STRATEGIES *for* CHRONIC CARE®
*Diabetes and CVD**

Transitions of Care Considerations for Populations With Type 2 Diabetes (T2D) and Cardiovascular Disease (CVD)

*CVD=cardiovascular disease

Common Elements for Assessment/Intervention in Transitions of Care

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Assess Medical Issues
- Diagnosis
- Symptoms
- Medication list and reconciliation of new medications
- Adherence assessment and intention
- Substance use and abuse disorders
- Lab tests, consultations, x-rays, and other relevant test results

Assess Physiologic Functioning
- Understanding of diagnosis, treatment options, and prognosis
- Life care planning and advance directive status
- Impact of illness, injury, or treatments on physical, psychosocial, and sexual functioning
- Ability to return to or exceed pre-illness or preinjury function level

Determine Psychosocial Functioning
- Past and current mental health, emotional, cognitive, social, behavioral, or substance use/abuse concerns
- Effect of medical illness or injury on psychological, emotional, cognitive, behavioral, and social functioning

Investigate Cultural Factors
- Affirm patient dignity and respect cultural, religious, socioeconomic, and sexual diversity
- Assess cultural values and beliefs, including perceptions of illness, disability, and death
- Use the patient's values and beliefs to strengthen the support system
- Understand traditions and values of patient groups as they relate to health care and decision-making

Assess Financial Factors
- Identify access to, type of, and ability to navigate health insurance
- Identify access to and ability to navigate prescription benefits
- Evaluate impact of illness on financial resources and ability to earn a living wage
- Assess barriers to accessing care and identify solutions to ensure access

Evaluate Physical and Environmental Safety
- Ability to perform activities of daily living and meet basic needs
- Environmental barriers that may compromise the ability to meet established treatment goals
- Ability of family or other informal caregivers to assist the patient
- Risk of harm to self or others

Evaluate Health Literacy and Linguistic Factors
- Provide information and services in preferred language, using translation services and interpreters
- Use effective tools to measure health literacy
- Provide easy-to-understand, clinically appropriate material in layperson's language
- Use graphic representations for patients with limited language proficiency or literacy
- Check to ensure accurate communication using teach-back methods
- Develop educational plan based on identified needs
- Evaluate caregiver's capacity to understand and apply health care information in assisting the patient

Identify Family and Community Support
- Identify formal and informal support systems
- How illness affects family structure and roles
- Provide support to family members and other informal caregivers

Ensure Continuity/Coordination of Care
- Specific clinical providers
- Date information sent to referring physician, primary care provider, or other clinical providers
- Necessary follow-up care

National Transitions of Care Coalition. NTOCC.org. Accessed May 25, 2017.

A Checklist for Transitions of Care in the Management of Patients With T2D and CVD

- ✔ Use this template across different transitions of care which may include:
  - Office to Home
  - Primary Care to Specialty Care
  - Inpatient to Rehab/SNF
  - Inpatient to Home
- ✔ Select the steps that meet the needs of your practice.
- ✔ Use this template to discuss your team's roles and responsibilities.
- ✔ Incorporate the information into your EMR system.

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	Discharge/Care Planning													Medication Reconciliation		Patient & Caregiver Education			Care Team Coordination	
	Obtain A1C if not performed within 3 months	Assess and manage blood pressure control	Identify and manage CVD risk factors	Initiate glycemic management protocol	Assess physiologic functioning	Determine psychosocial functioning	Investigate cultural factors	Assess financial factors	Evaluate physical and environmental safety	Determine most appropriate outpatient setting	Tailor a structured, individual discharge plan	Conduct follow-up call with patient within 48-72 hours of discharge	Schedule follow-up visit with appropriate provider within 7-10 days of discharge	Perform medication reconciliation	Review T2D and CVD medications with patient and family including drug name, dosage, and frequency	Evaluate health literacy and linguisitic factors	Identify family and community support	Provide T2D and T2D/ CVD patient education	Ensure continuity/ coordination of care	Develop structured discharge communications to relay T2D/CVD status with other members of care team
Primary Care Provider																				
Endocrinologist																				
Cardiologist																				
Clinical Nurse/ Specialist RN/ Case Worker																				
Diabetes Educator																				
Clinical Pharmacist																				
Physical/ Occupational Therapist																				
Case Manager																				
Medical Social Worker																				
Patient/ Family																				

EMR=electronic medical record; SNF=skilled nursing facility.

National Transitions of Care Coalition. NTOCC.org. Accessed May 25, 2017.
American Diabetes Association. Standards of medical care in diabetes–2017. *Diabetes Care.* 2017;40(suppl 1):S1-S135.

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Boehringer Ingelheim

Lilly