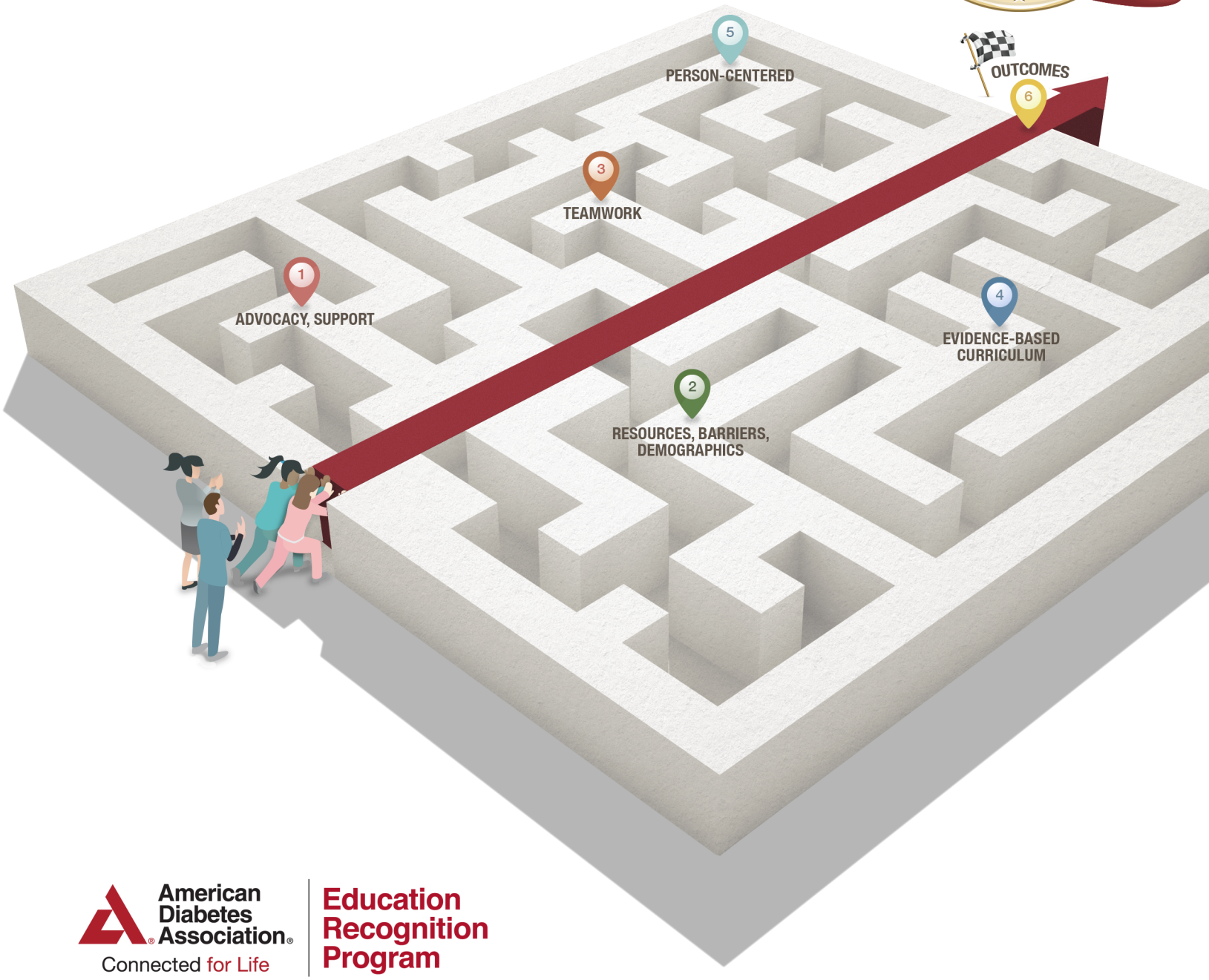
# ERP QUALITY COORDINATOR GUIDE

## 2022 National Standards for Diabetes Self-Management Education and Support


American Diabetes Association®
Connected for Life

Education Recognition Program

# ERP Quality Coordinator Guide

The ERP Quality Coordinator (QC) Guide was developed to take the guess work out of ensuring your DSMES service elements are reflective of the six 2022 National Standards for Diabetes Self-Management Education and Support (DSMES). If the requirements outlined in the guide and the templates displayed are always current, your service will always be audit ready too. ERP also has the editable templates available at the free on-line **ERP University**. These will provide you the option to have an electronic QC guide if you choose. See next page for guidance for developing and electronic QC guide.

**Instructions for Guide Use**

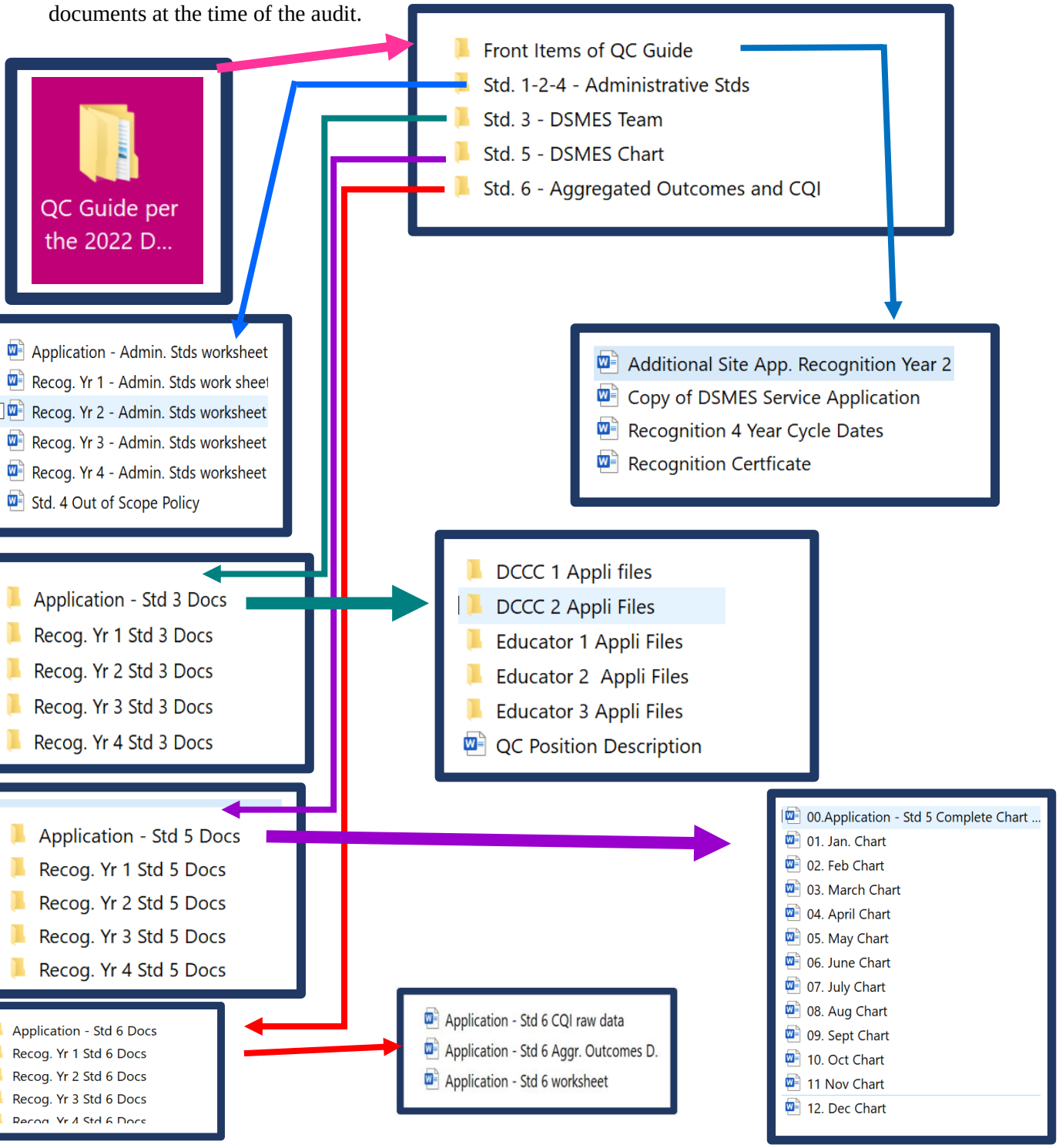
- Print ERP Quality Coordinator Guide.
- Insert pages in a 3-ring binder.
- Replace the 4 "Insert tab XYZ" pages with tabs labeled as the text indicated on the page.
  - Administrative Standards
  - Team Members
  - DSMES Chart
  - Aggregated Outcomes and CQI
- Replace the front certificate sample with your DSMES service certificate.
- Review pages 6 and 7 demonstrating how to determine your service's Recognition Anniversary Date.
- Complete your Service Recognition 4 Year Anniversary Dates Form.
- Documents should be kept for Recognition purposes for **six years**.

Three months prior to your DSMES service anniversary date set a calendar reminder each year to alert you to review the QC guide to ensure all the requirements for that year have been completed.

This will also allow you time to ensure that all team members that require annual CEUs or training have 3 months to complete any that are outstanding for **that Recognition year.**

**Electronic Quality Coordinator Guide Example**

As noted before, it is not required that the QC guide be hardcopy or electronic but if you would like to have an electronic QC guide here are some simple steps for setting it up. One advantage to an electronic QC guide is that if you have a Medicare or ADA audit you can simply upload the files into the Medicare or ADA portal. This will save you the hassle of having to print, scan, and upload documents at the time of the audit.



# Certificate of Recognition

The American Diabetes Association
recognizes the education service of

Replace with a copy of your DSMES Service Certificate

AS MEETING THE NATIONAL STANDARDS FOR DIABETES SELF-MANAGEMENT EDUCATION

AWARDED FOR THE PERIOD OF

Otis W. Kirksey,
PharmD, RPh, CDCES, BC-ADM
President, Health Care & Education

Amy Hess-Fischl, RDN, LDN, BC-ADM, CDE
Chair, Committee on Recognition

American Diabetes Association.

# Certificate of Recognition

The American Diabetes Association
recognizes the education service of

Diabetes Empowerment Services
DSMES Service
Maple Landing, VT

AS MEETING THE NATIONAL STANDARDS FOR DIABETES SELF-MANAGEMENT EDUCATION

AWARDED FOR THE PERIOD OF

March 1, 2022 - March 1, 2026

#001234

Otis W. Kirksey,
PharmD, RPh, CDCES, BC-ADM
President, Health Care & Education

Amy Hess-Fischl, RDN, LDN, BC-ADM, CDE
Chair, Committee on Recognition

American Diabetes Association.

