

AoA Diabetes Self-Management (DSMT) Toolkit

Area Agencies on Aging (AAAs) can play an integral role in expanding the use of Medicare's DSMT benefit among under-served seniors with a diagnosis of diabetes. AAAs provide vital health and nutrition services that help seniors age with dignity in their communities. Many of the seniors that AAAs serve could benefit from attending DSMT classes, particularly those who live in underserved areas. A large percentage of beneficiaries do not use their DSMT programs and AAAs can help them do so in community settings. AAAs can provide DSMT and use the Medicare reimbursement to expand the DSMT services offered to reach more seniors in need of assistance.

The purpose of this toolkit is to provide AAAs, community planners, and healthcare professionals with valuable information and insights that will help them develop and operate cost-effective, accredited DSMT programs that meet CMS guidelines for Medicare reimbursement.

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Prevalence of Diabetes

According to Medicare claims data, from 2009, approximately 27% of all Medicare beneficiaries have a diagnosis of diabetes. Studies have proven that effective management of diabetes has the benefit of decreasing mortality and morbidity and decreasing future medical care costs.

1. Key Definitions

- DSME – Diabetes Self-Management Education: This is the term the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE) use to cover the full range of diabetes self-management education services.
- DSMP – Diabetes Self-Management Program: This is the term Stanford University uses for its diabetes self-management program.
- DSMT – Diabetes Self-Management Training: This is the term the Centers for Medicare & Medicaid Services (CMS) uses for the Diabetes Self-Management Training benefit available to Medicare beneficiaries.

2. Medicare DSMT Benefit Overview

Medicare began offering a diabetes self-management training benefit in 2002. This benefit is available under Medicare Part B (part of “original Medicare”).

The Part B benefit provides payment for:

- Up to 10 hours of DSMT during the initial 12-month period following the submission of the first claim for this benefit.
- One hour of individual training, which may include insulin training and is part of the initial 12 month period’s 10 hour benefit limit.
- Up to 2 hours of DSMT for every 12-month period following the initial period.
- The above training can be performed in any combination of 1/2 hour increments.

Important Conditions

Three important conditions apply to Part B DSMT benefits:

1. Prior to receiving the initial and follow-up training, the beneficiary must have:
 - a diagnosis of diabetes, and
 - a written referral from a physician or other qualified medical provider including a nurse practitioner or physician assistant.
2. CMS accepts requests for reimbursement for DSMT only from DSMT programs that have achieved accreditation from AADE or ADA.
3. Once accreditation has been achieved, the Medicare provider must submit a copy of the accreditation certificate to CMS along with the Medicare provider status and National Provider Identification Number so that the DSMT program can be officially recognized by Medicare.

Multi-disciplinary Team

The referring medical provider, the licensed instructor, and the support staff all make up the multi-disciplinary team that are working in a collaborative manner to improve the overall health of patients with diabetes. An essential member of a multidisciplinary team is one licensed professional, who is called the primary qualified instructor. A primary qualified instructor must be a:

- Registered Nurse, or
- Registered Dietitian, or
- Registered Pharmacist

In addition to the qualified professional, a program should consider using community health workers as part of the multi-disciplinary team.

If a DSMT program is in a designated rural area, then Medicare will allow a registered dietitian to provide DSMT and receive Medicare reimbursement on his/her own, without the use of a multi-disciplinary team.

3. Medical Nutrition Therapy Benefit

The Medical Nutrition Therapy (MNT) benefit is a complementary service to DSMT that registered dietitians or nutrition professionals can provide to persons with diabetes. This

Medicare Part B benefit covers comprehensive nutrition therapy to foster behavior change. MNT provides 3 hours of individualized care during the first 12 month period following initiation of services.

Subsequent training

After a Medicare beneficiary receives the initial 3 hours of MNT in the first 12-month period, the beneficiary is eligible for additional follow-up training in subsequent years. The subsequent training benefit equates to two (2) hours per year as long as the beneficiary continues to have a diagnosis of diabetes. MNT can be provided individually or in a group setting and requires a written provider (e.g., physician or nurse practitioner) referral prior to the initiation of therapy.

If one of the following medical conditions exists, a medical provider can order additional MNT beyond the initial three (3) hour benefit. However, the additional hours must be first approved by the Medicare fiscal intermediary and will require clinical documentation to justify the need for additional services. If approved, the beneficiary will receive up to three hours of additional benefit. Some of the reasons that additional education can be authorized include the following items:

- Change in diagnosis,
- Change in medical condition, or
- Change in the treatment regimen

MNT and DSMT - Together

Like, DSMT, MNT also requires a formal referral, although unlike with DSMT, MNT can be provided to some persons that do not have diabetes. MNT can serve two groups of patients, 1) persons with a diagnosis of diabetes and 2) persons with chronic kidney disease. However, MNT can only be ordered by the treating physician. Non-physician providers are not eligible to write a referral for MNT services. This differs from DSMT in that MNT focuses on the nutritional component of diabetes management. It requires a nutritional intake assessment and then education tailored to the nutritional education deficits that are present.

DSMT and MNT can be provided to the same beneficiary during the same 12 month period. However, they both cannot be provided to the same beneficiary on the same date of service.

4. Medicare Billing Detail

Medicare, under its Fee for Service (FFS) payment system (“original Medicare”) reimburses 80% of the cost of the DSMT benefit. Beneficiaries pay coinsurance of 20% of the Medicare approved rate for DSMT. Sites that are providing DSMT in partnership with a Medicare FFS provider should work closely with their partner to understand what the beneficiary pays, the types of coverage that each beneficiary has and how the coverage affects DSMT billing.

NOTE: Those AAAs whose partner is a Federally Qualified Health Center operate under different billing and payment rules, which are described in the section titled “Working with FQHCs”.

To bill the Medicare Part B program for DSMT, a number of key elements must be in place.

The beneficiary must have:

- A diabetes diagnosis
- A written referral for DSMT, provided by a qualified provider
- Part B benefits under “original Medicare” (i.e., not benefits as a member of a Medicare Advantage Plan)
- Met their annual deductible or have Medicaid or other health insurance coverage (such as a “Medigap” policy) that pays the deductible.

The AAA’s DSMT program must have:

- Accreditation from a CMS-recognized organization – currently either AADE or ADA.
- A partnership with a Medicare provider that is able to bill the Medicare program, or be a Medicare provider in its own right.
- Recognition by CMS of the accredited Medicare Provider location where the DSMT will be provided.

The AAA’s Medicare provider partner generally will be responsible for:

- maintaining documentation of the beneficiary’s diabetes diagnosis in his or her medical record,
- verifying a beneficiary’s Part B coverage for DSMT,

- verifying that the beneficiary has already met the annual deductible, and
- determining whether the beneficiary has Medicare supplemental coverage through Medicaid or a private insurance policy.
- collecting the 20% coinsurance from the beneficiary or supplemental coverage, as applicable

When services are provided at a Federally Qualified Health Center (FQHC), the beneficiary does not need to have already met his/her Part B deductible. Therefore, the Medicare program will pay the full reimbursement amount to the FQHC even if the beneficiary has not met the Medicare deductible.

NOTE: The MNT benefit does not require the beneficiary to pay 20% coinsurance, so Medicare reimburses the provider at 100% of the approved rate.

HCPCS Coding

DSMT and MNT are billed to Medicare using the Healthcare Common Procedure Coding System (HCPCS) billing codes, as shown in the tables below.

Initial Calendar Year DSMT (2015 Fee Schedule)*

DSMT				
Code	Base Reimbursement	Unit Price	Allowable Units per annum	Total Reimbursement
G0108	\$53.27	Individual training in 30 minute increments	1 hour (2 units)	\$106.54
G0109	\$14.30	Group training in 30 minute increments	9 hours (18 units)	\$257.40
				\$363.94

*Total of 10 hours of DSMT services will be reimbursed at this level per Medicare beneficiary

Initial Calendar Year MNT (2015 Fee Schedule)*

DSMT				
Code	Base Reimbursement	Unit Price	Allowable Units per annum	Total Reimbursement
97802	\$35.04	Initial MNT, individual, in 15 minute increments	1 hour (4 units)	\$140.16
97804	\$16.12	Follow up Group MNT, in 30 minute increments	2 hours (4 units)	\$64.36
				\$204.52

*Total of 3 hours of MNT (1 hour initial and 2 hour group follow-up) will reimburse at this level per Medicare beneficiary

Please note that reimbursement amounts vary by region and are updated each calendar year and published in the CMS annual Physician Fee Schedule. The fees below represent the base reimbursement level, prior to the application of the regional variation factor for payment. Therefore, the amounts may be higher or lower than applicable in your region.

The dollar amounts in the charts throughout this guide are used to establish a baseline. The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule shows regional specific rates.

The current CMS rates are shown on the CMS website [here](#).

Post Initial Calendar Year Training (2015 Fee Schedule)

DSMT				
G0108	\$53.27	Individual training in 30 minute increments	2 hours (4 units)	\$213.08
G0109	\$14.30	Group training in 30 minute increments	1 hour (2 units)	\$28.60
MNT				
97803	\$30.81	Individual training, in 15 minute increments	1 hour (4 units)	\$123.24
97804	\$16.12	Follow up Group MNT, in 30 minute increments	1 hour (2 units)	\$32.24

5. The Role of Area Agencies on Aging and Community Partners in providing DSMT programs

Area Agencies on Aging (AAAs) are leaders in their communities, and many have developed relationships with health care providers, including those who can bill Medicare for DSMT services.

AAAs can receive participant referrals from health care providers, conduct the DSMT sessions, operate or collaborate to provide the infrastructure necessary to support an accredited program, and work with health care providers to maintain medical records and bill Medicare for payment. AAAs can also partner with health care providers by enrolling participants and marketing DSMT in community-based settings.

Role of Partners

Community partners (stakeholders) are essential to improving healthcare delivery systems and increasing access to diabetes self-management programs. Partnerships with key stakeholders can lead to improved quality of and access to care and medical outcomes for

persons who have diabetes.

