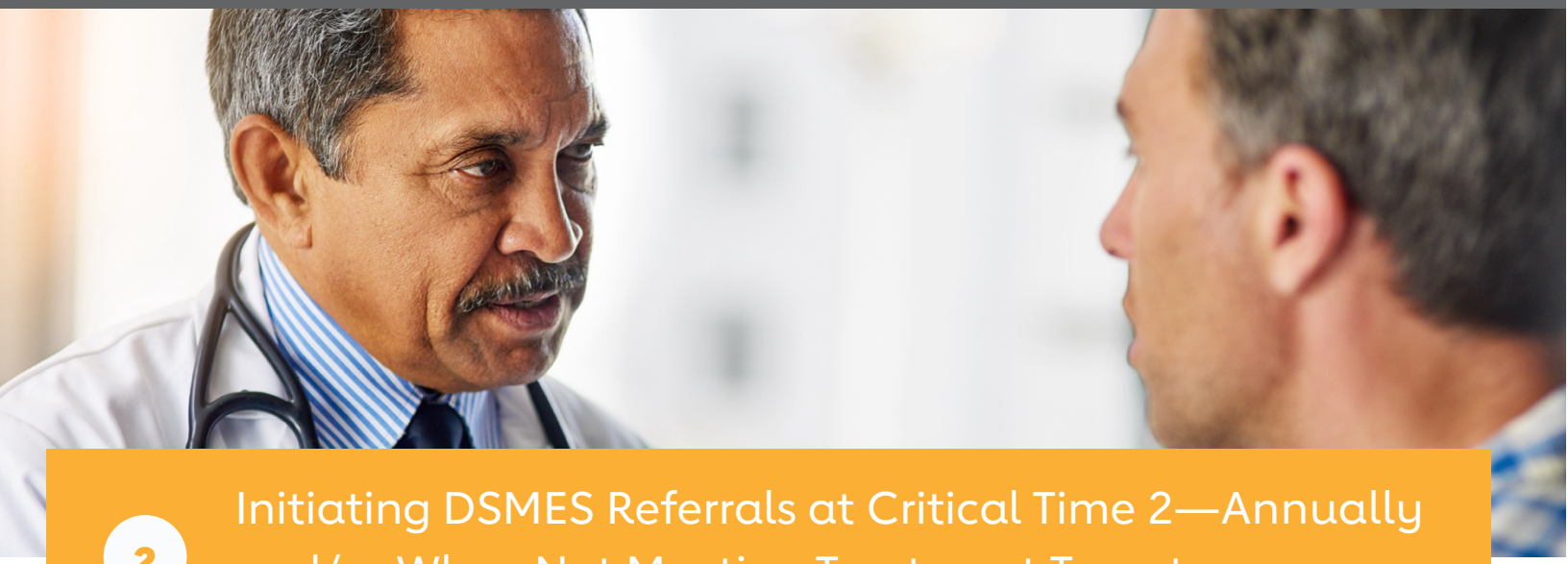

2 Initiating DSMES Referrals at Critical Time 2—Annually and/or When Not Meeting Treatment Targets

A Guide for Communicating with Patients and Implementing Team Care

Primary care visits for people with diabetes typically occur every three to six months. It is challenging for primary care providers to address all assessments during a visit, and this points to the need to utilize established diabetes self-management education and support (DSMES) resources and champion new ones to meet these needs, ensuring personal goals are met.

Annual visits for diabetes education are recommended to assess all areas of self-management, review behavior change and coping strategies and problem-solving skills, identify strengths and challenges of living with diabetes and make adjustments in therapy.

Providers should initiate a referral to and facilitate participation in DSMES at the four critical times 1) at diagnosis, 2) annually and/or when not meeting treatment targets, 3) when complicating factors develop and 4) when transitions in life and care occur.

This job aid focuses on *Critical Time 2—Annually and/or When Not Meeting Treatment Targets* and provides strategies for communicating with patients and implementing a team care approach during this critical time.

Communication

Key Factors to Consider for Patient Discussions

During the annual visit, conduct a review of knowledge, skills, psychosocial and behavioral outcomes or factors that inhibit or facilitate achievement of treatment target and goals. As you perform the review, listen closely for factors that indicate referral to DSMES services is needed, such as:

- Long-standing diabetes with limited prior education
- Treatment ineffective for attaining therapeutic target
- Change in medication, activity or nutritional intake or preferences
- Maintenance of clinical and quality-of-life outcomes
- Unexplained hypoglycemia or hyperglycemia
- Support to attain or sustain improved behavioral or psychosocial outcomes

Guiding a Person-Centered Discussion

- Possible barriers to achieving treatment goals, such as financial and psychosocial issues, life stresses, diabetes-related distress, fears, side effects of medications, misinformation, cultural barriers or misperceptions, should be assessed and addressed. People with diabetes are sometimes unwilling or embarrassed to discuss these problems unless specifically asked.

- Since the patient has now experienced living with diabetes, it is important to begin each maintenance visit by asking the patient about successes he or she has had and any concerns, struggles and questions. The focus of each session should be on patient decisions and issues—what choices has the patient made, why has the patient made those choices and whether those decisions are helping the patient to attain his or her goals—not on perceived adherence to recommendations. Instead, it is important for the patient/family members to determine their clinical, psychosocial and behavioral goals and to create realistic action plans to achieve those goals. Through shared decision-making, the plan is adjusted as needed in collaboration with the patient. To help to reinforce plans made at the visit and support ongoing self-management, the patient should be asked at the close of a visit to "teach-back" what was discussed during the session and to identify one specific behavior to target or prioritize.

Team Care

Topics and Strategies for Implementing an Effective Team Care Approach

Frequent DSMES visits may be needed when the individual is starting a new diabetes medication such as insulin, is experiencing unexplained hypoglycemia or hyperglycemia, has worsening clinical indicators or has unmet goals. Importantly, diabetes care and education specialists are charged with communicating the revised plan to the referring provider and assisting the person with diabetes in implementing the new treatment plan.

The health care team and others support the adoption and maintenance of daily self-management tasks, as many people with diabetes find sustaining these behaviors difficult. They need to identify education and other needs expeditiously in order to address the nuances of self-management and highlight the value of ongoing education.

Action Steps

Here are the action steps for providers, educators and specialists for DSMES during this critical time:

Primary Care Provider/Endocrinologist/Clinical Care Team's Role in Diabetes Education	Diabetes Care and Education Specialist's Role in Diabetes Education
☐ Refer for new techniques, technology and updated information.	☐ Review and reinforce treatment goals and self-management needs.
☐ Assess and refer if self-management targets are not met to address barriers to self-care.	☐ Review barriers to treatment effectiveness.
	☐ Emphasize reducing risk for complications and promoting quality of life.
	☐ Discuss how to adjust diabetes treatment and self-management to life situations and competing demands.
	☐ Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes.

Remember: Family members are an underutilized resource for ongoing support and often struggle with how to best provide this help. Including family members in the DSMES process on at least an annual basis can help to facilitate their positive involvement.

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