**ERP Original Application**

## Original Application

**Application History**

**June 6, 2022, submitted to ADA for Review**

Reporting Period

### Application Information

Signature Statement signed by

Name: John Doe

Title: Chief Operating Officer

Phone: 999-999-9999

Reporting Period

Start Date: March 1, 2022

End Date: June 1, 2022

### Program Information

#### Sponsoring Organization

Sponsoring Organization Name:

Diabetes Empowerment Services

Administrative Officer:

Name: John Doe

Title: Chief Operating Officer

Email: abc@abc.com

Phone: 999-999-9999

Fax: 999-999-9999

Add 1: 1701 North Beauregard Street

Add 2: Maple Landing VT 22311

**DSMES Service's Administrative Standards 1,2, and 4**

Standard 1: DSMES Stakeholders

- ✓ The DSMES service has identified service stakeholders.
- ✓ The DSMES service has identified how each stakeholder may provide purposeful input and/or advocacy.
- ✓ The stakeholders will be reviewed/revised annually

Standard 2: Population and Service Assessment

- ✓ The target population served is assessed annually.
- ✓ The DSMES Service's resources and design is assessed for any gaps annually.
- ✓ A plan is developed to address any gaps identified.

Standard 4: Delivery and Design of DSMES Services

The DSMES curriculum includes the following 9 topic areas:

- Diabetes disease process and Treatment options: ✓
- Incorporating nutritional management into lifestyle: ✓
- Incorporating physical activity into lifestyle: ✓
- Using medications safely: ✓

#### Program Coordinator

Contact Information:

Name: Cindy Coordinator

Title: Quality Coordinator

Email: coordinator@abc.com

Phone: 999-999-9999

Fax: 999-999-9999

Add 1: 1701 North Beauregard Street

Add 2: Maple Landing, VT 22311

Certifications:

Credentials: RDN, CDCES

Continuing Ed:

If the Quality Coordinator is not a CDCES or BC-

- ❑ There is documentation to support that this Staff member has received 15 or 20 contact hours in any one or a combination of diabetes specific topics, diabetes related topics, psychosocial topics, or educational topics within the 12 months prior to the date this application is being entered online.

Job Description:

- ✓ Has academic preparation and/or experiential preparation in program management.
- ✓ Has academic preparation and/or experiential preparation in the care of persons with a chronic disease.
- ✓ Oversees the planning, implementation, and evaluation of the DSME entity at all sites.

#### General Information

Type of Electronic Health Record:

- ✓ Epic
- ❑ Cerner
- ❑ Centricity
- ❑ Chronicle
- ❑ E-Clinical Works (ECW)
- ❑ Meditech
- ❑ All Scripts
- ❑ Diaweb
- ❑ Other:

## DSMES Service 4 Year Recognition Cycle Example

March 1, 2022 to March 1, 2026

The month reflected on the DSMES service Recognition certificate is the annual anniversary month.


**Application Reporting Period** *(See top of sample application on page 5)*
March 1, 2022 to June 1, 2022

| | | | | |
|---|---|---|---|---|
| **Recognition Year 1:** | March 1, 2022 | to | March 1, 2023 |
| **Recognition Year 2:** | March 1, 2023 | to | March 1, 2024 |
| **Recognition Year 3:** | March 1, 2024 | to | March 1, 2025 |
| **Recognition Year 4:** | March 1, 2025 | to | March 1, 2026 |

**Renewal Application Notes**

- The renewal application can be initiated in the ERP application portal up to 6 months prior to the DSMES service's Recognition expiration date.

- It is recommended that renewal applications be submitted at least 2 months prior to the expiration date to allow ERP to review and processes the application and the DSMES service to provide their Medicare MAC a copy of the new Recognition certificate.

# DSMES Service 4 Year Recognition Cycle

**Application Reporting Period:** _____ **to** _____

*(Month/Day/Year)* *(Month/Year)*

**Recognition Year 1:** _____ **to** _____

*(Month/Year)* *(Month/Year)*

**Recognition Year 2:** _____ **to** _____

*(Month/Year)* *(Month/Year)*

**Recognition Year 3:** _____ **to** _____

*(Month/Year)* *(Month/Year)*

**Recognition Year 4:** _____ **to** _____

*(Month/Year)* *(Month/Year)*

## Renewal Application Notes

- The renewal application can be initiated in the ERP application portal up to 6 months prior to the DSMES service's Recognition expiration date.
- It is recommended that renewal applications be submitted at least 2 months prior to the expiration date to allow ERP to review and processes the application and the DSMES service to provide their Medicare MAC a copy of the new Recognition certificate.

# Insert Administrative Standards Tab

**(The templates in this tab will meet standards 1, 2, and 4 requirements.)**

# Standard 1: Support for DSMES Services

*The Diabetes Self-Management Education and Support (DSMES) team will seek leadership support for implementation and sustainability of DSMES services.*

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| 1. *Support can also be from expert stakeholders, who can provide purposeful input and advocacy to promote awareness, value, access, increase utilization, and quality.* | 1. The DSMES service will identifying external service stakeholders and how each may provide purposeful input and/or advocacy. | ☐ | ☐ |
| | 2. This selection of external stakeholders will be reviewed/revised annually. | ☐ | ☐ |

## Standard 2: Population and Service Assessment

*The DSMES service will evaluate their chosen target population to determine, develop, and enhance the resources, design, and delivery methods that align with the target population's needs and preferences.*

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| A. *The DSMES service will identify their target population DSMES needs, preferences, and barriers and have a plan to address.* | Documentation exists that reflects annual assessment of:<br>a) The demographics of the target population<br>b) The target population's diabetes type<br>c) The DSMES preferences and needs, and<br>d) Target population's barriers to DSMES services. | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| | | ☐ | ☐ |
| B. *The DSMES service will use resources and delivery methods that align with the target population's needs and preferences*. | 1. Documentation exists that reflects annual assessment of DSMES service resources relative to the target population.<br><br>*(e.g. physical space, staffing, scheduling, equipment, interpreter services, multi-language culturally relevant education materials, low literacy materials, large font education materials, mobile devices, upload devices and DSMES clinic portal accounts, virtual education equipment and platforms)* | ☐ | ☐ |
| | 2. Annual documentation exists reflecting a plan to address any DSMES gaps to serve the target population. | ☐ | ☐ |

# Standard 4: Delivery and Design of DSMES Services

*DSMES services will utilize a curriculum to guide evidence-based content and delivery, to ensure consistency of teaching concepts, methods, and strategies within the team, and to serve as a resource for the team. Providers of DSMES will have knowledge of and be responsive to emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies relevant to the population they serve.*

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| A. *A written curriculum guides evidence-based content and delivery of DSMES services.* | An evidence-based curriculum with content, learning objectives, method of delivery and criteria for evaluating learning is in place and covers the following 9 topics.<br>a) Diabetes pathophysiology | ☐ | ☐ |
| | b) Healthy eating | ☐ | ☐ |
| | c) Being active | ☐ | ☐ |
| | d) Taking medications – oral, injectable, insulin pump, inhaled | ☐ | ☐ |
| | e) Monitoring glucose | ☐ | ☐ |
| | f) Acute complications prevention, detection, and treatment including hypoglycemia, hyperglycemia, diabetes ketoacidosis, sick day guidelines and severe weather or situation crisis and diabetes supply management | ☐ | ☐ |
| | g) Chronic complications prevention, detection, and treatment including immunizations and preventative eye, foot, dental care, and renal screens and examinations as indicated per the individual's duration of diabetes and health status | ☐ | ☐ |
| | h) Lifestyle and healthy coping | ☐ | ☐ |
| | i) Diabetes distress and support<br>*Note: Problem solving is person centered and addressed within each topic area when appropriate.* | ☐ | ☐ |

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| B. *There is evidence that the teaching approach is interactive, patient centered, and incorporates problem solving.* | The curriculum or other supporting documents are tailored/individualized and involves interaction and problem solving. | ☐ | ☐ |
| C. *The curriculum and/or supporting materials are reviewed/revised to ensure they align with current evidence.* | There is documentation reflecting at least annual review/revision of the curriculum and/or supporting materials by the DSMES team and/or the DSMES service stakeholders. | ☐ | ☐ |
| D. *For services outside of the scope of practice of the DSMES team or services, the DSMES team should document communication with referring providers and/or other qualified healthcare professionals to support person -centered care.* | There must be documentation reflecting a procedure for meeting participants' needs when they are outside the scope of practice of the DSMES team or service. | ☐ | ☐ |

# Annual Administrative Documentation
## Standard 1, 2 and 4

| Standard 1<br>Support for DSMES Services<br>DSMES Services Recognition Anniversary *(month and day)* 2/10<br>Recognition Year **1 ~ 2 ~ 3 ~ 4** - Annual Review/Revision Date: 3/12/2022 | |
|---|---|
| **External Service Stakeholder Names** | **How the External Stakeholder May Provide Input and/or Advocacy** |
| **Joy Burdette, PharmD** | *Joy can help us navigate which DM meds are preferred by specific insurance plans.* |
| **Sue Rugg, RN** | *Sue works in the wound center and can assist getting DSMES participants with wounds that need immediate attention in to see a provider ASAP.* |
| **Reverend Paul Smith** | *Reverend Smith does Wellness Weekends and has ask the DSMES team to participate in the past and this has led to DSMES referrals.* |
| **Anne Woodstep CGM Rep** | *The CGM rep can provides the DSMES center CGM X starter kits.* |
| **Becky Summer Insulin Pump Rep** | *Becky can provide guidance on the company's insulin pump requirements to order, infusion sets, use, portal and report interpretation. She can also refer people on her pump for pre pump education and post pump start advanced pump training.* |
| **Debbie Carter RD, CDCES** | *Debbie is the inpatient diabetes educator, and she can promote the outpatient DSMES services especially for people newly diagnosed with DM, or new to insulin, or wanting education for insulin pumps or cgm, or post DKA.* |
| **Will Rogers Insulin Rep** | *Will can keep the team abreast of new products on the market and discount coupons or programs.* |
| **Cindy Miller** | *Cindy is the manager of the local Meals on Wheels program, and we can reach out to her when we have participants who need and qualify for the Meals on Wheels program.* |
| **Kelly Doub** | *Kelly is a trainer at Gym XYZ and she can assist participants who are interested in starting a workout program that is appropriate for their fitness level and any activity barriers.* |
| **Paul Rice** | *Paul manages the senior center and can keep us abreast of all the services offered there such as meals, chair yoga etc…* |

