4 Initiating DSMES Referrals at Critical Time 4—When Transitions in Life and Care Occur

A Guide for Communicating with Patients and Implementing Team Care

Throughout the life span, changes in age, health status, living situation or health insurance coverage may require a reevaluation of the diabetes care goals and self-management needs. Diabetes self-management education and support (DSMES) services afford important benefits to patients during a life transition. Providing input into the development of practical and realistic self-management and treatment plans can be an effective asset for successful navigation of changing situations.

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 4—When Transitions in Life and Care Occur* and provides strategies for communicating with patients and implementing a team care approach during this critical time.

©2025 American Heart Association, Inc. All rights reserved.

Communication

Key Factors to Consider for Patient Discussions

Critical transition periods include transitioning into adulthood, hospitalization and moving into an assisted living facility, skilled nursing facility, correctional facility or rehabilitation center. Critical transition periods may also include life milestones such as marriage, divorce, parenthood, moving, death of a loved one, the start or completion of college, loss of employment, the start of a new job, retirement and other life circumstances.

During the patient visit, additional factors that may arise that indicate referral to DSMES services is needed. Listen closely to the patient to identify changes in:

- Living situation such as inpatient or outpatient or other change in living situation (i.e., living alone, with family, assisted living, etc.)
- Clinical care team
- Initiation or intensification of insulin, new devices or technology and other treatment changes
- Insurance coverage that results in treatment change (i.e., provider changes, changes in medication coverage)
- Age-related changes affecting cognition, vision, hearing, self-management, etc.

Team Care

Topics and Strategies for Implementing an Effective Team Care Approach

A written plan, prepared in collaboration with diabetes educators, the patient, family members and caregivers to identify deficits, concerns, resources and strengths, can help to promote a successful transition.

The plan should include personalized diabetes treatment targets; a medical, educational and psychosocial history; hypo- and hyperglycemia risk factors; nutritional needs; resources for additional support; and emotional considerations.

The health care provider can make a referral to a diabetes educator to develop or provide input to the transition plan, provide education and support successful transitions. The goal is to minimize disruptions in therapy during the transition while addressing clinical, psychosocial and behavioral needs.

©2025 American Heart Association, Inc. All rights reserved.

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
☐ Develop a diabetes transition plan.	☐ Adjust diabetes self-management plan as needed.
☐ Communicate the transition plan to new health care team members.	☐ Provide support for independent self-management skills and self-efficacy.
☐ Establish DSMES regular follow-up care.	☐ Identify level of significant-other involvement and facilitate education and support.
	☐ Help the person with diabetes face challenges that affect their usual level of activity, ability to function, health benefits and feelings of well-being.
	☐ Maximize quality of life and emotional support for the person with diabetes (and family members).
	☐ Provide education for others now involved in care.
	☐ Establish communication and follow-up plans with the provider, family and others.
	☐ Develop goals and personal strategies to promote health and behavioral change and improve quality of life.

References

- https://care.diabetesjournals.org/content/43/7/1636
- https://www.diabeteseducator.org/docs/default-source/practice/practice-resources/position-statements/dsme_joint_position_statement_2015.pdf?sfvrsn=0

©2025 American Heart Association, Inc. All rights reserved.