



2

## Initiating Diabetes Self-Management Education and Support 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. Clinicians can find it challenging to perform all needed assessments and provide appropriate patient education during these visits. For this reason, it is important to identify and partner with established diabetes self-management education and support (DSMES) resources and champion new ones to meet these needs.

Annual visits for diabetes education are recommended to:

- Assess all areas of self-management.
- Review behavior change, coping strategies and problem-solving skills.
- Identify strengths and challenges.
- Make needed adjustments in therapy.

Health care professionals (HCPs) should initiate referrals to and facilitate participation in DSMES services at the four critical times:

- 1) At diagnosis
- 2) Annually and/or when not meeting treatment targets
- 3) When complicating factors develop
- 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.

# Communicating with Patients



## Key Factors to Consider for Patient Discussions

During annual diabetes education visits, conduct a review of knowledge, skills, psychosocial and behavioral outcomes and factors that hinder or facilitate achievement of treatment targets and goals. As you perform the review, listen closely for factors that indicate a need for referral to DSMES services, such as:

- Long-standing diabetes with limited prior diabetes education
- Treatment that is not sufficient to attain therapeutic targets
- Changes in medication, activity, or nutritional intake or preferences
- Difficulty maintaining clinical and quality-of-life outcomes
- Unexplained hypoglycemia or hyperglycemia
- A need for support to attain or sustain improved behavioral or psychosocial outcomes



## Guiding Person-Centered Discussions

- Possible barriers to achieving treatment goals should be assessed and addressed, such as financial and psychosocial issues, life stresses, diabetes-related distress, fears, side effects of medications, misinformation and cultural barriers or misperceptions. People with diabetes are sometimes unwilling or embarrassed to discuss these problems unless specifically asked.
- Because patients have now experienced living with diabetes, it is important to begin each maintenance visit by asking them about successes, their concerns, struggles and questions. The focus of each session should be on patients' decisions and issues rather than on perceived adherence to recommendations. What choices have patients made and why? Have these decisions helped in attaining their diabetes-related goals?
- It is important for the patients/family members to determine their clinical, psychosocial and behavioral goals and to create realistic action plans to achieve those goals. The plan can be adjusted as needed through shared decision-making. To reinforce plans made at these visits and support ongoing self-management, patients 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 in the months ahead.

# Implementing a Team Care Approach

## Topics and Strategies

Frequent DSMES visits may be needed when individuals start a new diabetes medication such as insulin, experience unexplained hypoglycemia or hyperglycemia, have worsening clinical indicators or have unmet goals. Importantly, certified diabetes care and education specialists (CDCESs) are charged with communicating revised diabetes management plans to referring health care professionals (HCPs) and assisting people with diabetes in implementing their new plan.

The health care team and others support the adoption and maintenance of daily self-management tasks, which many people with diabetes find difficult to sustain. Team members must identify such difficulty expeditiously to address the nuances of self-management and provide and highlight the value of ongoing education as needed.

## Action Steps

Here are DSMES-related action steps for HCPs and CDCESs during this critical time:

Primary Care Provider/ Endocrinologist/Clinical Care Team	CDCES
<ul style="list-style-type: none"><li><input type="checkbox"/> Refer for new techniques, technology and updated information.</li><li><input type="checkbox"/> Assess and refer if self-management targets are not met to address barriers to self-care.</li></ul>	<ul style="list-style-type: none"><li><input type="checkbox"/> Review and reinforce treatment goals and self-management needs.</li><li><input type="checkbox"/> Review barriers to treatment effectiveness.</li><li><input type="checkbox"/> Emphasize reducing risk for complications and promoting quality of life.</li><li><input type="checkbox"/> Discuss how to adjust diabetes treatment and self-management to life situations and competing demands.</li><li><input type="checkbox"/> Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes.</li></ul>

**Remember:** Family members can be a valuable 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.

## Reference

Powers MA, Bardsley JK, Cypress M, et al. [Diabetes self-management education and support in adults with type 2 diabetes: a consensus report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners and the American Pharmacists Association.](#) *Diabetes Care* 2020;43:1636–1649