## Standard 2 and 4
## Target Population, DSMES Service Design and Delivery Assessment

Annual Assessment Review/Revision Date: **5/24/2022**

| Key: The % can be estimates rather than actual numbers. 0 = No 1= ~25% or less 2 = ~ 50% or less 3 =~>50% | DSMES Target Population Assessment |
|---|---|
| **Race of Population** | |
| American Indian or Alaskan Native | 0 - **1** - 2 - 3 |
| Asian/Chinese/Japanese/Korean/Pacific Islander | 0 - **1** - 2 - 3 |
| Black/African American | 0 - 1 - 2 - **3** |
| Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino | 0 - 1 - **2** - 3 |
| White/Caucasian | 0 - **1** - 2 - 3 |
| Middle Eastern | 0 - **1** - 2 - 3 |
| **Age of Population** | |
| 19 years or less | 0 - **1** - 2 - 3 |
| 19-44 years | 0 - 1 - **2** - 3 |
| 45 – 65 years | 0 - 1 - 2 - **3** |
| >65 years | 0 - 1 - **2** - 3 |
| **Type of Diabetes** | |
| Pre-Diabetes Age up to 19 years | **0** - 1 - 2 - 3 |
| Pre-Diabetes > 19 years | **0** - 1 - 2 - 3 |
| Type 1 Diabetes 0-18 years | 0 - **1** - 2 - 3 |
| Type 1 Diabetes >18 years | 0 - 1 - **2** - 3 |
| Type 2 Diabetes 0 – 18 years | **0** - 1 - 2 - 3 |
| Type 2 Diabetes > 18 years | 0 - 1 - 2 - **3** |
| Pregnancy with Pre-existing DM | 0 - **1** - 2 - 3 |
| Gestational Diabetes | 0 - 1 - **2** - 3 |
| **Diabetes Treatments** | |
| Oral Anti-Diabetes Medication | **Yes** **No** |
| Insulin | **Yes** **No** |
| Concentrated Insulin – U-500, U-300 | **Yes** **No** |
| Inhaled Insulin | Yes **No** |
| Injectable Anti-Diabetes Medications other than Insulin | **Yes** **No** |
| Insulin Pumps | **Yes** **No** |
| CGM | **Yes** **No** |
| **Unique Needs of Population** | |
| Hearing Impaired (Requiring Sign language) | **Yes** **No** |
| Visual Impaired (Requiring Print augmentation) | **Yes** **No** |
| Low Literacy Population | **Yes** **No** |
| Physical Facility Needs (Classroom space, ramps, elevators, etc.…) | **Yes** **No** |
| Technical Savvy Participants | **Yes** **No** |
| Insured | **Yes** **No** |
| Uninsured *PWD who are uninsured are served at the free clinic that is grant* funded. | Yes **No** |
| **DSMES Barriers** | |
| Transportation Barriers | Yes **No** |
| Technology Barriers for Virtual Visits | **Yes** **No** |
| Technology Barriers for sending Remote Data (Insulin pump data, BG meter data, CGM data) | **Yes** **No** |

| | | |
|---|---|---|
| Uninsured | **Yes** | **No** |
| Co Pay Barriers | **Yes** | **No** |
| Language Barrier (Requiring Interpreters) | **Yes** | **No** |

Languages that require interpreter services:

Deaf
Samoan
Arabic
Japanese

| Using the DSMES target population data assess the service's design and resources and develop a plan to serve any gaps identified. | | |
|---|---|---|
| **DSMES Locations** | Service's current resources and assets | Plan to address identified needs |
| *Out main site is at the hospital 's outpatient medical Building across from the hospital and we have expansion site at the senior center and the local maternal fetal medicine office.* | | *No gaps identified.* |
| **DSMES Hours/Scheduling** | Service's current resources and assets | Plan to address identified needs |
| *The DSMES hours are from 8am to 8pm Monday through Friday to allow for people who work during the day to be able to come after work. 4 of the CDCES work from 8am to 4:30pm and 2 of them work from 11:30am to 8pm.* | | *No gaps identified* |
| **Physical Space** | Service's current resources and assets | Plan to address identified needs |
| *Our facilities are all compliant with the American Disabilities Act requirements. We have noticed that our chairs are hard for some of the patient to stand up from.* | | *We plan to ask management to provide us with 6 chairs that are higher for each of the CDCES rooms.* |
| **Staffing** | Service's current resources and assets | Plan to address identified needs |
| *We currently have 6 CDCES. 1 is a social worker, 1 is a pharmacist,3 RDNs, 1 RN, 4 are certified insulin pump trainers*<br>*We have 2 Diabetes Community Care Coordinators (DCCC their title used to paraprofessionals)* | | *No gaps identified* |
| **Equipment** | Service's current resources and assets | Plan to address identified needs |
| *We currently have 1 meter, pump and cgm download station.*<br>*We have a conference room where we can hold group session. We have cameras on our computers that allow for telehealth sessions.* | | *Ask management if we can get another computer and software for at least one more download station as team members have to often wait until another members has finished downloading a device to use the one station.* |
| **Interpreter Services** | Service's current resources and assets | Plan to address identified needs |
| *We have interpreter services for all languages and a sign language service for people who are deaf.* | | *No gaps identified* |
| **Education Materials (Ed. Mat.) Languages** | Service's current resources and assets | Plan to address identified needs |
| We have education materials and teaching props in all the languages we service. | | No gaps identified |
| **Ed. Mat. - Cultural Designs** | Service's current resources and assets | Plan to address identified needs |
| *We have education materials that are culturally appropriate for our population served but we do need to develop more sample menus for some cultures.* | | *We need sample Arabic and pacific island meals.* |
| **Ed. Mat. - Low Literacy** | Service's current resources and assets | Plan to address identified needs |
| *We do have materials that are low literacy and materials for the 9 DSMES curriculum areas that are pictures.* | | *No gaps identified* |
| **Ed. Mat. - Large Print** | Service's current resources and assets | Plan to address identified needs |
| *We do have large print materials and materials that are large print in each of the 9 DSMES topic areas.* | | *No gaps identified.* |

| **Electronic Education Materials** | Service's current resources and assets | Plan to address identified needs |
|---|---|---|
| *Most of our materials we have digital versions of but we are still in the process of getting the low literacy picture materials professionally scanned into digital format.* | | *The QC will appeal to the marketing department to complete this project before the fall of 2022.* |
| **Ability to offer Virtual or Telehealth Services** | Service's current resources and assets | Plan to address identified needs |
| *Only 3 of the CDCES session rooms have cameras for virtual services, so CDCES have to switch rooms in the middle of the day if they have virtual appointments.* | | *Ask manager if we can get 3 more cameras or have specific virtual days for CDCES.* |
| **Remote monitoring resources and portal** | Service's current resources and assets | Plan to address identified needs |
| *We have all the portal software and adaptors to download devices, but we need at least one more download station as noted above.* | | *See equipment comment* |
| **Curriculum & Supporting Documents** | Service's current resources and assets | Plan to address identified needs |
| **Contains 9 Topic Areas with**:<br>*Content:*<br>**Yes or Need**<br>*Learning Objectives:*<br>**Yes or Need**<br>*Method of Delivery:*<br>**Yes or Need**<br>*Method of Evaluating Learning:*<br>**Yes or Need**<br><br>**Individualized Delivery**<br>*The curriculum or other supporting documents are tailored/individualized and involve interaction and problem solving:*<br>**Yes or Need**<br><br>**Participant Needs Outside of Scope of Service:**<br>*Attached documentation of procedure for meeting participants' needs when they are outside the scope of practice of the DSMES team or service.*<br>**Yes or Need** | *List curriculum title and origin year*<br>**9 Topic Areas**<br>*DM Pathophysiology:*<br>**Yes or Need**<br>*Healthy Eating:*<br>**Yes or Need**<br>*Being Active:*<br>**Yes or Need**<br>*Taking Medications:*<br>**Yes or Need**<br>*Monitoring Glucose:*<br>**Yes or Need**<br>*Acute Complications:*<br>▪ Low and high bg<br>**Yes or Need**<br>▪ DKA:<br>**Yes or Need**<br>▪ Sick Days:<br>**Yes or Need**<br>▪ Severe weather or situation DM supply management:<br>**Yes or Need**<br>*Chronic Complications:*<br>▪ Immunizations:<br>**Yes or Need**<br>▪ Preventative Care (eye, foot, dental and renal screening):<br>**Yes or Need**<br>*Lifestyle and Healthy Coping*:<br>**Yes or Need**<br>*DM Distress and Support:*<br>**Yes or Need** | *WE need to xpand our pump DKA materials to address automated pumps with closed loop systems to guide wears to take their pump out of auto mode for 3 hours after injecting insulin when trouble shooting high bg with ketones to prevent the automated mode fomr stacking insulin as it will not be tracking the injected insulin.*<br><br>*Being the new QC I cannot find the out of scope plan, so the DSMES team needs to develop one and make it a policy this time and keep it in the QC Guide folder that we hope to make digital in 2022.* |

# Annual Administrative Documentation
## Standard 1, 2 and 4

| **Standard 1**<br>**Support for DSMES Services**<br>**DSMES Services Recognition Anniversary** *(month and day)* _____<br>Recognition Year **1 ~ 2 ~ 3 ~ 4** - Annual Review/Revision Date: _____ | |
|---|---|
| **External Service Stakeholder Names** | **How the External Stakeholder May Provide Input and/or Advocacy** |
| | |

## Standard 2 and 4
## Target Population, DSMES Service Design and Delivery Assessment

Annual Assessment Review/Revision Date: _____

| Key: The % can be estimates rather than actual numbers. 0 = No 1= ~25% or less 2 = ~ 50% or less 3 =~>50% | DSMES Target Population Assessment |
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| 19-44 years | 0 - 1 - 2 - 3 |
| 45 – 65 years | 0 - 1 - 2 - 3 |
| >65 years | 0 - 1 - 2 - 3 |
| **Type of Diabetes** | |
| Pre-Diabetes Age up to 19 years | 0 - 1 - 2 - 3 |
| Pre-Diabetes > 19 years | 0 - 1 - 2 - 3 |
| Type 1 Diabetes 0-18 years | 0 - 1 - 2 - 3 |
| Type 1 Diabetes >18 years | 0 - 1 - 2 - 3 |
| Type 2 Diabetes 0 – 18 years | 0 - 1 - 2 - 3 |
| Type 2 Diabetes > 18 years | 0 - 1 - 2 - 3 |
| Pregnancy with Pre-existing DM | 0 - 1 - 2 - 3 |
| Gestational Diabetes | 0 - 1 - 2 - 3 |
| **Diabetes Treatments** | |
| Oral Anti-Diabetes Medication | Yes No |
| Insulin | Yes No |
| Concentrated Insulin – U-500, U-300 | Yes No |
| Inhaled Insulin | Yes No |
| Injectable Anti-Diabetes Medications other than Insulin | Yes No |
| Insulin Pumps | Yes No |
| CGM | Yes No |
| **Unique Needs of Population** | |
| Hearing Impaired (Requiring Sign language) | Yes No |
| Visual Impaired (Requiring Print augmentation) | Yes No |
| Low Literacy Population | Yes No |
| Physical Facility Needs (Classroom space, ramps, elevators, etc.…) | Yes No |
| Technical Savvy Participants | Yes No |
| Insured | Yes No |
| Uninsured | Yes No |
| **DSMES Barriers** | |
| Transportation Barriers | Yes No |
| Technology Barriers for Virtual Visits | Yes No |
| Technology Barriers for sending Remote Data (Insulin pump data, BG meter data, CGM data) | Yes No |

| | | |
|---|---|---|
| Uninsured | **Yes** | **No** |
| Co Pay Barriers | **Yes** | **No** |
| Language Barrier (Requiring Interpreters) | **Yes** | **No** |