Partners can:

- Provide referral and education
- Serve as strategic planners and policymakers
- Use their leadership and communications skills to get the word out that DSMT saves lives
- Volunteer to network and mentor people with diabetes
- Work with diabetes organizations
- Network with committed peers
- Motivate and empower persons with diabetes to assume responsibility for the self-management of their diabetes
- Serve as liaisons to the community
- Assist with resources
- Serve as Health Counselors
- Provide services and goods to enhance a DSMT program

Role of Health Care Providers

Health care providers and health care institutions also play a critical role in communities. Lifestyle change counseling conducted by health care providers, particularly physicians and dietitians, can help people lose excess weight, be physically active, maintain desired weight loss, etc.

Providers' related interests are as follows:

- Quality of community-based diabetes self-management education and training
- Persons with diabetes and their implementation of self-care regimens
- Achievement of targeted clinical outcomes and improved participant health
- Achievement of recommended standards on diabetes, improved participant outcomes, greater professional satisfaction and patient satisfaction.

Community partnerships for providers are very important in leveraging limited resources. Providers can foster community partnerships by working with AAAs, local health departments, other health care providers, and various partners capable of providing or supporting programs that promote better diabetes self-management. CDEs can serve as

effective bridges between primary and specialty care providers and community-based partners in the AAAs.

Role of Federally Qualified Health Centers/Community Health Centers

Federally Qualified Health Centers (FQHCs) are local, non-profit, community-oriented health providers that provide high quality, affordable primary care and prevention services to vulnerable populations. FQHCs serve people who live in medically underserved areas. The main purpose of the Federally Quality Health Center (FQHC) Program is to enhance the provision of primary care services in underserved urban and rural communities.

While they have an overall mission to provide primary care services to vulnerable populations, regardless of insurance status, FQHCs often have substantial insured populations. So, FQHCs often serve large numbers of low-income Medicaid and Medicare patients. In addition, FQHCs receive increased reimbursement for serving vulnerable populations. As a safety net provider, FQHCs are often a key part of the community.

Partnerships between AAAs and FQHCs may be beneficial because FQHCs have an existing Medicare provider number and receive increased reimbursement when they do provide services for a Medicare beneficiary. This type of relationship can be mutually beneficial as it will provide the FQHC with access to another population of patients that they may not be serving. At the same time, the DSMT program would benefit by partnering with an established primary care provider with an existing billing system.

FQHCs provide the following preventive primary health services to Medicare beneficiaries:

- nutritional assessment and referral,
- preventive health education,
- blood pressure measurement,
- weight measurement,
- physician examination targeted to risk,
- visual acuity screening, and
- cholesterol screening.

FQHCs also provide:

- transportation,
- translation,
- health education,
- disease management,
- home visiting,
- prevention services, and

- outreach.

FQHCs provide linkages to community organizations for referral and other resources. FQHC-enabling services include patient education, translation/interpretation and community education.

Partnerships are essential to the success of an accredited DSMT program.

6. CMS Approved Accrediting Organizations

[American Association of Diabetes Educators \(AADE\)](#)

The AADE is a non-profit membership organization that was founded in 1973. The organization is a multidisciplinary group of healthcare professionals, which provides education and self-management to people with diabetes and related chronic conditions.

[American Diabetes Association \(ADA\)](#)

The American Diabetes Association (ADA) is a nonprofit organization founded in 1940. The focus of ADA is to support research that aims to prevent, manage, or cure diabetes. Members are physicians, consumers, and allied health care professionals, among others.

7. Ten National Standards for Diabetes Self--Management Education

The two CMS-approved accrediting organizations for DSMT base their accreditation process on the national standards for diabetes education. The national standards were developed after the convening of a joint task force of the American Diabetes Association, American Association of Diabetes Educators, and other stakeholders in 2012. This task force developed a series of established standards that must be included in any structured DSMT program.

The ten DSME National Standards include the following:

Standard 1 - Internal Structure

The provider(s) of DSME will document an organizational structure, mission statement, and goals. For those providers working within a larger organization, that organization will recognize and support quality DSME as an integral component of diabetes care.

Standard 2 - External Input

The provider(s) of DSME will seek ongoing input from external stakeholders and experts to promote program quality.

Standard 3 - Access

The provider(s) of DSME will determine whom to serve, how best to deliver diabetes education to that population, and what resources can provide ongoing support for that population.

Standard 4 - Program Coordination

A coordinator will be designated to oversee the DSME program. The coordinator will have oversight responsibility for the planning, implementation, and evaluation of education services.

Standard 5 - Instructional Staff

One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be an RN, RD, or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes and with supervision and support.

Standard 6 - Curriculum

A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSME. The needs of the individual participant will determine which parts of the curriculum will be provided to that individual.

Standard 7 - Individualization

The diabetes self-management, education, and support needs of each participant will be assessed by one or more instructors. The participant and instructor(s) will then together develop an individualized education and support plan focused on behavior change.

Standard 8 - Ongoing Support

The participant and instructor(s) will together develop a personalized follow-up plan for ongoing self-management support. The participant's outcomes and goals and the plan for ongoing self-management support will be communicated to other members of the healthcare team.

Standard 9 - Patient Progress

The provider(s) of DSME and DSMS will monitor whether participants are achieving their personal diabetes self- management goals and other outcome(s) as a way to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

Standard 10 - Quality Improvement

The provider(s) of DSME will measure the effectiveness of the education and support and look for ways to improve any identified gaps in services or service quality, using a systematic review of process and outcome data.

Each accreditation body has its own accreditation process. When submitting for accreditation, the program must adhere to the accreditation requirements of the entity it chooses to seek accreditation from – either AADE or ADA. Both organizations incorporate the 10 national standards into their process, but the accreditation process varies depending on which organization accredits a program.

When preparing for accreditation, it is important to closely review the differences between the two accrediting organizations. Once an accrediting organization is chosen, the DSMT program must meet the minimum accreditation requirements for initial accreditation, and maintain those requirements for subsequent reaccreditation. The length of time that a single accreditation term lasts depends on the accrediting organization. In determining the length of the accreditation period, the accrediting organization considers multiple factors including the outcome of the initial accreditation review.

8. AADE Accreditation Guidelines

AADE

To seek accreditation from AADE, complete an AADE application and mail it along with the initial application fee. In addition, AADE requires a comprehensive description of the program, which includes the program's curriculum. Generally, accreditation lasts for a period of three (3) years and reaccreditation lasts for a period of four (4) years. However, AADE has the discretion to modify the accreditation period term.

AADE Fees: The current prices (2012) for accreditation for the initial application and any subsequent reaccreditation are:

- Programs with up to ten (10) sites providing DSMT services - \$800.00

- Programs with eleven (11) – twenty (20) sites providing DSMT services - \$1,200.00
- Programs with over twenty (20) sites providing services must contact AADE for customized pricing based on the specific number of sites and size of the organization.

Once a site receives accreditation, it can add additional sites – up to 10 – without paying an additional fee to AADE.

AADE Application Process: Once AADE receives the application and fee, the average length of time for review is 4-6 weeks. It is important to note that AADE requires that the program be in operation long enough to take at least one participant through to the development of the participant's follow-up plan at the completion of the course, follow-up prior to submitting for accreditation. The application process requires the submission of supporting documentation about the program and will include a complete review of select patient records to ensure that the program adheres to the National Standards for DSMT. Lastly, the program must have a fully implemented quality improvement program to ensure that high quality services are being monitored to improve healthcare outcomes for individuals participating in the program.

AADE Instructors: Programs must have a primary qualified instructor. This instructor must be a licensed registered nurse, licensed dietitian, or licensed pharmacist. The person must have a current license to serve in this role. Current status as a certified diabetes educator does not supersede the licensure requirement. To obtain accreditation, a certified diabetes educator (CDE) does not have to be part of the program's staff. In addition, instructors must have documentation showing that they obtained at least 15 continuing education hours of diabetes-specific training, annually. The program must also have a defined program coordinator. The program coordinator is not required to be a CDE, registered nurse, licensed dietitian, or licensed pharmacist. However, the program coordinator must be a professional that has experience and training in managing chronic disease programs.

AADE Accreditation: Once the program attains accreditation, it will need to obtain recognition from CMS. After recognition occurs, the program can begin submitting to Medicare for reimbursement.

In addition to the accreditation requirement, the program must have a Medicare provider number to bill for services. DSMT services are billed under the Medicare "G" billing codes. It is important to note that accreditation does not guarantee reimbursement from Medicare. There are additional guidelines for Medicare reimbursement that will affect the process of

reimbursement. It is important that the program adhere to Medicare billing guidelines in order to obtain reimbursement for services.

A continuous quality improvement (CQI) process is required to obtain accreditation under AADE guidelines. However, participant health outcomes have no bearing on the program's ability to obtain initial accreditation or reaccreditation.

AADE Role of Community Health Workers: Community health workers (CHWs) are an approved part of AADE programs. The CHW is required to play a role that is non-technical and non-clinical. The instruction provided by CHWs is meant to connect professional healthcare services to the community. CHWs can play a key role in identifying potential program participants, as well as providing program support to increase adherence and decrease attrition. CHWs can also play a key role in areas that have diverse populations. In these areas, CHWs are trusted members of the community and have the ability to leverage this trust to encourage community residents who would benefit from the program, to participate. CHWs must obtain ongoing education and guidance from diabetes educators and other healthcare professionals involved in the program. The training of CHWs should be focused on core diabetes concepts.

A complete records review is a mandated part of the AADE accreditation process. The records review is conducted to ensure that the care provided meets DSMT standards. An AADE reviewer will review and document whether the information in the record meets AADE standards.

AADE Documents Required to Submit for Accreditation: The following are required items that must be identified in the records selected for review:

- Individual assessment
- Goal-setting
- Educational plan
- Implementation plan
- Evaluation of DSMT effectiveness
- Compliance with developing personalized follow-up plans for on-going self-management support
- Compliance with using qualified instructors
- Physician Communication

When submitting program records for review, it is important to adhere to certain guidelines

and to remove all personally identifiable information (PII). The submission of personal information, without the individual's consent, is a violation of the Health Insurance Portability and Accountability Act (HIPAA).

