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Initiating Diabetes Self-Management Education and Support 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 and health insurance coverage may require reevaluation of individuals' diabetes care goals and self-management needs. Diabetes self-management education and support (DSMES) services afford important benefits to patients during such life transitions. Providing knowledgeable input into the development of practical and realistic self-management and treatment plans can greatly facilitate patients' successful navigation of changing circumstances.

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 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.

Communicating with Patients



Key Factors to Consider for Patient Discussions

Critical transitions may include emerging adulthood, hospitalization and relocation to an assisted living facility, skilled nursing facility, correctional institution or rehabilitation center. Critical transitions may also include life milestones such as marriage, divorce, parenthood, change of residence, 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 patient visits, additional factors may arise that indicate a need for referral to DSMES services. Listen closely to patients to identify changes in:

- Living situation (e.g., newly living alone, moving in with family, receiving inpatient or outpatient care or entering assisted living)
- Clinical care team
- Diabetes management plan (e.g., initiation or intensification of insulin therapy, new devices or technology or other treatment changes)
- Insurance coverage that results in a treatment change (e.g., a new provider or a change in medication coverage)
- Age-related changes affecting the ability to self-manage diabetes (e.g., changes in cognition, vision, hearing or dexterity)

Implementing a Team Care Approach

Topics and Strategies

Written plans to identify deficits, concerns, resources and strengths can facilitate a successful transition. Plans should be prepared through collaboration among HCPs, certified diabetes care and educational specialists (CDCESs), patients, family members, and other care givers.

These plans should include a medical, educational and psychosocial history; hypoglycemia and hyperglycemia risk factors; individualized diabetes treatment targets; nutritional needs and physical activity recommendations; emotional and psychosocial considerations and resources for additional support.

HCPs can make a referral to a CDCES to develop or provide input on transition plans and provide education and support to help ensure their success. The goal is to minimize disruptions in therapy during transitions while addressing clinical, psychosocial and behavioral needs.

Action Steps

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

Primary Care Provider/Endocrinologist/Clinical Care Team	CDCES
<input type="checkbox"/> Develop diabetes transition plans.	<input type="checkbox"/> Adjust diabetes self-management plans as needed.
<input type="checkbox"/> Communicate transition plans to new health care team members.	<input type="checkbox"/> Provide support for independent self-management skills and self-efficacy.
<input type="checkbox"/> Establish DSMES follow-up care as needed.	<input type="checkbox"/> Assess the degree to which patients' significant others are involved in care and facilitate their education and support.
	<input type="checkbox"/> Help people with diabetes face challenges that may negatively affect their usual level of physical activity, ability to function, health benefits and feelings of wellbeing.
	<input type="checkbox"/> Maximize wellbeing for people with diabetes and their family members or caregivers.
	<input type="checkbox"/> Provide education for any other individuals now involved in patients' diabetes care.
	<input type="checkbox"/> Establish communication and follow-up plans with patients' HCPs, family members and others as needed.
	<input type="checkbox"/> Develop individualized strategies to promote health and behavior changes and improve quality of life.

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](#)