Languages that require interpreter services:

| Using the DSMES target population data assess the service's design and resources and develop a plan to serve any gaps identified. | | |
|---|---|---|
| **DSMES Locations** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **DSMES Hours** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Physical Space** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Staffing/Scheduling** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Equipment** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Interpreter Services** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Education Materials** (Ed. Mat.) **Languages** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Ed. Mat. - Cultural Designs** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Ed. Mat. - Low Literacy** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Ed. Mat. - Large Print** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Electronic Ed. Mat.** | Service's current resources and assets | Plan to address identified needs |
| | | |

| **Ability to offer Virtual or Telehealth Services** | Service's current resources and assets | Plan to address identified needs |
|---|---|---|
| | | |
| **Remote monitoring resources and portal** | Service's current resources and assets | Plan to address identified needs |
| | | |
| **Curriculum & Supporting Documents** | Service's current resources and assets | Plan to address identified needs |
| **Contains 9 Topic Areas with**:<br>*Content:*<br>**Yes or Need**<br>*Learning Objectives:*<br>**Yes or Need**<br>*Method of Delivery:*<br>**Yes or Need**<br>*Method of Evaluating Learning:*<br>**Yes or Need**<br><br>**Individualized Delivery**<br>*The curriculum or other supporting documents are tailored/individualized and involve interaction and problem solving:*<br>**Yes or Need**<br><br>**Participant Needs Outside of Scope of Service:**<br>*Attached documentation of procedure for meeting participants' needs when they are outside the scope of practice of the DSMES team or service.*<br>**Yes or Need** | *List curriculum title and origin year*<br>**9 Topic Areas**<br>*DM Pathophysiology:*<br>**Yes or Need**<br>*Healthy Eating:*<br>**Yes or Need**<br>*Being Active:*<br>**Yes or Need**<br>*Taking Medications:*<br>**Yes or Need**<br>*Monitoring Glucose:*<br>**Yes or Need**<br>*Acute Complications:*<br>▪ Low and high bg<br>**Yes or Need**<br>▪ DKA:<br>**Yes or Need**<br>▪ Sick Days:<br>**Yes or Need**<br>▪ Severe weather or situation DM supply management:<br>**Yes or Need**<br>*Chronic Complications:*<br>▪ Immunizations:<br>**Yes or Need**<br>▪ Preventative Care (eye, foot, dental and renal screening):<br>**Yes or Need**<br>*Lifestyle and Healthy Coping*:<br>**Yes or Need**<br>*DM Distress and Support:*<br>**Yes or Need** | |


Example

# Out of Scope of Practice Policy

Purpose: To provide guidance when a Diabetes Self-Management Education and Support (DSMES) participant's education needs are outside of the scope of practice of the DSMES service's team members.

Procedure: When a DSMES participant has needs that are outside of the scope of practice of the DSMES team members the following will occur:

- The DSMES participant will be provided a list of providers that can provide the service/s needed.
- The referring provider will be notified of the DSMES participant's needs not provided. because they were outside of the scope of practice of the DSMES team members.
- The communication to the referring provider will be documented in the participant's medical record.

# Insert

# Team Members

# Tab

**(The templates in this tab will meet standards 3 requirements.)**

## Standard 3: DSMES Team

*All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement. At least one team member will be identified as the DSMES quality coordinator and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes. Other members of the DSMES team must have proper qualifications to provide DSMES services.*

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| A. *The DSMES service has a designated coordinator who oversees the planning, implementation, and evaluation of the service at all sites.* | There is documentation of one quality coordinator as evidenced by a position description or performance appraisal tool. | ☐ | ☐ |
| B. *The DSMES team includes one or more healthcare professional with current credentials: Registered Nurse (RN), Registered Dietitian Nutritionist (RDN), pharmacist, Board Certified Advanced Diabetes Management professional (BC-ADM®), or Certified Diabetes Care and Education Specialist (CDCES®).* | 1. At least one DSMES team member is a RN or RDN, or pharmacist or BC-ADM®, or CDCES®. | ☐ | ☐ |
| | 2. All healthcare professional DSMES team members must have current licensures and/or registration | ☐ | ☐ |
| C. *Professional team members must demonstrate mastery of diabetes knowledge and training.* | Professional team members must demonstrate ongoing training in DSMES topics per the CBDCE examination content areas.<br>a) BC-ADM® and CDCES® team member credentials must be current. | ☐ | ☐ |
| | b) Non-BC-ADM® or non CDCES® professional team members must have documentation reflecting 15 hours of continuing education (CE) from the Certification Board for Diabetes Care and Education (CBDCE) approved CE providers annually per the DSMES service's anniversary month. | ☐ | ☐ |

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| | c) Non-BC-ADM® or non CDCES® professional team members who do not have 15 hours CEs within the 12 months prior to joining the DSMES team must accrue the 15 hours of CEs within the first four months of joining the DSMES service as a professional team member. | ☐ | ☐ |
| *D. Diabetes Community Care Coordinators (DCCC), previously referred to as paraprofessionals, must be qualified and provide diabetes care and education within their scope of practice and training.* | 1. DCCC team members must have evidence of previous experience or training in: diabetes, chronic disease, health and wellness, healthcare, community health, community support, and/or education methods as evidenced by a resume or certificate. (e.g., community health worker, health promotor, pharmacy, lab or diet technician, medical assistant, peer education, trained peer leader) | ☐ | ☐ |
| | 2. DCCC team members must have supervision by a professional DSMES team member. Supervision can be demonstrated by a position description or performance appraisal tool. | ☐ | ☐ |
| | 3. DCCC team members must have documentation reflecting competency and 15 hours of training prior to providing DSMES services and annually per the DSMES service's anniversary month. *(e.g., documented in-service training, medication or device training, etc.)* | ☐ | ☐ |

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# DSMES Service Team List and Tracker

All DSMES team members and the quality coordinator credentials and CEUs (if applicable) must be kept on file from the DSMES service's most recent new or renewal application until the service re-applies for a new Recognition cycle of 4 years.

| DSMES Service #:<br>Service Anniversary Date:<br>4-year Recognition Cycle Dates:<br>*(Example: 3/1/2022 to 3/1/2026)*<br>Site Name: | | | 12 months prior to most recent DSMES service new or renewal application<br>*(Example 3/1/021-3/1/2022)* | | DSMES Service Certificate Year 1<br>*(Example 3/1/2022–3/1/2023)* | | DSMES Service Certificate Year 2<br>*(Example 3/1/2023-3/1/2024)* | | DSMES Service Certificate Year 3<br>***(Example 3/1/2024-3/1/2-25)*** | | DSMES Service Certificate Year 4<br>*(example 3/1/2025-3/1/2026)* | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Name** | **DSMES Service Hire Date** | **DSMES Service Term Date** | **Appropriate licensure or CDR for RDs** | **CDCES or BC-ADM or 15 hrs. of CEUs*** | **Appropriate licensure or CDR for RDs** | **CDCES or BC-ADM or 15 hrs. of CEUs*** | **Appropriate licensure or CDR for RDs** | **CDCES or BC-ADM or 15 hrs. of** | **Appropriate licensure or CDR for RDs** | **CDCES or BC-ADM or 15 hrs. of** | **Appropriate licensure or CDR for RDs** | **CDCES or BC-ADM or 15 hrs. of** |
| **Quality Coordinator** | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| **Professional Team Members** | **(If a team member works at multiple sites indicate which site binder the licenses and credentials will be kept on file)** | | | | | | | | | | | |
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| **Diabetes Community Care Coordinator (DCCC) Team Members** | | | Documentation reflecting competent in the areas she/he teaches | 15 hrs. of Training annually | Documentation reflecting competent in the areas she/he teaches | 15 hrs. of Training annually | Documentation reflecting competent in the areas she/he teaches | 15 hrs. of Training annually | Documentation reflecting competent in the areas she/he teaches | 15 hrs. of Training annually | Documentation reflecting competent in the areas she/he teaches | 15 hrs. of Training annually |
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| **Temp Employees** | | | Appropriate licensure or CDR for RDs | Has 4 months from hire date to obtain 15 CEUs if not CDE or BC-ADM | Appropriate licensure or CDR for RDs | Has 4 months from hire date to obtain 15 CEUs if not CDE or BC-ADM | Appropriate licensure or CDR for RDs | Has 4 months from hire date to obtain 15 CEUs if not CDE or BC- ADM | Appropriate licensure or CDR for RDs | Has 4 months from hire date to obtain 15 CEUs if not CDE or BC-ADM | Appropriate licensure or CDR for RDs | Has 4 months from hire date to obtain 15 CEUs if not CDE or BC- ADM |
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**Admin Staff** are staff that do not provide education and should not be included on the DSMES service application. This staff type can do data entry but does not provide education.

**Referring providers** should not be on the DSMES service application unless they are providing 10% or more of the DSMES education.