To comply with HIPAA guidelines, the following information regarding individuals must be removed from submissions that are part of the accreditation review:

- Name
- Phone number
- Address
- Social Security number
- Medicare number
- Medical record number
- Health plan beneficiary number
- E-mail address
- Account number

AADE accreditation application materials can be obtained from the AADE website [here](#).

AADE also requires an annual status report, which can be found [here](#).

It is important to note that after a DSMT program receives accreditation from AADE and Medicare recognition from the fiscal intermediary, the program may experience a CMS audit after billing begins. CMS performs the audit and coordinates this effort with AADE and/or ADA in selecting sites.

9. ADA Accreditation Guidelines

The ADA accreditation program also is based upon the national standards for diabetes self-management education.

The initial application fee is \$1,100.00 [2012] for a single, primary site. Each additional site, under a primary program, costs an additional \$100.00. The duration of the initial recognition is four (4) years. A primary site can add additional sites at any time during the four (4) year recognition period. Each additional site requires the payment of another \$100 fee. There is no limit to the number of additional sites but the program must show how each additional site will be managed under the existing management structure.

The DSME entity must adhere to the following standards to obtain accreditation under ADA guidelines:

- The DSME entity must have the organizational structure, mission and goals that support quality DSME to improve diabetes care.
- The entity must have an advisory group in place that ensures and promotes the quality of the services provided to participants. The advisory group should include healthcare providers, consumers and community stakeholders.
- The program must conduct a review of the community's needs, determine the target population and, ultimately, provide services that meet the needs of the priority group within that community.
- The program must have a program coordinator who provides oversight and management for the program. The program coordinator will have the academic preparation and experience to oversee a chronic disease management program.
- The program must have one or more instructors who participate in the diabetes education provided. Instructors must have recent education and experience in diabetes management education. The instructor is not required to be a Certified Diabetes Educator. At least one of the instructors has to be a registered nurse, dietitian, or pharmacist. Program staff must have documentation of all licenses, CEU credits and other training for each staff member requiring these credentials.

Once the program has the essential components in place, staff can submit for accreditation from the ADA. The program must have a written curriculum that reflects currently accepted practice guidelines.

The components of an approved curriculum include the following items:

- Participant learning objectives
- Methods of delivery
- Strategies for evaluation learning
- Content outline

The program must also provide an individual assessment and education plan to address the individualized needs of each participant. This assessment and education plan must be documented in the patient's medical record and adhered to by participating education providers. The education plan and assessment will be used to determine the outcome, evaluation measures. Each medical record requires personalized, evaluation goals as well as a

follow-up plan. The plan must be developed, using a collaborative approach with healthcare providers involved in the care of the patient. The information in this collaborative plan is required to be submitted to the primary care provider as part of the continuum of care.

Lastly, the program must have a detailed evaluation program and provide quality assurance. A continuous quality improvement (CQI) program must be in place and evaluated as part of the program. Outcome measures must be reviewed and documented for each participant. However, the program's ability to improve participant outcomes is not a requirement of ADA to obtain initial accreditation or reaccreditation.

The program must provide both participant data and program data to ADA as part of the accreditation process. The program data must cover at least a six (6) month period prior to submission for accreditation. Within this time period, the program must show that there has been a minimum of fifteen (15) participants.

ADA requires a review of the participant's medical record to complete the accreditation process. In order to adhere to HIPAA guidelines, the program must ensure that no personally identifiable information (PII) is submitted for the medical record review. The submission of personal identification, without the individual's consent, is a violation of the Health Insurance Portability and Accountability Act (HIPAA).

The following information must be removed from all areas of the information submitted as part of the accreditation review:

- Name
- Phone number
- Address
- Social Security number
- Medicare number
- Medical record number
- Health plan beneficiary number
- E-mail address
- Account number

Items that must be submitted as part of the program documentation include the following:

- Patient chart with personal information removed as per HIPAA regulations;
- Program curriculum
- Documentation of participation of the oversight/advisory group;
- Program coordinator job description and resume of the individual serving in the position as program coordinator;
- Continuous Quality Improvement (CQI) plan and process.

To maintain accreditation under ADA guidelines, the program must submit annual status reports. In addition, program staff has to complete a process evaluation and outcome evaluation using the CQI process. The evaluation must be accompanied by an improvement plan that is used to improve the program quality.

An additional criterion for recognition is to ensure that the structure of the program has the following, minimum components:

- Documentation of an advisory group that provides input to the program;
- The priority population of the program is well defined and the need is documented;
- A qualified program coordinator is in place to manage the overall program. In addition, the program coordinator must meet the minimum qualification standards as a professional to manage the program
- Qualified instructional staff.

To obtain more information about ADA's accreditation application and application process, please go to the following website:

<http://professional.diabetes.org/Recognition.aspx?typ=15&cid=84040>

It is important to note that after a DSMT program receives accreditation from ADA or AADE and Medicare recognition from CMS. CMS recognized sites are subject to random program audits. CMS performs the audit and coordinates this effort with AADE and/or ADA in conducting random site selection.

10. Required Program Infrastructure for Stanford Model Programs

All DSMT programs require accreditation to receive Medicare reimbursement. If the program decides to use the Stanford Diabetes Self-Management Program as its DSMT program curriculum, Stanford requires the program to have a current license. A Stanford licensed DSMP must:

- Have a program coordinator, master trainers, and trained lay leaders
- Implement a systematic participant recruiting effort
- Have professional backup
- Occur in community sites
- Include program materials and have a program license
- Have a quality assurance (QA) component

It is critical to understand that AADE and ADA -- the accreditation organizations -- require a primary qualified instructor that is a licensed individual who maintains responsibility for supervising lay leaders and must be available to participants who receive instruction from lay leaders.

11. Role of the Program Coordinator

The program coordinator is responsible for the program, coordinating the classes, meeting regulatory requirements and supervising the class staff. The program coordinator can range from a full-time employee to a part-time employee, depending on the size and frequency of the training program. Under the Stanford Model, the program coordinator can be the master trainer, who is responsible for training each of the lay leaders, supervising the lay leaders, and coordinating the training sessions.

A program coordinator must have the academic preparation and experience to oversee a diabetes self-management training and education program. The program coordinator manages the program.

12. Program Licensed Instructors

Each DSMT program seeking accreditation must have one or more licensed instructors who are currently licensed as at least one of the following: registered nurse, dietitian, or pharmacist.

Registered Nurse

A registered nurse can play an integral role in a DSMT program. Registered nurses can provide education to participants on diabetes management, nutrition, exercise, and diet. All registered nurses must be licensed in the state where they are practicing. There are three educational paths to become a registered nurse. The three educational paths include earning a bachelor's degree, earning an associate's degree, and earning a diploma.

A registered nurse is commonly known as an RN. In order to be a registered nurse, an individual must graduate from an accredited associate degree or bachelor degree nursing program and pass a national licensure examination known as the NCLEX-RN exam. Once an applicant has passed the national nursing examination, he or she can apply to obtain a registered nursing license in the state where there is an intent to practice. Nurses can be licensed to practice in more than one state. The requirements to maintain licensure are mandated by the nurse practice acts in each state and governed by the relevant State board of nursing.

Registered Dietitian

A registered dietitian is a food and nutrition expert. The registered dietitian is certified to manage meal servings and nutrition programs. Many also are employed as program managers and given the educational background of RDs, some also serve as case managers. The registered dietitian has at least a four year degree and possesses a license in the state where he or she intends to practice. A registered dietitian can hold a license in more than one state. The bachelor's degree program must be accredited and approved by the Commission on Accreditation for Dietetics Education (CADE) of the American Dietetic Association (ADA). In addition to obtaining the required bachelor degree, a registered dietitian must complete a CADE-accredited supervised practice program. Once a RD candidate has completed the education and supervised practice program, he or she must pass the national examination administered by the Commission on Dietetic Registration (CDR).

A registered dietitian is not the same as a nutritionist. A registered dietitian has fulfilled the education and training to sit for the national registration examination. Upon passage of the registration examination, the individual can then be classified as a registered dietitian. Licensure requirements vary by state.

Pharmacist

A Pharmacist is a professional who distributes prescribed drugs to individuals. They also advise patients and professionals about prescribed drugs. In all states and the District of Columbia, pharmacists must operate with an active license. To obtain a license, a pharmacist

must have obtained a Doctor of Pharmacy (Pharm. D.) degree from an accredited college. The Pharm. D. degree is now the entry level degree required to become a Pharmacist and has replaced the previously accepted Bachelor of Pharmacy degree. Pharmacists that held the previously accepted Bachelor of Pharmacy are listed as Registered Pharmacists (R Ph).

An individual that has a Pharm. D. degree can sit for a national examination provided by the National Association of Boards of Pharmacy (NABP). Licensing requirements vary by state so professionals seeking licensure must review the licensing requirements of their particular state.

Certified Diabetes Educator

A Certified Diabetes Educator (CDE) is a certified healthcare professional with expertise in providing diabetes education and self-management training to persons with diabetes. The types of healthcare professionals that often seek the CDE certification include nurses, dietitians, pharmacists, doctors, exercise specialists, podiatrists, and social workers. The education is focused on how to manage diabetes. The education provided includes diabetes self-management and training that includes blood glucose monitoring, meal planning, lifestyle management, and medication management. Before a healthcare professional can be considered a CDE, he or she must pass a formal examination provided by the National Certification Board for Diabetes Educators. Before they can sit for the examination, the professional must have at least 1,000 hours of educating persons with diabetes.

13. Conducting a Needs Assessment

When deciding whether to provide DSMT services, an organization must first assess the level of demand for this service in the area being considered. Without adequate consumer demand, the program will surely fail. Another key factor is the number of competing programs. If the local market is currently saturated with programs, it will be difficult to achieve success when competing with other established DSMT service providers. Therefore, a complete needs assessment is necessary prior to making the initial financial commitment to start a new DSMT program.

Key Elements of a Needs Assessment

1. Statement of the problem
2. Prevalence and Incidence
3. Sub-categories of potential participants
4. Current services available and their costs to the consumer

5. Evaluation of program effectiveness and cost-effectiveness of services
6. Outcome measures and targets

1. Statement of Problem

The statement of the problem describes the issue that the program will address. This section of the needs assessment should include all of the major issues or controversies that are specific to the service area.

