Transitions of Care Considerations for Populations With Type 2 Diabetes (T2D) and Cardiovascular Disease (CVD)
Common Elements for Assessment/Intervention in Transitions of Care

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

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

### Discharge/Care Planning

| 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 | 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 | Medication Reconciliation | Patient & Caregiver Education | Care Team Coordination |
|---------------------------------------------|----------------------------------------|-----------------------------------|-------------------------------------|---------------------------------|---------------------------------|-------------------------------|--------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| **Primary Care Provider**                   | **Endocrinologist**                    | **Cardiologist**                  | **Clinical Nurse/ Special RN/ Case Worker** | **Diabetes Educator** | **Clinical Pharmacist** | **Physical/Occupational Therapist** | **Case Manager** | **Medical Social Worker** | **Patient/ Family** |

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


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