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# Diabetes Community Care Coordinators (DCCC)

*(enter name)*_____**Annual Training**

- DCCC team members require 15 hours of training each DSMES service recognition year or the previous 12 months prior to a service's new or renewal application.
- DCCC team members require annual documentation reflecting competency in the areas of DSMES they teach.
- DSMES services must have documentation reflecting DCCC's experience prior to joining the Service.
- DCCCs cannot perform the participant assessment or establish the education plans.
- DCCCs should be trained to defer questions outside of their scope, documented competency, or all clinical questions back to a professional team member.
- The professional team member does not have to be present for the DCCC to teach within their scope of practice per their annual documented training
- DCCC team members do not determine if a DSMES service is a single discipline or multi-discipline service

**DSMES Service Recognition Year: _____ to _____**

| Date | Training Topic, Method, and Provider | Hours | DSMES Category C= Competent |
|---|---|---|---|
| *01.01.2022 Example* | *Sweet BG Meter Rep provided training on their meters that our DSMES service participants use. Training included meter set up (time, date, participants BG parameters), using the meters, and uploading the meters and meter reports. The Sweet BG Meters reviewed were: (list meters).* | *2.5 hrs.* | *5 C Competency noted as team member presented back all tasks.* |
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**DCCC DSMES Training Category Key**

| | |
|---|---|
| 1 – Diabetes Pathophysiology | 6 – Acute Complications |
| 2 – Healthy Eating | 7 – Chronic Complications |
| 3 – Being Active | 8 – Lifestyle and healthy coping |
| 4 – Taking Medications | 9 – Diabetes distress and support |
| 5 – Monitoring Glucose | |

Signature and date indicating that the supervising team member attests to the above training and competencies:

_____

# DSMES Team Member and Staff Type

- **Professional instructional team member**
  - A licensed or credentialed healthcare provider that is eligible to sit for the CDCEs exam
  - Credentials current during 4-year Recognition period
  - *CEU's if not a CDCES or BC-ADM required
  - Must conduct at least 10% of the DSMES cycle
  - A professional instructor must do the initial and follow up assessments and establish the education plan
  - Include on applications
- **Diabetes Community Care Coordinators (DCCC)**- *previously referred to as paraprofessionals*
  - Proof of training/experience prior to joining DSMES service
  - Proof of 15 hrs. of training per Recognitions year
  - Proof of competency in areas of DSMES service she/he teaches each Recognition year
  - Cannot do the initial or follow up assessment or set the education plan
  - Include on applications

**All CEUs and credentials must be kept on file during the 4-year Recognition cycle including the CEUs and credentials submitted with the most recent service application.*

**Recognition year is a 12-month period based on the month on the DSMES service's Recognition certificate.*


- **Temporary instructional team member**
  - Two types of Temporary Instructors
    - A professional instructor that fills in while permanent instructor is on vacation
    - A permanent professional instructor can be a temporary instructor for the first 4 months after hire (not DCCC ) to allow time to obtain CEUs
  - Do not include on application
  - Credentials must be current
  - Keep proof of hire date in case of an audit

| Administrative staff | Referring providers |
|---|---|
| ▪ Does not provide education<br>▪ No credentials or CEUs required<br>▪ Do not include on application | ▪ Are not instructional staff<br>▪ Do not include on application<br>▪ Credentials and CEUs do not have to be kept on file for DSMES recognition |

## Annual Professional Team Members' CEU Requirements and Diabetes Community Care Coordinators' Training Requirements

- Professional team members that are not a CDCES® or BC-ADM require documentation reflecting 15 hours of CEUs annually per the DSMES service anniversary month that meet all the below guidelines.
- Diabetes Community Care Coordinators (DCCC) team members require documentation reflecting 15 hours of training annually per the DSMES service anniversary month and the below topic guidelines.
- The CEUs and training are required:
    - At the time of the DSMES service application
    - The 12 months prior to the DSMES service application submission date
    - During the DSMES service's 4-year Recognition period.
        - The annual requirements are based on the DSMES service's anniversary month

### CEU Providers and Topics

- It is important to understand that the annual professional DSMES team member CEU requirement replaces the requirement that professional team members be a CDCES® or BC-ADM
- Professional team member CEUs must be diabetes related per the Certification Board for Diabetes Care and Education (CBDCE) exam content areas which can be found in the Exam Handbook: https://www.cbdce.org/eligibility
- The CEU must be provided by a CBDCE approved CEU organization found on: https://www.cbdce.org/eligibility

### CEU Topics

- **Diabetes Specific**
- **Diabetes Related**: nutrition, exercise, retinopathy, nephropathy, neuropathy, cardiovascular disease, stroke, lipids, obesity, metabolic syndrome, etc.
- **Psychosocial:** psychological, behavioral, or social content related to diabetes, self-management or chronic disease.
- **Education:** knowledge assessment, learning principles, education, training, or instructional methods
- **Program Management (only for QC):** operations of the DSME, including business operations, performance improvement, case, and disease management.

*If the program title does not fit one of the above: Include a copy of the official program brochure with objectives or a copy of the official course outline*.

- **CEU Certificates and Logs**
  - The CEU certificate must display the following
    - DSMES team member's name
    - Title of the CEU program
    - Date/s the CEU hours were earned
    - Number of CE hours
    - Name of the CBDCE approved credentialing body
  - RDN or CDCES logs are not accepted because they are populated by the RD
  - Pharmacists CPE logs are accepted
    - CPE (Accreditation Council for Pharmacy Education) will no longer provide CEU certificates. CPE populates the logs with the CEU data

- **CEUs - Not accepted**
  - Exhibit hall hours
  - BLS* and ACLS** courses
  - Poster Sessions: unless accompanied by objectives provided during the session
  - Academic credits (college credits) unless the college or university:
    - *is approved by an CBDCE recognition organization*
    - *the college/university converts the credits to CEU hours and provides verification of conversion on official letterhead*

*BLS – Basic Life Support

**ACLS – Advanced Cardiac Life Support

Replace

# Quality Coordinator
# Position Description Template

1. The title of this position should be one that indicates leadership, such as coordinator, manager, or director.
2. The following must be included in the description of the tasks:

- Oversight of the planning, implementation, and evaluation of the DSMES service (at all sites, if there is more than one site in the DSMES service).
- The following must be included in the qualifications for this position:
- Academic and/or experiential preparation in program management
- Academic and/or experiential preparation in the care of people with a chronic disease
- Education requirements
- License/Registrations/Certifications as applicable.

**EXAMPLE**

**POSITION TITLE: Diabetes Quality Coordinator**
**DEPARTMENT: Outpatient Clinic**
**REPORTS TO: VP of Nursing**

**POSITION SUMMARY**

The Diabetes Quality Coordinator (QC) is responsible for overseeing the day-to day operations of the DSMES service at all sites. The QC ensures that the National Standards for DSMES (NSDSMES) are met and maintained at all times.

**DUTIES AND RESPONSIBILITIES**

1. Oversees the planning, implementation, and evaluation of the DSMES service.
2. Coordinates the identification of DSMES stakeholders and a liaises between the DSMES team members, the stakeholders, other departments and administration.
3. Monitors and facilitates maintenance of DSMES team members qualification (CE credits, training, competency, licensures, and registrations).
4. Ensures DSMES outcomes are tracked.
5. Ensures the DSMES service has a quality improvement projects underway at all times.
6. Completes the Recognition annual status report in the ERP portal in a timely manner.
7. Responsible for maintaining ADA Recognition and participating in the evaluation of the DSMES service's effectiveness.

**QUALIFACTIONS**

1. Required/expected academic preparation.
2. Required licenses, registrations, certifications for area of specialty.
3. Required experience in clinical practice.
4. Required experience in program management.

Revised per the 2022 NSDSMES 2/2022

# Insert

# DSMES Chart

# Tab

**(The templates in this tab will meet standards 5 requirements.)**

## Standard 5: Person-Centered DSMES

*Person-centered DSMES is a recurring process over the life span for a PWD. Each person's DSMES plan will be unique, based on their concerns, needs, and priorities collaboratively determined as part of a DSMES assessment. The DSMES team will monitor and communicate the outcomes of the DSMES services to the diabetes care team and/or referring provider.*

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| *A.* An assessment of the participant is performed in the following areas to develop the person centered DSMES plan. *Participants receive a comprehensive assessment that includes baseline diabetes self-management knowledge, skills, and readiness for behavioral change* | 1. An assessment of the participant is performed in the following areas to develop the person centered DSMES plan.<br>a) Diabetes pathophysiology and treatment options | ☐ | ☐ |
| | b) Healthy eating | ☐ | ☐ |
| | c) Being active | ☐ | ☐ |
| | d) Taking medications | ☐ | ☐ |
| | e) Monitoring glucose | ☐ | ☐ |
| | f) Acute complications | ☐ | ☐ |
| | g) Chronic complications | ☐ | ☐ |
| | h) Lifestyle and healthy coping | ☐ | ☐ |
| | i) Diabetes distress and support | ☐ | ☐ |
| | j) Clinical history (diabetes and other pertinent clinical history) | ☐ | ☐ |
| | k) Health literacy (ability to understand and interpret) *(e.g. glucose targets, A1C target, carb awareness, carb counting, carb choices etc.)* | ☐ | ☐ |
| | *2.* Parts of the initial assessment may be deferred if applicable and the rationale for deferment is documented. | ☐ | ☐ |

| Interpretive Guidance | Indicator | Yes | No |
|---|---|---|---|
| *B. Each DSMES participant has a person centered DSMS plan with outcomes measured* | 1. Participant's DSMES plan is documented in the medical record. | ☐ | ☐ |
| | 2. Each DSMES session is documented in the medical record. | ☐ | ☐ |
| | 3. The outcome evaluation of the DSMES is documented for the topic areas covered during each session. | ☐ | ☐ |
| *C. Each participant will develop an action oriented behavioral change plan to reach their personal behavioral goal/s.* | 1. DSMES participants will develop at least one action oriented behavioral change goal. | ☐ | ☐ |
| | 2. The outcome of the behavioral change goal/s will be measured and documented. The outcome measurement timing will vary based on the individual and the outcome to be measured. | ☐ | ☐ |
| *D. Clinical outcome measures reflect the impact of the DSMES services on the health status of the participant.* | The DSMES service will determine at least one participant clinical, or quality of life outcome and it will be measured at baseline and post DSMES for each participant. The outcome assessment timing will vary based on the individual and the outcome to be measured.<br><br>*(e.g. clinical, quality of life, hospital days, ER visits, baby weight, C-section delivery rates, DKA, A1C, missed school work or school days etc.).* | ☐ | ☐ |
| *E. The DSMES team will monitor and communicate the outcomes of the DSMES services to the participant's diabetes care team.* | There is evidence that the DSMES planned or provided, and outcomes will be communicated to the referring provider and/or other members outside of the DSMES service of the participant's diabetes care team.<br><br>*Note: The outcomes may include one or more of the following: education, behavioral goal/s, and/or other outcome/s.* | ☐ | ☐ |

# Initial Comprehensive DSMES Cycle–Standard 5

Referral if required by participant's insurance

A

Comprehensive Assessment of participant

B

Development of education plan

C

Education Intervention

D

Education Learning Outcomes

E

Behavioral goal/s set

F

Behavioral goal/s follow up

G

Measurement of participant outcomes

H

Completed DSMES communicated with referring provider

I

Following the assessment each element is completed with participant, in no particular order

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# Complete Chart Tracker

_____

(Enter Multi-Site Name)

| # Multi Sites | The # of charts reflecting the Complete DSMES Cycle required during an ADA audit from each multisite for the current period and the most recent service's application reporting period. |
|---|---|
| 1– 2 Multi Sites | 5 Charts per Multi Site per Period |
| 3– 4 Multi Sites | 3 Charts per Multi Site per Period |
| 5+ Multi Sites | 2 Charts per Multi Site per Period |