2. Prevalence and Incidence

Understanding the prevalence and incidence rates of diabetes in the service area is critical to knowing the program's target population. Data on incidence and prevalence of diabetes can be obtained from state or local health departments. In addition, national data are available from the Centers for Disease Control and Prevention at <http://www.cdc.gov/nchs/nhis.htm>.

The diabetes incidence rate refers to the number of new cases of diabetes over a specific time period -- usually one year. Since diabetes is a chronic condition, there are many more people who have diabetes than are indicated in the incidence rate. However, a newly diagnosed person with diabetes is the likely candidate for a DSMT program. It is also important to look at incidence rate trends. If the incidence rate is trending upward, then the program can be reasonably assured that there will be an increasing number of potential participants in the DSMT program. Another important trend is the incidence rate among specific minority groups. According to the Centers for Disease Control and Prevention, there are significant disparities among minority groups with diabetes. In many areas, African Americans, American Indians, and Latinos have a higher incidence rate of diabetes than other groups. Therefore, if the program service area has a large population of any of these groups, it is important to know the rate of diabetes among that them and target marketing efforts to them based on the observed incidence rate.

The prevalence rate provides additional information about the number of people with diabetes, within a given population. Although different from the incidence rate, the prevalence rate provides valuable information about the total number of persons with diabetes in a service area. Prevalence rates are the total number of cases of a disease in a given period of time, which includes new and existing cases of a disease. Prevalence rates are often provided over a year, similarly to the incidence rate. Assessing prevalence rate trends shows how the total population of persons with diabetes grows over time.

3. Subcategories of participants

Your program should focus on providing services based on the need of the population served. Your potential participants will be more than just a person with diabetes. They may have specific cultural or religious practices that impact the management of their diabetes. As a result, you should document the subcategories of participants. Two categories that often have an impact on diabetes are race, ethnicity, and religion.

4. Current services available and their costs to the consumer

The availability of other programs in your area provides information about access to diabetes self-management education programs in your area. Access should be closely correlated with the prevalence of diabetes in the defined service area. Access to existing services is a key component of the needs assessment process.

5. Evaluation of program effectiveness and cost-effectiveness of services

If there are programs that are currently providing diabetes self-management education in your community, you need to conduct an assessment about the effectiveness of these programs. Very few programs are community-based. Most follow a clinical model and are located inside large clinical facilities such as hospitals. Unfortunately, low-income vulnerable populations rarely comply with hospital-based education programs. Even if the programs are offered for free there are “opportunity costs” that must be considered. The opportunity costs are the additional costs to the consumer that must be overcome before the consumer can take part in the offering. In the case of hospital-based education, if a free diabetes self-management education program is being provided in the community and the resident must take two buses to get there and forfeit their meal at a congregate meal program, then this program has substantial cost to the consumer. If the consumer does not recognize the value of the course as being greater than the loss incurred to seize the opportunity, then the consumer will not attend the education program, because the “opportunity costs” are too great. A community-based program may have less opportunity costs associated with the program and thus have greater consumer participation. A community-based model can and should co-exist with these hospital-based clinical models. This will increase the effectiveness of both programs to meet the need of the entire community.

6. Outcome measures and targets

Outcome measures and targets are the program objectives to meet the needs of the target population. This section should detail how the program will target the needs of the consumer and measure the outcomes.

14. Business Planning

Establishing a business plan for a DSMT program involves having a clear understanding of total costs and potential revenue. The expenses and revenue sources must be firmly understood, prior to developing the business plan. When developing the list of program expenses, it is important to note that everything that a program provides has an attached cost. No aspects of the program are provided for free. There is a cost for each service that must be quantified in order to ensure that the DSMT program will be sustainable. Costs of DSMT programs relate to the following:

- Staff
- Facilities
- Transportation
- Instructor training and materials
- Consultants
- Marketing

15. Program Budget Planning

When establishing the program budget, it is imperative to have a detailed understanding of expenses and revenues. Without this understanding, it will be impossible to know about a proposed program's level of surplus. It is important to note that fee-for-service, DSMT has a fixed reimbursement level mandated by CMS or other health insurance plans. Thus, the program will not have the ability to alter the level of Medicare reimbursement for providing DSMT services to beneficiaries because this reimbursement amount is set by the CMS. The program does, however, have control over the expenses. Therefore, program expenses will have to be adjusted to ensure a surplus that can be used to sustain or expand the program.

Total revenues are a factor of participant volume and reimbursement. Since CMS sets the reimbursement level, the volume of participants is a factor that can be manipulated in an equation to provide additional revenue. The total reimbursement is calculated by multiplying the number of participants receiving DSMT by the level of reimbursement provided per

beneficiary, for that same service. When planning to increase participant volume, the program must take into account the impact that the increased volume will have on the expense column of the budget. When the level of service increases, some of the associated costs often increase. It is important to know what costs are variable (meaning they are based on the number of participants) and what costs are fixed (the cost stays the same no matter how many participants there are). Some costs are a combination of variable and fixed. Balancing increased costs of services with associated projected revenue is critical to program surplus. The additional expenses that can occur with increasing the services provided can include increased compensated staff time, increased use of consumable supplies, and increased facility costs.

16. Break-Even Analysis

A final step in planning the program's projected revenue is to examine the minimum number of participants the program must serve to meet the expenses of providing the service. This minimum level is the break-even point. A break-even point is the level of services that have to be provided in order to ensure that the total revenue received equals the total costs associated with delivering the program. Once a break-even point is established, a program can accurately assess if they can achieve surpluses by reviewing the current demand for the service. For example, if the program's break-even analysis shows that a minimum of thirty (30) participants per quarter are required to meet the level of program expenses, then the demand for services must consistently meet or exceed the break-even point of 30 to ensure sustainability. If the program participant numbers are at or below the break-even point, then it is not recommended that the program proceed in its present state.

17. Program Income Calculation Sample

In calculating projected program revenue, begin by calculating the level of revenue that can be secured by one person completing the DSMT. Using conservative estimates is critical to developing a realistic business model. For that reason, the business model should assume that the program will only receive the 80% CMS reimbursement. The coinsurance amount will vary based on the type of supplemental insurance and the ability of the participant to pay for his or her share of the costs. However, the Medicare reimbursement is a definite level of funding that will be provided as long as the beneficiary receives covered services.

In the case of DSMT, CMS will provide up to ten (10) hours of reimbursement. Included in the ten hours is one (1) hour of individual training, which is reimbursed at an incremental rate of \$53.27 (2015) for each unit of 30 minutes, for a total of \$106.54 ($\53.27×2). There are an

additional nine (9) hours of group training which are reimbursed at an incremental rate of \$14.30 (2015) for each unit of 30 minutes, for a total of \$257.40 ($\14.30×18). The total is \$363.94 ($\$106.54 + \257.40). That is the baseline level of reimbursement without consideration of an adjustment in the reimbursement based on location. These numbers are taken from the 2015 Physician Fee Schedule rates and may vary slightly, based on the location because of variances in payment based on the cost of living in different areas of the country. Therefore, for every beneficiary that completes ten (10) hours of DSMT, the program will potentially receive \$363.94. This funding amount should be used in comparison to the program expenses, to develop an estimate of the number of participants who have to complete a program each year, in order to maintain program solvency.

If the program also provides medical nutrition therapy (MNT), then this level of program revenue should also be calculated. Some programs decide to combine the DSMT and MNT training by offering it as a complete package. However, remember that CMS will not reimburse DSMT and MNT if they are given on the same day. If both programs are given, the maximum billable amount for MNT will be added to the DSMT reimbursement. The MNT benefit provides for three hours of services per calendar year. Included in these three hours is one hour of individual training and two hours of group training. The reimbursement for individual training is \$35.04 (2015) for each unit of 15 minutes for a total of \$140.16 ($\35.04×4). The reimbursement for group training is \$16.09 (2015) for 30 minutes for a total of \$64.36 ($\16.09×4).

The grand total for the MNT benefit is \$204.52 for 3 hours (1 hour individual and 2 hrs group). A program that offers both DSMT and MNT as a package service for participants will provide a total of thirteen (13) hours of training for a reimbursement from CMS of \$568.46/ participant. This figure should be used when assessing program solvency estimates and the program's break-even point.

18. Sample Revenue Projection per Class

Please note that the reimbursement amounts listed do not take into account regional variations. The current edition of the CMS Provider Fee Schedule will contain current reimbursement rates that are specific to the region.

DSME/MNT Program Revenue Projections (2015 Fee Schedule)

Program	Code	Reimbursement	Qty	Total
DSME (Individual)	G0108	\$53.27	Ea/30 min (2 Units)	\$106.54
DSME (Group)	G0109	\$14.30	Group/30 min (18 Units)	\$257.40
MNT (Individual)	97802	\$35.04	Ea/15 min (4 Units)	\$140.16
MNT (Group)	97804	\$16.09	Ea/30 min (4 Units)	\$64.36
			Grand Total	\$568.46
			Revenue/15 participants	\$8,526.90

19. Working with a Medicare Provider Partner

In order to receive the Medicare reimbursement for DSMT and MNT services, the Medicare provider must submit a claim for reimbursement to the Medicare fiscal intermediary. One claim must be submitted for every qualified service provided to a Medicare beneficiary. The payment for services rendered will be submitted back to the Medicare provider. It is imperative that there be an agreement executed between the Medicare provider partner and the AAA, prior to the submission of claims for services. This agreement will govern the responsibilities of each organization and how to administer funds when received for services. In most cases, the two organizations should execute a memorandum of understanding or contract prior to providing billable services for Medicare beneficiaries.

Agreement elements

A key element of an agreement includes the governance of how money will be distributed. Prior to any share of money, both programs must first cover their costs of administering the program. The costs should be mutually agreed upon prior to deciding to participate in the program. Once both organizations mutually agree upon the final costs of delivering the program, this is the final program budget. All revenue earned over expenses will be considered the earned surplus. The surplus is what is shared after both organizations cover their mutually agreed upon program

administration costs. In addition, the agreement should spell out the responsibilities of each organization. For example, the AAA will provide the Stanford DSMP course. It will be the responsibility of the AAA to maintain the program according to the Stanford licensing requirements. It will be the responsibility of the Medicare provider partner to maintain good standing with the Medicare program, submit timely claims, and report back to the AAA on the status of claims filed. If problems arise that will inhibit the filing of timely claims, then both organizations should discuss the barriers to submitting claims and develop a plan to address the barrier to billing.