**Each month print a chart that reflects the complete DSMES Cycle that was completed within the past 1 to 3 months.**

| Application Reporting Period | How to always be prepared with current period complete DSMES charts | | | | |
|---|---|---|---|---|---|
| | | Year 1 | Year 2 | Year 3 | Year 4 |
| | | 1 Chart per Multi Site each month | | | |
| **1. Print** the number of charts per multi-site indicated on the chart above from the last DSMES service application reporting period.<br><br>**2.Label** charts with each of the DSMES elements (A – I)<br><br>**3.File** in QC Guide binder | **January** | | | | |
| | **February** | | | | |
| | **March** | | | | |
| | **April** | | | | |
| | **May** | | | | |
| | **June** | | | | |
| | **July** | | | | |
| | **August** | | | | |
| | **September** | | | | |
| | **October** | | | | |
| | **November** | | | | |
| | **December** | | | | |

Edit per 2022 NSDSMES 2/2022

| Standard 5<br>DSMES Chart Review Form<br>11th Edition | DSMES Cycle | Charts | | |
|---|---|---|---|---|
| | | Yes | No | Page this element is found on and notes |
| **Provider referral if insurance requires one. Medicare requires a referral** | **A** | | | |
| **Participant assessment: on the 11 topics areas** | | | | |
| 1. Clinical: Health history | **B** | | | |
| 2. Cognitive: Functional health literacy and numeracy | **B** | | | |
| 3. Ability to describe **Diabetes Pathophysiology** | **B** | | | |
| 4. Ability to incorporate **Healthy Eating** into lifestyle | **B** | | | |
| 5. Ability to incorporate **Being Active** into lifestyle | **B** | | | |
| 6. Ability to **Take Medications** safely (if applicable) | **B** | | | |
| 7. Ability to **Monitor Glucose** and other parameters, interpreting and using results | **B** | | | |
| 8. Ability to prevent detect and treat **Acute Complications** | **B** | | | |
| 9. Ability to prevent detect and treat **Chronic Complications** | **B** | | | |
| 10. Ability adapt **Lifestyle** for **Healthy Coping** | **B** | | | |
| 11. Ability to recognize **Diabetes Distress** and identify **Support options.** | **B** | | | |
| **Education Plan based on participant concerns and assessed needs** | **C** | | | |
| **Summary of education intervention with date, content taught and instructor's name** | **D** | | | |
| **Education learning outcomes** | **E** | | | |
| **Participant selected behavioral goal set** | **F** | | | |
| **Participant selected behavioral goal follow up** | **G** | | | |
| **Clinical or Quality of Life outcome/s measured** | **H** | | | |
| **Documentation reflecting communication with referring provider or HCP outside of the DSMES service regarding education plan, or education provided and outcomes** | **I** | | | |

Audit ready Tip: Identify 5 completed DSMES charts per multisite at a minimum every 6 months or identify one chart every month.

11th Edition – revised 02/2022

# Standard 5

# Person Centered DSMES

# Sample Templates

Name: Name you prefer to be called: DOB: Date:

**Lifestyle/Coping**

Status: ☐Single ☐Married ☐Divorced ☐Widowed – Who else in household?_____

Do you work? ☐Yes ☐No Type of work and work hours: _____Primary Language: _____

Race: _____ Please list cultural or religious beliefs that may impactyour care _____

Last grade completed?_____Can you read/Write English? ☐Yes ☐No - Learning Barriers: ☐Visual ☐Auditory ☐Literacy ☐Language Other:

How do you learn best? ☐Written materials ☐Verbal Discussion ☐Video ☐_____

Tobacco Use ☐No ☐Yes Type/Amount/Quit Date: _____

Alcohol Use ☐No ☐Type/Amount/Quit Date: _____

If you have pain, how does it affect your lifestyle?

**Diabetes Distress Support**

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Who else in your family has diabetes? _____

List anything about Diabetes that causes you Stress or Distress? _____

How do you deal with this stress/distress? Primary Support Person:

**Being Active/Physical Activity**

What physical activity to you do regularly? _____ow often: _____

What if any barriers do you have to physical activity?

| **Clinical History** | | ***Educator Completes This Section*** |
|---|---|---|
| **Yes** | **No** | **Diabetes Pathophysiology and Treatment** |
| ☐ | ☐ Eye Problems: | Diabetes type: When diagnosed? |
| ☐ | ☐ Nerve Problems: | Ht.: Wt.: Last A1C (date/Value): |
| ☐ | ☐ Kidney Problems: | Labs (Date:_____): Chol.:_____HDL:_____ LDL: _____ |
| ☐ | ☐ Stomach or Bowel Problems: | Triglycerides: _____ GFR: _____ |
| ☐ | ☐ Foot: | If previous diabetes education when/where: |
| ☐ | ☐ Impotence: | |
| ☐ | ☐ Frequent Infections: | What are your goals for the education session? |
| ☐ | ☐ Heart Problems: | |
| ☐ | ☐ Lung Breathing Problems: | **Monitoring Glucose and Health Literacy*** |
| ☐ | ☐ High/Low Blood Pressure: | SMBG Times? _____ |
| ☐ | ☐ Stroke: when notes: | BG/CGM type: |
| ☐ | ☐ Arthritis notes | BG History: Breakfast: to Lunch to |
| **Chronic Complications: Preventing Detecting Treatment** | | Dinner to HS to |
| ☐ | ☐ Do you have a primary care doctor? Last Visit date? | What are bg targets*? |
| ☐ | ☐ Did MD exam feet? | If using CGM what is your TIR target*? |
| ☐ | ☐ Do you exam your feet daily? | What is your A1C target*? |
| ☐ | ☐ Do you see a Podiatrist? Last visit date: | **Taking Medications and Health Literacy*** |
| ☐ | ☐ Do you see a dentist? Last visit date: | DM oral medications/dose*/can it cause low bgs*? |
| ☐ | ☐ Do you see ab eye doctor? Last visit date: | |
| ☐ | ☐ Did you get the flu vaccine? Last date: | Insulin/DM Injectables: Type/when/dose*/sliding scale*/sites/storage/can it cause low bgs*? |
| ☐ | ☐ Did you get the shingles vaccines? Which one: | |
| ☐ | ☐ Did you get the COVID 19 vaccine? Which: | |
| ☐ | ☐ Are you pregnant? If so, when are you due? | |
| ☐ | ☐ Are you planning to get pregnant? | **Healthy Eating and Health Literacy*** |
| List any pregnancy complications: | | Diet: _____ |
| **Acute Complications: Preventing Detecting Treatment** | | Knows which foods raise bg*? _____ |
| ☐ | ☐ Do you wear a medical ID? | Can ead food labels*? Lunch ☐Yes Lunch ☐No |
| ☐ | ☐ Hyperglycemia (350 or more)? How often: | Food allergies/ GI issues: _____ |
| How do you treat hyperglycemia? | | Who shops/cooks: _____ |
| ☐ | ☐ Have you ever had DKA? When? | Meals eaten: ☐ Breakfast ☐ Lunch ☐Dinner ☐ Snacks |
| ☐ | ☐ Do you ever test for ketones? | Food Beverage Snack Notes: |
| What would you do if you have ketones? | | |
| ☐ | ☐ Do you have hypoglycemia? How often? | |
| ☐ | ☐ Can you tell when you have hypoglycemia? | **☐Needs referral to RD for MNT** |
| How do you manage your diabetes when you are sick? | | **Educators Signature/Date** |
| | | **Other Medications:** *List or attach* |
| How are you prepared with diabetes medications and supplies in case you had to leave your home with little notice and uncertainty of how long? | | |

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Education Recognition Program

## Sample Participant DSMES Assessment Data Collection and Review Policy

***This policy can be used by Recognized Diabetes Self-Management Education and Support (DSMES) Services that do not compile all of the DSMES assessment data in one location in the participant record (paper or electronically).***

Purpose:

- To define what data must be reviewed and the data location in the participant's record to allow for a complete and thorough DSMES assessment.

Procedure:

- An assessment of the DSMES participant is performed to determine the participant concerns and educational needs in the following topics in preparation for the DSMES planning and provision.
- The participant's DSMES education plan is set based on their concerns and the above assessment.
- If any part of the initial DSMES assessment needs to be deferred to another time this must be documented along with the deferment rationale.
- In the case of a DSMES audit or application all assessment data points must be included as part of the DSMES chart.

| Topic | Medical Record Location |
|---|---|
| Clinical: Health history | |
| Cognitive: Functional health literacy and numeracy | |
| Diabetes Distress and Support Systems | |
| **Assessment of the 9 Topic Areas** | |
| Ability to describe the **Diabetes Pathophysiology** | |
| Ability to incorporate **Healthy Eating** into lifestyle | |
| Ability to incorporate **Being Activity** into lifestyle | |
| Ability to **Take Medications** safely (if applicable) | |
| Ability to **Monitor Glucose** and other parameters; interpreting and using results | |
| Ability to prevent, detect and treat **Acute Complications**. | |
| Ability to prevent detect and treat **Chronic Complications** | |
| Ability to adapt **Lifestyle** to promote **Healthy Coping**<br>Examples: Psychosocial and Self Care Behaviors: Emotional Response to Diabetes, Cultural Influences, Health Beliefs, Health Behavior, Lifestyle Practices, Barriers to Learning, Relevant Socioeconomic Factors | |
| Ability to recognize **Diabetes Distress** and seek or identify **Support** options | |

Note: This policy may be used as is or adapted per an ADA Recognized DSMES service's needs.

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Education Recognition Program

**Participant Name:** _____ **DOB:** _____ **Referring Provider:** _____

American Diabetes Association. Education Recognition Program

**Assessment/Scale:** **1= needs instruction** **2= needs review** **3= comprehends key points** **4= demonstrates understanding/competency** **NC= not covered** **N/A= not applicable**

## Diabetes Self-Management Education and Support Participant Record

| Topics Learning Objectives | Initial | Initial or Post Srvc | Initial or Post Srvc | Initial or Post Srvc | Initial or Post Srvc | Initial or Post Srvc | Initial or Post Srvc | Post Service | Comments |
|---|---|---|---|---|---|---|---|---|---|
| | Pre Edu-Assessment/ Education Plan | Edu outcome or reassess | Edu outcome or reassess | Edu outcome or reassess | Edu outcome or reassess | Edu outcome or reassess | Edu outcome or reassess | Edu outcome or Reassessment | |
| ***Educator Initial:*** | | | | | | | | | |
| ***Date:*** | | | | | | | | | |
| **Diabetes Pathophysiology** *Define diabetes and identify own type of diabetes; list 3 options for treating diabetes* | | | | | | | | | |
| **Healthy Eating** *Describe effect of type, amount and timing of food on blood glucose; list 3 methods for planning meals* | | | | | | | | | |
| **Being Active** *State effect of exercise on blood glucose levels* | | | | | | | | | |
| **Taking Medications** *State effect of diabetes medicines on diabetes; name diabetes medication taking, action and side effects* | | | | | | | | | |
| **Monitoring Glucose** *Identify recommended blood glucose targets and personal targets* | | | | | | | | | |
| **Acute Complications** *List symptoms and treatment of hyper- and hypoglycemia, DKA, sick day guidelines and guidelines for severe weather or situation crisis and diabetes supply management* | | | | | | | | | |
| **Chronic Complications** *Define the relationship of blood glucose levels to long term complications of diabetes and screening and preventative measures* | | | | | | | | | |
| **Lifestyle and Healthy Coping** *Describe lifestyle and healthy coping strategies to promote diabetes self-management* | | | | | | | | | |
| **Diabetes Distress and Support** *Recognize diabetes distress and be able to identify support options* | | | | | | | | | |