Lastly, the agreement should have a termination clause. Both organizations should have the right to terminate the agreement at any time. The agreement to terminate should require written notification and an acceptable notification period, prior to the final termination date. Timely notification is a minimum of thirty (30) days notice.

20. Consumer Enrollment Process

In order to process a claim, the Medicare provider partner will need the insurance information for each participating beneficiary, along with each person's supplemental insurance information. This information should be captured when a consumer is identified as a potential participant in a DSMT class. If this intake occurs at the AAA, then the AAA should be trained on the Medicare provider partner's intake process. This will include having copies of the forms and other authorizations required to complete the registration process. If the Medicare provider partner is using an electronic medical record, then the AAA will need access to the EMR system to enter information on each potential participant. Electronic access to the Medicare provider partner's system can occur via Internet for cloud-based systems, or through a virtual private network (VPN), for server based systems, so that information can be entered directly into the Medicare provider partner's system. The process of verifying consumer information and entering it into the Medicare provider partner's system will require staff training. The Medicare provider partner will be responsible for coordinating the training for AAA staff. Any system licensure issues will be the responsibility of the Medicare provider partner. If system access requires the Internet, then both organizations must implement a plan to ensure Internet access at all locations where services will be rendered. The Internet access can occur via Wi-Fi or wireless devices. Cloud-based systems and VPN access provides adequate security for consumer intake in remote locations.

**The information obtained during the intake process is protected health information (PHI) and subject to HIPAA regulations. Any identifying information about a consumer must be protected. In general, no patient information can be shared via regular e-mail. This includes

internal e-mail. You must have a special e-mail encryption service in order to send any patient information over e-mail.

21. Program Evaluation and Continuous Quality Improvement

Evaluation designs can become complex and scientific in nature. However, two simple design models that can provide ongoing information about the DSMT program's effectiveness include a pre- and post- test design, as well as a time-series design.

These program evaluation designs concern the implementation of a defined intervention. In this case, it would be the DSMT and/or MNT benefit. The program evaluation will seek to assess how the training affects the participant's ability to self-manage their diabetes. Since participation in the management of the disease is a key component, both qualitative and quantitative measures should be assessed. Examples of the measures that can be used to determine the program's effectiveness includes the following:

- Fasting blood sugar levels;
- Hgb A1C;
- Presence of diabetes complications;
- Adherence to recommended diabetes screenings (i.e., diabetic retinopathy screenings, podiatry screening, etc.);
- Medication management compliance;
- Knowledge of dietary impact on disease management;
- Knowledge of necessary dietary restrictions in diabetes;
- Opinion on the quality of instruction received;
- Opinion on ability to self-manage diabetes.

In the case of a pre- and post-test design, each of these measures will be assessed prior to the start of the DSMT classes to obtain the pre-test measure. The same information should be obtained at the end of the participant's attendance in the DSMT education series, to assess the post-test measures. The intervention in the pre/post test design is the entire DSMT course. If the program is effective, there should be an improvement in the participants' data. When assessed as a whole, a positive trend will show general improvement among all of the participants.

A time series design is similar to a pre-test/post-test design in that it will provide periodic measurements, over a period of time. An example would be to assess the ongoing Hgb A1C measurement for DSMT class participants over time. The expectation is that there will be an

improvement over time that will be sustained because of the benefit of the class. Employing a time series design involves selecting when the program makes the predetermined observations. For example an Hgb A1C can be obtained at the beginning of a class, at the end of the class and then in three (3) month increments there after, for a total of 6 months. This will provide an assessment of the level of impact on the Hgb A1C that was realized by a class participant over time.

Program Evaluation Implementation

After determining the design of the program evaluation approach, you must then take on the task of implementing the program evaluation process. The program evaluation will provide information for quality assurance and ensures that the program is benefiting the beneficiary. The program evaluation should be uniform and systematic in nature. The steps to establishing a limited, program evaluation include the following:

- Planning
- Data collection
- Data analysis

Planning –

The program evaluation should utilize a systematic process to assess a defined DSMT program. The program evaluation should identify the types of questions that will provide useful data as to how the program is affecting the target population. In the planning phase, the program should establish the types of questions that will be asked, when these questions will be asked, and how the answers to the questions will be obtained. These answers provide the program data. The pre/post test example in the previous section was used as an example. Given this example, the program would collect data that relates to the defined measures in the pre/post test design.

Data collection –

In order to obtain objective information on all participants it is imperative that the outcome measure is obtained on each participant in the same manner. For example a fasting blood sugar should be obtained at the same time in the program to provide a true comparison among participants.

Data analysis –

All of the participant-level data should be aggregated to provide a method of analyzing the entire program. Regular review of the data obtained should occur and comparisons should be made over time to evaluate the effectiveness of the program. If the data provides information that the program has little or no impact on participants, then changes must be

implemented to improve the program's effectiveness.

22. How to work with a Federally Qualified Health Center (FQHC)

The term Federally Qualified Health Center or FQHC refers to three types of clinics:

1. Health Centers funded under Section 330 of the Public Health Service (PHS) Act including:
 - Community Health Centers (CHSs)
 - Migrant Health Centers (MHCs)
 - Homeless Health Centers (HCHs), and
 - Public Housing Primary Care Centers (PHPCs)
2. FQHC "Look-Alikes" – sites that have been identified by the Health Resources Services Administration (HRSA) and certified by CMS as meeting the definition of a health center under Section 330, but they do not receive funding under Section 330. It is important to note that Look-Alike facilities do participate in the special reimbursement programs set up for grant-funded FQHCs/
3. Outpatient health programs and facilities operated by tribal organizations under the Indian Self-Determination Act.

FQHCs serve as safety net providers, primarily serving underserved populations. They must be located in a designated Medically Underserved Area (MUA) or provide services to a Medically Underserved Population (MUP).

FQHCs must be a nonprofit, tax-exempt corporation or public agency. The organization must have an independent governing board of directors. There are specific criteria for board participation including the fact that at least 51% (simple majority) of the board members must be consumers that the health center serves and represent the population being served by the health center.

Section 330 FQHC grantees receive funding annually from the Health Resources and Services Administration (HRSA). As grantees, they have requirements to serve the target population regardless of their ability to pay. In addition, grantees must show an increase in the number of patients that they serve each year or potentially receive a reduction in their grant award.

Contracted Services

An FQHC can contract with another entity to provide services to FQHC patients. However the contract must have board approval and be part of the site's scope of allowable services.

In approaching FQHCs about potential partnerships it is important to stress the advantages to FQHCs, such as new source of patient referrals, recurring patients, referrals for other services, etc. FQHCs receive their funding from the Health Resources and Services Administration (HRSA). Each facility receives an annual grant to support its operations. A requirement of this grant program is annual reporting to HRSA on multiple aspects of service delivery, including increases in the number of consumers receiving healthcare services, diversity in the types of consumers served and varying payor mixes. An increase in the number of Medicare beneficiaries served, meets both of these objectives for the FQHC. The AAA could highlight these facts when discussing providing DSMT in partnership with the FQHC.

Reimbursement

Medicare reimbursement to a FQHC is based on an All-Inclusive Reimbursement Rate (AIRR). The AIRR is determined by the average cost that the FQHC incurs for providing services. Based on the average cost of providing services to beneficiaries, the FQHC will receive the all-inclusive rate for each Medicare beneficiary that receives services from a qualified FQHC. It is important to note that this fixed amount is paid to the center for each Medicare beneficiary that is seen. The level of service provided is not factored into the amount that is paid to the FQHC. In contrast, the non-FQHC Medicare provider receives a graded payment based on the level of services provided to the beneficiary. The AIRR method of reimbursement ensures that the FQHC receives funding that will support the program, as long as it serves the correct number of patients per year.

It is also important to note that FQHC providers have productivity expectations that they must meet. If they do not see an acceptable number of patients each year, they could be cited by HRSA and continual infractions could result in a mandatory change in scope or reduction in grant award. Therefore, it is to the benefit of any FQHC to work with organizations that can help them meet their patient productivity goals each year.

The actual rate that the FQHC receives is based on its all-inclusive reimbursement rate as compared to the national capped amount. The center receives the lower of the two. The national capped amount is the maximum level of reimbursement that a FQHC can receive for

services rendered to beneficiaries. The national capped amount is calculated based on the average cost of delivering medical services, based on the Medical Economic Index applicable to primary healthcare practitioner services. The 2012 national capped amount is as follows:

Year	Urban Payment	Rural Payment
2012	\$128.49	\$111.21

Many health centers receive an all-inclusive rate that is close to the national capped amount for each face- to-face encounter between the patient and the center health provider. This same amount is paid to the center if the patient has a 5 minute visit and receives only one service or if the patient is there for an hour and receives multiple services. FQHCs are reimbursed 80% of the all-inclusive rate and the patient is responsible for a coinsurance amount equal to 20% of the billed charges.

FQHCs and DSMT

FQHCs have limits on the services they are allowed to provide. Beginning January 1, 2006, FQHCs could begin providing Diabetes Self-Management Training (DSMT) and Medical Nutritional Therapy (MNT) services after the Deficit Reduction Act of 2005 amended the Social Security Act to add these services to the list of core FQHC services. In order to provide DSMT, the FQHC must be accredited and accepted by CMS. Once they obtain certification, they can receive per-visit payments for DSMT. FQHCs are paid at the All-Inclusive Rate for DSMT services. The all-inclusive rate is paid for services rendered to each eligible beneficiary.

Generally FQHCs can only be reimbursed for one service per person/day. However, they are allowed to bill for a basic service and DSMT on the same day. The exception is for MNT. MNT and DSMT cannot be billed on the same day. Medicare makes payments to FQHCs at the all-inclusive encounter rate that they receive for any medical service.