**Participant Selected Behavioral Goal/s and Outcomes:** _____

_____

**Clinical or Quality of Life Outcomes/s:** _____

**Comments:** _____

☐ **DSMES education and outcomes were communicated to referring provider or other provider outside of the DSMES service.** **Clinician Signature:** _____

***Instructions for Form Use:***

***This form can be used for initial comprehensive DSMES and for post program DSMES. The top two rows of the above table are used to indicate this.***

***Top Row: Indicate if the participant visit/session is initial comprehensive DSMES or post program DSMES.***

***Second Row: Indicate if the column is being used to document education outcomes or re-assess the participant's needs.***

# Behavior and Other Participant Outcomes

**My _____ *(name)* health goal/s I have chosen to focus on are:**

1. **Health Goal: _____**

   In order to meet this goal, I will: _____

   How many times/minutes per day? _____ Or per week? _____

2. **Health Goal: _____**

   In order to meet this goal, I will: _____

   How many times/minutes per day? _____ Or per week? _____

**Clinical or Quality of Life outcome baseline**: _____ Date: _____

Clinician Signature: _____ Date: _____

## Follow Up Documentation

**Date of follow-up**: _____

**Behavioral goal 1 met:**

| All the Time | Most of the time | Half the time | Occasionally | Never |
|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |

**Behavioral goal 2 met:**

| All the Time | Most of the time | Half the time | Occasionally | Never |
|---|---|---|---|---|
| 5 | 4 | 3 | 2 | 1 |

**Clinical or Quality of Life follow-up**: _____ Date: _____

Clinician Signature: _____ Date: _____

# *EXAMPLE*

Communication with the Referring Provider or Other HCP Outside of the DSMES Service

EDUCATION PLAN or EDUCATION PROVIDED and OUTCOMES

(Enter Date)

Dear Provider,

Thank you for referring (Participant's Name) to the (DSMES Service Name) service. Mr./Ms. XYZ has completed his/her personalized initial comprehensive education plan. The education plan included the following topics: Disease Process, Nutrition, Exercise, Blood Glucose Monitoring, Medication, Acute and Chronic Complications, Behavioral and Lifestyle Change and Healthy Coping.

(Participant's Name) education outcomes: (examples below- not all have to be present)

- Participant selected behavioral goal: Nutrition- decrease portion sizes using the plate method for all meals.
    - **Outcome Post Education: Met 75% of the time**
- Other participant outcome: A1C-Pre-education- 9.0
    - **Outcome 3 Months Post Education: 7.8% (1.2% reduction)**
- Education Learning Outcomes for All Education Topics (see above):
    - **Outcome Post Education: Competent in all subject areas**

Please contact me if you have any questions at (Educator's Email Address and Phone Number).

Regards,

(Educator's Signature)

(DSMES Service Name)

American Diabetes Association Recognized Diabetes Self –Management and Support Service

# Insert

# Aggregated Outcomes and CQI

# Tab

**(The templates in this tab will meet standards 6 requirements.)**

## Standard 6: Measuring and Demonstrating Outcomes of DSMES

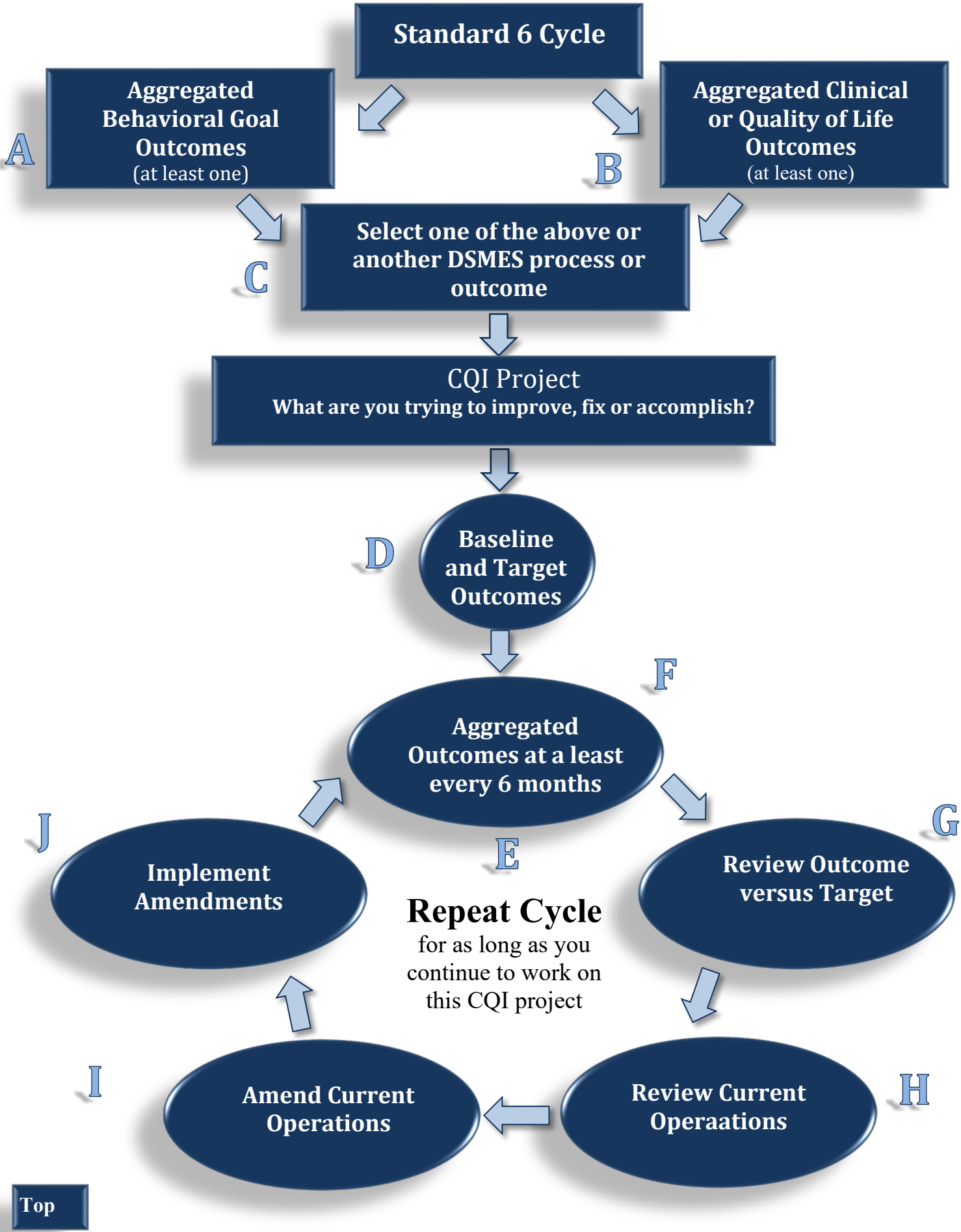
*DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services. Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services redesign and optimization.*

| | | | |
|---|---|---|---|
| A. *To demonstrate the benefit of DSMES, members of the team track and aggregate relevant participant outcomes* | 1. At least one category (healthy eating or being active or taking medication, etc..) of participant behavioral goal outcome will be identified and aggregated at a minimum annually.<br>*Note: All participants are not required to select a behavioral goal for this category but for those that did select a goal in this category the outcomes will be aggregated.* | ☐ | ☐ |
| | 2. At least one other participant clinical or quality of life outcome will be identified and aggregated at a minimum annually.<br>*Note: For the other outcome, the DSMES provider will attempt to collect this for all participants.* | ☐ | ☐ |
| B. *Formal CQI strategies provide a framework to strive for excellence, quantify successes and identify future opportunities.*<br><br>By measuring and monitoring outcome data on an ongoing basis, the Recognized DSMES team can identify areas for improvement. They can then adjust engagement strategies and service offerings to optimize outcomes. | The DSMES provider will always have a documented quality improvement project and implement new projects when appropriate. The project will include: | ☐ | ☐ |
| | a) Opportunity for DSMES service improvement or change *(What are you trying to improve, fix, or accomplish?)* | ☐ | ☐ |
| | b) Recognized DSMES services will have baseline CQI project data | ☐ | ☐ |
| | c) Project outcome targets | ☐ | ☐ |
| | d) Project assessment and evaluation schedule at a minimum every 6 months | ☐ | ☐ |
| | e) Recognized services will have project outcomes measured, assessed and evaluated at a minimum every 6 months | ☐ | ☐ |
| | f) Recognized DSMES services will have a plan to address gaps identified or service change needs | ☐ | ☐ |

# Standard 6
# Aggregated Outcomes and CQI Toolkit

In this toolkit you will find an explanation of what is required by ADA Recognized DSMES services to meet the 2022 National Standards for Diabetes Self-Management and Support Standard 6's criteria. You will also find a user friendly sample worksheets, templates, and examples.

**Contents:**

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DSMES services completing an original Recognition application are required to have the items highlighted in blue at the time of the original application and all items within 6 months of the application.

## Standard 6: CQI Project and Aggregated Outcomes Worksheet

A. DSMES service's one or more aggregate participant elected behavioral goal outcomes
- Behavioral Goal Category and Aggregated Outcome:
- Add more lines if needed

B. DSMES service's one or more aggregated participants' clinical or quality of life outcomes
- Other Participant Outcome Monitored and Aggregated Outcome:
- Add more lines if needed.

C. CQI Project
- Select either one of the above aggregated outcomes from A or B above or select another DSMES process or outcome that the CQI project will address
  - _____
- What your CQI project will be trying to improve fix or accomplish?
  - _____

D. What is the CQI project outcome baseline (the initial project achievement and target (the % outcomes the DSMES service is trying to achieve)?
- Baseline measurement: _____% or # and Target Outcome: _____% or #

E. Determine the CQI project outcomes reporting and review cycle: At a minimum this must be every 6 months or more frequently.

a. Outcome Report and review cycle will be every _____ months.