Current regulations only allow FQHC reimbursement for individual, face-to-face DSMT and MNT services. FQHCs cannot be reimbursed for group DSMT or MNT. However, FQHCs can bill the AIRR for all individual visits with a licensed professional who works with individual class participants. During a standard class it is expected that each participant will visit with a licensed professional to conduct an initial assessment, individual instruction, as needed (i.e., insulin training), and an evaluation assessment post training.

FQHC reimbursement is limited to the individual services because CMS expects that the cost of

the group services is included in the standard all-inclusive rate that is provided for the individual, face-to-face services for FQHCs. This is a significant difference in billing procedures at a FQHC versus a standard Medicare provider. A regular Medicare provider can bill for both individual and group DSMT and MNT services, although at a substantially lower billing rate.

23. Business Plan Case Study

Recently in Anywhere, USA, the local AAA had a vacancy for an executive director of the organization. After a long selection process, the Anywhere AAA hired Mrs. Jennifer Sugar to be their next Executive Director. Mrs. Sugar has a passion for seniors and pledged to initiate many new programs to facilitate healthy aging. One thing that Mrs. Sugar noticed is that there are a high number of clients who have significant complications resulting from poorly controlled chronic diseases such as diabetes.

Mrs. Sugar pledged to decrease these preventable complications. To learn what can be done to improve the health of persons with diabetes, Mrs. Sugar attended a diabetes education class at the local hospital. This class was sponsored by a pharmaceutical company as a one-time course offering for persons with diabetes and their family members. During the course, Mrs. Sugar learned that an approved diabetes education program could submit to CMS for reimbursement. Mrs. Sugar became inspired to improve the health of the population with diabetes in Anywhere, USA and decided to start a diabetes self-management education and training program (DSMT).

Mrs. Sugar contacted the U.S. Administration on Aging to identify training resources to help the Anywhere AAA begin providing DSMT to Medicare beneficiaries. Mrs. Sugar received a scholarship to attend the diabetes education program at Stanford University. While attending the training program at Stanford, Mrs. Sugar learned of their lay leader training self-management program. Upon return to Anywhere, USA,

Mrs. Sugar conducted a needs assessment to learn the incidence, prevalence, and current population of persons with diabetes in the area. After identifying the percentage of persons with diabetes in the area, Mrs. Sugar had to make an analysis of the subcategories of persons with diabetes in her area. These subcategories include persons by age, by race, and type of diabetes. Lastly, Mrs. Sugar went on to make an assessment of the number of diabetes education programs in the region. In order to get the listing of Medicare approved programs,

Mrs. Sugar contacted the American Diabetes Association (ADA) and American Association of Diabetes Educators (AADE) to obtain their list of accredited programs.

Mrs. Sugar obtained the information from AADE and ADA because local programs cannot submit for reimbursement from CMS until they achieve successful accreditation of their program by ADA or AADE. Based on the list of accredited programs, Mrs. Sugar realized that there were two programs in her immediate area. Unfortunately, both of these programs are offered through the academic medical center, Anywhere University. Unfortunately, Anywhere U is not on the bus line and is about a 20-minute drive from the senior public housing in the area.

The needs assessment revealed that there is a tremendous need for DSMT services in Anywhere, USA. Mrs. Sugar came to this conclusion after reviewing the results of the needs assessment. The key points are as follows:

1. The highest incidence rate is among low-income minority groups in the area
2. There is a large population of African Americans and Latinos that frequent the local community hospital for services and rarely visit Anywhere U for medical care
3. African Americans with diabetes in the area have the highest rate of diabetic retinopathy and peripheral vascular disease resulting from poorly controlled diabetes

Mrs. Sugar immediately held a meeting with her board of directors to get approval to start a DSMT program. The board ordered that the program can be started but it must be at least cost neutral to the Anywhere AAA budget. Given this mandate, Mrs. Sugar sought to identify a funding mechanism that will allow the DSMT program to operate in a profitable manner.

Mrs. Sugar began reviewing CMS regulations to learn what is required from CMS in order to be reimbursed for providing diabetes self-management programs. After this review she went on to see the best way to maximize the use of the Medicare DSMT benefits for beneficiaries with a diagnosis of diabetes in her area. The Medicare program provides direct reimbursement to Medicare providers that provide DSMT programs using a CMS-recognized program.

The first step was for the Anywhere AAA to develop a business model based on the CMS-approved reimbursement amount. With the anticipated reimbursement, Mrs. Sugar developed a program budget. The program budget included each of the items needed to provide the service annually. The expenses were then compared with the potential revenue.

Mrs. Sugar realized that the program would be budget neutral if they could have 7 full classes per year.

She realized that anything above that would produce an excess of revenue over expenses – a surplus. A full class would be 15 participants. Each person would have to attend all of the training modules to ensure that the program secured reimbursement for all of the services rendered. The course would be taught over 7 weeks to provide all of the required information to meet minimum accreditation standards.

Mrs. Sugar developed the following expense listing to establish her program budget:

Description of Expense	Itemized Expense	Total Project Expense
Personnel		
Program Coordinator - Registered Nurse	0.125 FTE @ \$75K/annum + fringe @ 20% (fringe = benefits, FICA, Health)	\$11,250.00
Registered Dietitian/Lead Instructor	0.125 FTE @ \$70K/annum + fringe @ 20% (fringe = benefits, FICA, Health)	\$10,500.00
Lay Leader Stipend	Stipend amount is recommended at \$200/6-week course per person. 2 lay leaders per class = \$400/class @ 7 classes	\$2,800.00
Lay Leader Training	Lay Leader training on the Stanford Model. Training will cost \$150/person. Budget will provide for training for 6 lay leaders	\$900.00
Continuing Education	Staff members are required to participate in annual continuing education. This line item in the budget provides funding for staff and lay leaders to participate in training on diabetes education. Included in this line item is the travel for staff to training sites.	\$2,500.00

Facility	Itemized Expense	Total Project Expense
Conference room	30 square feet per person in conference style seating with 15 clients per class paid to housing authority for a flat rate of \$4,000/year (classes will also be conducted at the partnering physician	\$4,000.00
Consultant Services		
Medicare Billing Service	Contractual billing service to submit Medicare claims for DSMT services provided to Medicare beneficiaries - services will be provided if the AAA pays the contractor 10% of collected revenue	\$4,720.80
Registered Nurse (In-Kind)	Provide contract services as a registered nurse providing health education as part of an ongoing DSMT program. The contract rate is \$40/hr for a total of 6 hours per month (3 hrs for each class including prep time provided as an in-kind service from partnering physician practice). In-kind services are services that someone donates to your program without charging the program the market rate for the service. This donation has value that should be calculated here.	\$0.00
Transportation		
Travel Stipend funding	Stipend to pay participants for minor travel expenses to participate in the classes. Stipend will be made available to low-income participants.	\$3,000.00
Program Expenses		
Office Paper Supplies	Consumable office supplies including printing and copier paper @ \$250/mo	\$3,000.00

Miscellaneous	Itemized Expense	Total Project Expense
Marketing Material Design	Graphic arts production of program marketing materials	\$1,500.00
Marketing Material Production	Mass production of DSMT program marketing materials	\$1,500.00
Outreach and recruitment	Community outreach and marketing to recruit new participants in the program	\$1,500.00
Grand Total		\$47,170.80

Once Mrs. Sugar developed an outline of her expenses, she had to project how much income could be obtained from providing the service. The primary payor for the services will be Medicare. Mrs. Sugar went to the Medicare fee schedule to determine what her reimbursement amount would be for providing services. Using the 2015 Medicare fee schedule for her region, Mrs. Sugar looked at the reimbursement amount, and noted that Medicare would reimburse at 80% of the total reimbursement rate for the DSMT benefit —the participant would be responsible for 20% of the cost as a co-pay.

Mrs. Sugar knows that challenged populations often have difficulty meeting the Medicare co-payment, so it may not always be a reliable source of income. To account for this, Mrs. Sugar routinely sets her budget according to the Medicare reimbursement only, since the 20% she will collect from the beneficiary is not guaranteed. Using this budgeting methodology, Mrs. Sugar is assured that her program will meet minimum budgetary requirements, even if none of the beneficiaries can pay the required Medicare co-payment.

According to the Medicare fee schedule, the following reimbursement is provided in Mrs. Sugar's geographic region:

Program Revenue Projections (2015 Fee Schedule)

Program	Code	Reimbursement	Qty	Total
DSME (Individual)	G0108	\$53.27	Ea/30 min (2 Units)	\$106.54
DSME (Group)	G0109	\$14.30	Group/30 min (18 Units)	\$257.40
MNT (Individual)	97802	\$35.04	Ea/15 min (4 Units)	\$140.16
MNT (Group)	97804	\$16.09	Ea/30 min (4 Units)	\$64.36
			Grand Total	\$568.46
			Revenue/15 participants	\$8,526.90

When Mrs. Sugar completed her break-even analysis, she realized that they could easily meet the break-even number. To determine this break-even number, Mrs. Sugar took her expenses and compared these expenses to revenue for each class. Once she understood this, she added the revenue per class until her revenue met her expenses.

The point where revenue meets expenses is the break- even point. Based on her conservative assessment, through the ADRC, Medicaid Waiver program, and nutrition programs, they are seeing about 400 new seniors with diabetes each year. Based on her locally identified incidence rate, Mrs. Sugar realized that she could conduct two classes per month (15 participants/class = 30 participants /month or 360 participants/year). Because her demand easily provides the volume to host two classes per month, Mrs. Sugar listed this number as her program goal. She developed a separate spreadsheet for her program goal that will be shared internally with her staff. Mrs. Sugar was ecstatic about the financial projections and potential for her diabetes program.

Suddenly Mrs. Sugar realized that her diabetes program could serve as a surplus center that could generate revenue to expand her other programs and help more needy seniors. She immediately began an implementation plan to deliver services as soon as possible. With the break-even revenue projections provided, Mrs. Sugar realized that her program would have to provide both DSMT and Medical Nutrition Therapy (MNT). MNT is a billable service under Medicare guidelines. A registered dietitian provides MNT services, with an order from a medical provider. Therefore, Mrs. Sugar made sure that her program utilized the services of a registered dietitian to obtain this additional revenue and ensure program profitability. In addition, Medicare guidelines authorize the provision of both DSMT and MNT services with a valid order from a medical provider, although they cannot both be provided on the same day. If they are, Medicare will not reimburse for them.