## CQI Cycle

F. Outcomes aggregated at least every 6 months
G. Review outcomes versus target
H. Review current operations as they relate to the CQI project
I. Amend current operations to improve CQI outcomes
J. Implement improvements

# Repeat cycle starting with F.

| E) Reporting Review Date | *Enter Date to Report/Review* | *Enter Date to Report/Review* | *Enter Date to Report/Review* | *Enter Date to Report/Review* |
|---|---|---|---|---|
| D) CQI Target | Baseline = Target= | | | |
| F) CQI Outcome | | | | |
| G) Review | | | | |
| H) Review current operations and consider amendments | | | | |
| I)List amendments to current operations | | | | |
| J) Date change Implemented | | | | |

## Sample Standard 6 with CQI Project of A1C

A. DSMES service's one or more aggregate participant elected behavioral goal outcomes
   - Behavioral Goal Category and Aggregated Outcome: **Healthy Eating 83%**

B. DSMES service's one or more aggregated participants' clinical or quality of life outcomes
   - Other Participant Outcome Monitored and Aggregated Outcome: **A1C reduction after DSMES 57%**

C. CQI Project
   - Select either one of the above aggregated outcomes from A or B above or select another DSMES process or outcome that the CQI project will address
     - **A1C**
   - What your CQI project will be trying to improve fix or accomplish?
     - **Increase the number of DSMES participants who have an A1C reduction after one or more DSMES encounters**.

D. What is the CQI project outcome baseline (the initial project achievement and target (the % outcomes the DSMES service is trying to achieve)?
   - Baseline measurement: **43%** and Target Outcome: **85%**

E. Determine the CQI project outcomes reporting and review cycle: At a minimum this must be every 6 months or more frequently.
   a. Outcome Report and review cycle will be every **6** months.

### CQI Cycle

F. Outcomes aggregated at least every 6 months
G. Review outcomes versus target
H. Review current operations as they relate to the CQI project
I. Amend current operations to improve CQI outcomes
J. Implement improvements

## Repeat cycle starting with F.

| E) Reporting Review Date | **06/01/2022** *Enter Date to Report/Review* | **12/01/2022** *Enter Date to Report/Review* | ***06/01/2023*** | ***12/01/2023*** |
|---|---|---|---|---|
| D) CQI Target | Baseline =43% Target= 85% | Baseline =43% Target= 85% | Baseline =43% Target= 85% | Baseline =43% Target= 85% |
| F) CQI Outcome | 57% | 68% | | |
| G) Review Outcomes | Post DSMES A1C reduction is 28% below target | Outcomes improved by 11% but still 17% below target. | | |
| H) Review current operations and consider amendments | Currently A1C targets are presented to DSMES participants but no information is provided that correlates A1C value and reduction to DM complications | Participants are still having a hard time correlating A1C to CGM data points and fingersticks. | | |
| I) List amendments to current operations | Add to the back of the current A1C handout the % DM complications are reduced with each % A1C reduction. | Add to handout average bg and pre and post prandial bgs for A1C levels from 6.5% to 15% in 0.5% increments. Add GMI review to CGM training. | | |
| J) Date change Implemented | 7/10/2022 | 12/09/2022 | | |

## Sample Standard 6 with CQI Project of Physical Activity

F. DSMES service's one or more aggregate participant elected behavioral goal outcomes
- Behavioral Goal Category and Aggregated Outcome: **Physical Activity (PA) 51%**

G. DSMES service's one or more aggregated participants' clinical or quality of life outcomes
- Other Participant Outcome Monitored and Aggregated Outcome: **14-day CGM GMI less than 7% = 57%**

H. CQI Project
- Select either one of the above aggregated outcomes from A or B above or select another DSMES process or outcome that the CQI project will address
  - **Physical Activity**
- What your CQI project will be trying to improve fix or accomplish?
  - **Explore barriers to PA and assist participants in meeting their PA goals.** .

I. What is the CQI project outcome baseline (the initial project achievement and target (the % outcomes the DSMES service is trying to achieve)?
- Baseline measurement: **51%** and Target Outcome: **100%**

J. Determine the CQI project outcomes reporting and review cycle: At a minimum this must be every 6 months or more frequently.
a. Outcome Report and review cycle will be every **6** months.

### CQI Cycle

F. Outcomes aggregated at least every 6 months
G. Review outcomes versus target
H. Review current operations as they relate to the CQI project
I. Amend current operations to improve CQI outcomes
J. Implement improvements

# Repeat cycle starting with F.

| E) Reporting Review Date | **06/01/2022** *Enter Date to Report/Review* | **12/01/2022** *Enter Date to Report/Review* | ***06/01/2023*** | ***12/01/2023*** |
|---|---|---|---|---|
| D) CQI Target | Baseline =51% Target= 100% | Baseline =51% Target= 100% | Baseline =51% Target= 100% | Baseline =51% Target= 100% |
| F) CQI Outcome | 51% | 72% | | |
| G) Review Outcomes | Post DSMES PA outcomes are 49% below target | Outcomes improved by 21% but still 28% below target. | | |
| H) Review current operations and consider amendments | PA materials reviewed and it was found that PA impact on post prandial bgs and especially people with T2DM it can help them be more sensitive and use insulin especially after meals was not addressed. | Participants liked the idea of setting PA goal to move for 10 to 15 minutes after meals. Participants with CGMS were able to see the impact of the PA immediately and had the best PA outcomes. | | |
| I)List amendments to current operations | Add to materials how PA helps with insulin resistance and that 10 to 15 minutes of PA after meals can help body use the insulin it has made, or you have injected for that meal more effectively. | Discussed with referring providers to order CDCES to place a CGM pro on all participants who do not have personal CGM so they can also see the impact of PA on sensor glucose readings. | | |
| J) Date change Implemented | 6/15/2022 | 12/09/2021 | | |

## Sample Standard 6 with CQI Project of DSMES Referrals

K. DSMES service's one or more aggregate participant elected behavioral goal outcomes
- Behavioral Goal Category and Aggregated Outcome: **Physical Activity (PA) 51%**

L. DSMES service's one or more aggregated participants' clinical or quality of life outcomes
- Other Participant Outcome Monitored and Aggregated Outcome: **14-day CGM GMI less than 7% = 57%**

M. CQI Project
- Select either one of the above aggregated outcomes from A or B above or select another DSMES process or outcome that the CQI project will address
  - **DSMES referrals**
- What your CQI project will be trying to improve fix or accomplish?
  - **Increase DSMES referrals. The healthcare system the DSMES service is associated with annual report indicated that 15,654 of their patients have DM, 2,630 newly diagnosed cases of DM, insulin was initiated with 1,862, and that only 43% of the PWD were meeting their A1C target. The DSMES service only received 1,362 referral last year.**

N. What is the CQI project outcome baseline (the initial project achievement and target (the % outcomes the DSMES service is trying to achieve)?
- Baseline measurement: **1, 362 referrals** and Target Outcome: **4,000 referrals annually or 1,000 per quarter.**

O. Determine the CQI project outcomes reporting and review cycle: At a minimum this must be every 6 months or more frequently.
a. Outcome Report and review cycle will be every **3** months.

### CQI Cycle

F. Outcomes aggregated at least every 6 months
G. Review outcomes versus target
H. Review current operations as they relate to the CQI project
I. Amend current operations to improve CQI outcomes
J. Implement improvements

# Repeat cycle starting with F.

| E) Reporting Review Date | **12/1/2022** *Enter Date to Report/Review* | **3/31/2023** *Enter Date to Report/Review* | ***6/30/2023*** *Report/Review* | ***9/30/2023*** |
|---|---|---|---|---|
| D) CQI Target | Baseline =1,362 Target= 1,000 | Baseline=1,362 Target=1,000 | Baseline=1,362 Target=1,000 100% | Baseline=1,362% Target=1,000 |
| F) CQI Outcome | 1,362 for 2021 | | | |
| G) Review Outcomes | Reviewing the DSMES referrals and organization annual report identified a large gap in DSMES utilization. | | | |
| H) Review current operations and consider amendments | The large gap in DSMES utilization was reviewed with leadership along with the DSMES outcomes. The QC proposed and leadership agreed to modify the charting platform so that when a new diagnoses of DM, A1C 1% of > above target or insulin is initiated a popup DSMES referral appears. The provider can select one button to make the referral or if they can modify the referral. | | | |
| I)List amendments to current operations | The DSMES popup referral was built into the charting platform and all providers were informed of the new referral process. | | | |
| J) Date change Implemented | 12/09/2022 | | | |

# Other CQI Plans

**CQI Process Examples:**

**Ask**—What are you trying to improve, fix or accomplish and will the change improve what we do and how will we know?

- **Plan Do Check Act PLAN**
  - The who, what, where, when and how of the needed improvement
  - Develop the plan.
- **Do**
  - Test the plan—small scale
  - Document issues/problems
  - Collect and analyze data—note deviations from the plan
- **CHECK**
  - Completion of data analysis
  - Compare to expected/predicted results
  - Is the process improved or the problem solved?
- **ACT**
  - ID any modifications needed for the plan
  - Decide on the next cycle

- **FOCUS - PDCA**
  - F - Find a process to improve
  - O - Organize to improve a process
  - C - Clarify what is known
  - U - Understand variation
  - S - Select a process improvement plan
  - P - Plan
  - D – Do
  - C - Check
  - A - Act

- **DMAIC Cycle**
  - D - Define
  - M - Measure
  - A – Analyze
  - I – Improve
  - C - Control

**Example of a CQI Project**

**Example CQI Project**
**QI Model: PDCA**
(Plan, Do, Check, Act)

**Plan:** To ensure all DSMES participants on multiple daily injections (MDI) or insulin pumps (CSII) are aware of the new glucagon options and the importance of always having unexpired glucagon available.

**Do:** Many of the DSMES participants on MDI or CSII do not have glucagon, or it may be expired. The plan is to implement revisions to the participant glucagon education to include the newer glucagon options and communicate to referring providers the need for glucagon to be ordered.

**Check:** we will be monitoring the number of participants on MDI or CSII who do not have unexpired glucagon.

| | Dates | # Of Participants (Pts) on MDI or CSII | # Of Pts without Glucagon | # MDI or CSII Pts with Unexpired Glucagon Goal | Quarter Outcome |
|---|---|---|---|---|---|
| **Baseline** | July – Sept. 2022 | 463 | 143 | 100% | *143/463* = 31% |
| **Quarter 1** | Oct- Dec. 2022 | 528 | 204 | 100% | *204/528* = 38% |
| **Quarter 2** | Jan – March 2023 | | | 100% | |
| **Quarter 3** | April – June 2023 | | | 100% | |
| **Quarter 4** | July – Sept. 2023 | | | 100% | |

## Analysis of data:

The first quarter outcome indicates a small increase in the number of pts getting glucagon ordered and picking it up. Pts. That did not pick up the glucagon indicated that their providers ordered it but the copay when they went to the pharmacy to pick it up was over $100 so they chose to forego getting the glucagon.

## Act:

The DSMES team reviewed and discussed the outcomes and the pts feedback. They decided to implement the following steps.

1. Contact the glucagon reps and ask about a list of commercial and government insurance plans coverage of their product. Based on the coverage advise inform he pts of this and communicate to the referring provider which glucagon to order.
2. Ask the glucagon reps about glucagon discount or assistance programs and inform the pts about these.