Mrs. Sugar calculated that the maximum allowable billable amount for both DSMT and MNT is \$578.94, given the base level funding amount. Mrs. Sugar is projecting that she will keep the class size at 15 participants. With 15 Medicare beneficiaries, with traditional fee-for-service Medicare (Medicare Advantage beneficiaries do not have the same fee-for-service DSMT benefit) the projected billable revenue will be \$8,526.90. If \$8,526.90 will be earned for each class of 15, then Anywhere AAA will have to conduct six (6) classes to meet the minimum revenue required to cover all expenses. In addition, all 90 (15 x 6) participants will have to complete the entire course. Mrs. Sugar realized that was probably unrealistic, so she decided to plan for 7 classes of 15 to account for those who will not be completers.

The benefit covers services provided during one calendar year. After the initial one year of training, the beneficiary can receive additional follow-up training annually, with a medical provider order. Given this information, Mrs. Sugar decided that she should factor in the reimbursement for follow-up training during the year 2 and year 3 projections.

The table below provides the Medicare reimbursement amount for follow-up DSMT and follow-up MNT services:

Post Initial Calendar Year Training (2015 Fee Schedule)

DSMT				
G0108	\$53.27	Individual training in 30 minute increments	2 hours (4 units)	\$213.08
G0109	\$14.30	Group training in 30 minute increments	1 hour (2 units)	\$28.60
MNT				
97803	\$30.81	Individual training, in 15 minute increments	1 hour (4 units)	\$123.24
97804	\$16.12	Follow up Group MNT, in 30 minute increments	1 hour (2 units)	\$32.24

The follow-up training funding will be in addition to the base level funding for providing the DSMT and MNT to beneficiaries in their first year of training. In addition, Mrs. Sugar projects that during year 2, her program will be able to provide ten classes of initial training per calendar year. Using the same methodology, Mrs. Sugar projects that her program will be able to provide twelve (12) classes during the third year. Twelve classes would mean providing a new class each month. Mrs. Sugar feels confident that she will be able to recruit enough Medicare beneficiaries to conduct a new class each month, because of the high incidence rate among the target population for her program. The high incidence rate reveals that there is a steady stream of newly diagnosed persons with diabetes that could receive a referral to her program to obtain DSMT and MNT services.

24. Sample AADE Chart Auditor Checklist

EDUCATIONAL RECORD REVIEW FORM

Item	Comments
Referral for DSME/T in chart	Must be by the treating physician or midlevel practitioner
Relevant medical history	Other diagnosis or co-morbidities basically a health history
Present health status, health service or resource utilization	What is going on now, do they see the doctor often, have they had dental exam, foot exam, visual exam etc....
Risk factors	Genetic, obesity etc...
Diabetes knowledge and skills	Past education, do they monitor etc....
Cultural influences	Any special diet or herbs.....special resources needed i.e.. members of tribal communities will often not comply unless the chief agrees with treatment
Health beliefs and attitudes	Misconceptions, prayer.....
Health behaviors and goals	Goal setting and usual behavior
Support systems	Do they live alone, married.....
Barriers to learning	Education level, literacy issues, blind, deaf.....
Socioeconomic factors	Financial situation
Collaborative participant assessment	Overall assessment either completed with the patient or reviewed after completion with the patient
Plan of care based on assessment and meets the individual's needs	Actual plan of care
Intervention per plan provided and outcomes evaluated	Follow-up with items in plan, interventions, education, teach back etc,...
Collaborative development of education goal, objectives and plan	Who set the goals and what is the plan
Is the AADE7 Integrated	Is the 7 self-care behaviors a part of the overall plan
Communication of educational services to physician/ qualified non-physician practitioner (Standard 8)	Documentation of the communication with the physician or midlevel practitioner. Not sufficient for policy to say EHR
Does the chart show evidence of a personalized process for on-going self-management support? - (Standard 8)	What have you encouraged your patients to do after education, resources (websites, booklets, local community services, weight programs

25. Sample Physician Order – DSMT and/or MNT Services

<http://www.diabeteseducator.org/export/sites/aade/resources/pdf/DiabetesServicesOrderFormFINAL.pdf>

26. Sample AADE Application

ABC Area Agency on Aging

ABC Area Agency on Aging Accreditation Application

Standard 1: The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care. Essential Elements Checklist:

- Documentation of organizational chart of DSME/DSMT program
- Documentation of program mission and goals
- Policies and procedures are available
- Job descriptions for all positions relating to the DSME/DSMT program

Program Description: (Standard 1)

The DSMT program is an eight-week intervention, which begins with each participant undergoing a detailed individual assessment. The program primary qualified instructor (PQI) [registered nurse, registered dietitian, or registered pharmacist] conducts an initial individual assessment. Based on the results of the individual assessment, the PQI develops a comprehensive education plan. A key component of the individual assessment and education plan is the establishment of individualized goals and self-management support strategies. Upon completion of the individual assessment and education plan, each consumer will participate in the six (6) week Stanford Diabetes Self-Management Training program (group). Two trained Group Leaders, under the supervision of the PQI, facilitate the group workshops from a highly detailed manual. Participants, in the group education sessions, will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their individualized self-management program. The primary qualified instructor directs the material covered during the group sessions. In addition, the group instruction occurs in a setting that allows for interaction between the participants and the trained group leaders. However, the licensed instructor will maintain responsibility for providing direct supervision of the educational process in the least obtrusive manner possible.

Physicians and other health professionals both at Stanford and in the community have reviewed all materials in the course. In addition, the instructional materials have been provided to our program advisory board as part of our continual quality improvement review process. Classes are conducted in a manner to encourage full participation by all members as the group works to learn improved self-management capability for their disease. Group participation in the learning process provides the opportunity for mutual support and enables participants to build on the success of their peers.

Here is a link to more information about the Stanford program: _

<http://patienteducation.stanford.edu/programs/diabeteseng.html>

At the completion of the group training sessions, each participant will participate in follow up assessments with the PQI to review effectiveness of their ability to achieve the goals of their individualized education plan. This review provides the PQI with an opportunity to augment and modify the participant's disease self-management plan, if necessary. All follow up is communicated by PQI to participant and the referring primary care manager.

Mission Statement:

Our mission is to empower our clients with the self-care management skills necessary to improve their quality of life, using what they have learned through diabetes education and disease management strategies.

Job Description

TITLE: Diabetes Educator/Professional Diabetes Program Instructor (PQI)

REPORTS TO: DSME/T Program Coordinator

SUPERVISES: Professional and Non-professional instructional staff

POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators (AADE, 2005).
- Provides direct supervision of the participating non-professional instructional staff and group leaders (i.e., community health workers) that assist in delivering the diabetes self-management education program to class participants. The primary qualified instructor is responsible for selecting community health workers, monitoring their performance, and assuring that they are properly trained. Direct supervision occurs

during program instruction and entails: 1) oversight of the instructional material, 2) fidelity checks to ensure that approved material is being delivered as intended, 3) direct observation of community health worker-led instruction, and 4) constant physical availability to assist and answer questions that arise during community health worker led instruction periods.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Collects DSME/T program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSME/T program participants.
- Provides educational interventions that utilize primarily interactive, collaborative, skill based training methods and maximizes the use of interactive training methods.
- Collaboratively develops an individualized follow-up plan with each program participant.
- Evaluates effectiveness of educational services provided by measuring attainment of learning objectives.
- Conducts a follow-up assessment upon completion of DSME/T program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data, educational plan, educational services provided and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.

20% of the time:

- Participates in the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSME/T program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other professional instructional staff.

- Maintain education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

KNOWLEDGE, SKILLS AND ABILITIES:

- In-depth knowledge about current diabetes treatment management.
- Able to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).

EXPERIENCE/EDUCATION:

- A healthcare professional who is also a certified diabetes educator, or who is eligible to become a certified diabetes educator.
- Credentialed as a diabetes education specialist or diabetes clinical management specialist preferred.
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.

Job Description

TITLE: Group Leader

REPORTS TO: PQI

SUPERVISES: Non-Supervisory Position

POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators (AADE, 2005). Maintains a non-technical role in providing instruction to program participants.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Under the supervision of the program instructor, collects DSME/T program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Under the supervision of the program instructor, collaboratively develops educational

goals, learning objectives and a plan for educational content and teaching methods with DSME/T program participants.

- Provides non-technical educational interventions that utilize primarily interactive, collaborative, skill based training methods and maximizes the use of interactive training methods.
- Collaboratively with the PQI, develops an individualized follow-up plan with each program participant.
- Collaboratively with the PQI, Evaluates effectiveness of educational services provided by measuring the attainment of learning objectives.
- Collaboratively with the PQI, Conducts a follow-up assessment upon completion of DSME/T program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data of the PQI developed educational plan, educational services provided, and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.

20% OF THE TIME:

- Contributes to the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSME/T program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other non-professional instructional staff.
- Maintain 15 hours of continuing education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

KNOWLEDGE, SKILLS AND ABILITIES:

- In-depth knowledge about current diabetes treatment management.
- Able to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).

EXPERIENCE/EDUCATION:

- Experience working with community based groups and providing outreach to seniors
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.
- Experience making oral presentations on health topics in community settings

Job Description**TITLE: DSME/T Program Coordinator**

REPORTS TO: Program Director

SUPERVISES: DSME/T program staff

POSITION OVERVIEW:

Provides oversight for planning, implementation and evaluation of the DSME/T program and ensures the systematic and coordinated delivery of diabetes educational services.

DUTIES AND RESPONSIBILITIES:

- Provides direction for the selection, and ongoing review, of the curriculum and educational materials to ensure they meet the needs of the population targeted.
- Directs marketing activities
- Develops and directs the implementation of an annual program evaluation plan and performance improvement activities, including CQI projects.
- Ensures that DSME/T program accreditation requirements are met and maintained.
- Oversees the diabetes educational process and ensures that services are provided in an individualized and fiscally feasible manner.
- Develops and maintains relationships and partnerships with community groups, payers and potential referral sources.
- Interfaces with the Volunteer Accreditation Advisory Group.
- Maintain 15 hours of continuing education annually as it relates to the profession.

KNOWLEDGE, SKILLS AND ABILITIES:

- Knowledge about chronic disease management and disease self-management educational processes
- Supervisory abilities
- Knowledge about program management

- Proficient in various computer applications, including spreadsheets
- Marketing skills

EXPERIENCE/EDUCATION:

- Education and/or experience in program management (*specific extent of education or experience specified according to size/scope of program*).
- Education in, and/or experience with, chronic diseases and disease self-management

Standard 2:

The DSME entity shall appoint an advisory group to promote program quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.

Essential Elements Checklist:

- Advisory Group Policy
- Advisory Group Function
- Advisory Group actively reviews and makes recommendations on the
- DSME/DSMT annual program plan and evaluation
- Advisory Group includes (suggested):
 - A primary care provider
 - Educator
 - Community member with diabetes

Advisory Board: (Standard 2 & 3)

The diabetes self-management education advisory group will meet, as needed, but no less than annually to review and analyze the diabetes self-management education program.

Membership shall include, but is not limited to, the following (sample):

- Medical Director/PCP
- PQI
- Community member/former participant with diabetes
- Community Health Center Educator, Certified Diabetes Educator

Advisory Committee functions:

- Actively reviews the DSMT program

- Actively reviews the CQI data reports developed by the program coordinator
- Makes recommendations to help improve and maintain the program
- Reviews the annual program plan and evaluation
- Reviews the continuous Quality Improvement Plan

Standard 3:

The DSME entity will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet those needs.

Essential Elements Checklist:

- An identifiable process was used to assess the needs of the target Population.
- Unique needs of target population are specified.
- Allocation of resources are specified

Target Population

Geographic Region: Expansive Geographic Area

Expected Volume: 21-100 monthly

Settings:

Community Site: Aging Service Access Point

Setting Descriptors

Target Population's unique characteristic: Older Adults (generally age 60+)

Tailoring to target population: To meet the needs of this older adult population, the DSME program will be particularly tailored to address challenges which include, but are not limited to: low vision, hearing loss, limited mobility. Educational material using large print will be utilized when necessary. Hearing assistance devices will be available. All site locations will accommodate walkers, wheelchairs and other devices designed to improve mobility. Program instructors will have particular experience in working with older adults so as to have a heightened ability to recognize other needs of the population. While the majority of the target population is English speaking, educational material will be available in the other languages prevalent in the geographic areas served (Spanish, Cambodian) and translation services will be made available when necessary. Further, some segments of the target population have incomes at or below the federal poverty limits.

To address the challenge of meeting the needs of low-income elderly consumers, the program includes information *on* finding low-cost medication and services. Efforts to assist with transportation will be incorporated when possible. Any additional barriers and challenges discovered for members within the target population will be communicated to the participant's primary care provider. All resources expended in support of this DSME will be allocated to meet the needs of this target population.

At least annually, an assessment of the target population will be performed to address access to health care services, cultural influences, barriers to education, and appropriate allocation of resources. Resources allocated include funding for program intervention and assessment, physical space, transportation costs, etc.).

Standard 4:

A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education, and in program management.

Essential Elements Checklist:

- Coordinator's resume reflects academic, continuing education and/or experiential preparation
- Position description describes program oversight by coordinator

Job Description

TITLE: DSME/T Program Coordinator

REPORTS TO: Program Director (manager, administrator, CEO, etc.)

SUPERVISES: DSME/T program staff (primary qualified instructors, group leaders)

POSITION OVERVIEW:

Provides oversight for planning, implementation and evaluation of the DSME/T program and ensures the systematic and coordinated delivery of diabetes educational services.

DUTIES AND RESPONSIBILITIES:

- Provides direction for the selection, and ongoing review, of the curriculum and educational materials to ensure they meet the needs of the population targeted.
- Directs marketing activities.

- Develops and directs the implementation of an annual program evaluation plan and performance improvement activities, including CQI projects.
- Ensures that DSME/T program accreditation requirements are met and maintained.
- Oversees the diabetes educational process and ensures that services are provided in an individualized and fiscally feasible manner.
- Develops and maintains relationships and partnerships with community groups, payers and potential referral sources.
- Interfaces with the Volunteer Accreditation Advisory Group.
- Maintain 15 hours of continuing education annually as it relates to the profession.

KNOWLEDGE, SKILLS AND ABILITIES:

- Knowledge about chronic disease management and disease self-management educational processes
- Supervisory abilities
- Knowledge about program management
- Proficient in various computer applications, including spreadsheets
- Marketing skills

EXPERIENCE/EDUCATION:

- Education and/or experience in program management
- Education in, and/or experience with, chronic diseases and disease self-management

<Insert Primary Coordinator resume here>

<Insert copy of license of program coordinator here (if applicable)>

<Insert copies of any pertinent training for the program coordinator here>

Standard 5:

Diabetes self-management education will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participants' needs are met if those needs are outside the instructor's scope of practice and expertise.

Essential Elements Checklist:

- Instructors' current credentials
- Instructors' current resume
- 15 hours annual CE for all instructors
- At least one of the instructors is an RN, RD, or pharmacist
- CHW training, continuing education, and name of supervisor, if applicable
- Mechanisms for ensuring participants' needs are met
- Team coordination/interaction is documented

Job Descriptions

Primary Qualified Instructors PQI and Group Leaders

TITLE: Professional Diabetes Program Instructor/Primary Qualified Instructor (PQI)

REPORTS TO: DSME/T Program Coordinator

SUPERVISES: Non-professional instructional staff, Group Leaders

POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators (AADE, 2005).
- Provides direct supervision of the participating non-professional instructional staff and group leaders (i.e., community health workers) that assist in delivering the diabetes self-management education program to class participants. The primary qualified instructor is responsible for selecting community health workers, monitoring their performance, and assuring that they are properly trained. Direct supervision occurs during program instruction and entails: 1) oversight of the instructional material, 2) fidelity checks to ensure that approved material is being delivered as intended, 3) direct observation of community health worker-led instruction, and 4) constant physical availability to assist and answer questions that arise during community health worker led instruction periods.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Performs DSME/T program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSME/T program participants.
- Provides educational interventions that utilize primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods.
- Collaboratively develops an individualized follow-up plan with each program participant.
- Evaluates effectiveness of educational services provided by measuring attainment of learning objectives.
- Conducts a follow-up assessment upon completion of DSME/T program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data, educational plan, educational services provided and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.
- Communicates relevant participant information to primary care provider

20% of the time:

- Participates in the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSME/T program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other professional instructional staff.
- Maintain 15 hours of continuing education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

KNOWLEDGE, SKILLS AND ABILITIES:

- In-depth knowledge about current diabetes treatment management.
- Able to lead and effectively manage groups.

- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).

EXPERIENCE/EDUCATION:

- A Registered Nurse, Registered Dietitian, or Pharmacist who is or who is eligible to become a certified diabetes educator.
- Credentialed as a diabetes education specialist or diabetes clinical management specialist preferred.
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.

<Insert Resume of Primary qualified instructor here>

<Insert Copy of Primary Qualified Instructor license>

<Insert relevant training for primary qualified instructor here>

Job Description

TITLE: Group Leader

REPORTS TO: DSME/T Program Coordinator and Primary Qualified Instructor

SUPERVISES: Non-Supervisory Position

POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators (AADE, 2005). Community Health Workers maintain a non- technical role in providing instruction to program participants.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Under the supervision of the program instructor, collects DSME/T program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Under the supervision of the program instructor, collaboratively develops educational goals, learning objectives and a plan for educational content and

teaching methods with DSME/T program participants.

- Provides non-technical educational interventions that utilize primarily interactive, collaborative, skill based training methods and maximizes the use of interactive training methods.
- Collaboratively with the PQI, develops an individualized follow-up plan with each program participant.
- Collaboratively with the PQI, Evaluates effectiveness of services provided by measuring the attainment of learning objectives.
- Collaboratively with the PQI, Conducts a follow-up assessment upon completion of DSME/T program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data of the PQI developed educational plan, educational services provided, and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.

20% of the time:

- Contributes to the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSME/T program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other non-professional instructional staff.
- Maintain 15 hours of continuing education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

KNOWLEDGE, SKILLS AND ABILITIES:

- In-depth knowledge about current diabetes treatment management.
- Able to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).
- Completion of Stanford CDSMP Training (4 days).

EXPERIENCE/EDUCATION:

- Experience working with community based groups and providing outreach to seniors.
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.
- Experience making oral presentations on health topics in community settings.

<Insert Resume of any instructors that will participate as a group leader>

Standard 6:

A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the frame work for the DSME program. Assessed needs of the individual with pre-diabetes or diabetes will determine which of the content areas listed below are to be provided.

Essential Elements Checklist:

- A written curriculum tailored to meet the needs of the target population
- Adopts principles of AADE7 and includes disease content
- Curriculum is kept updated reflecting current evidence and practice guidelines and is culturally appropriate
- Curriculum maximized use of interactive training methods

DSMT Curriculum:

The Eight (8) week DSMT curriculum set forth below is designed to provide each participant with an individual assessment and education plan that has been developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies.

Week 1:

Individual Assessment with Registered Dietitian or Registered Nurse (PQI): Each new participant will undergo a 1:1 in person assessment with either a Registered Dietitian, or Registered Nurse with particular training in diabetes. The assessment will include information about the individual's relevant medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, self- management skills and behaviors, readiness to learn, health literacy

level, physical limitations, family support, and financial status. The current assessment tool is attached hereto and subject to modification as part of our ongoing quality improvement efforts. During this assessment, educational goal/s, and learning objectives and the plan for educational content and method/s will be developed collaboratively between the participant and instructor(s). This plan will include, where appropriate, ongoing assessment with the Registered Dietitian, or Registered Nurse and/or referral to the Stanford Diabetes Self-management program (Standard 7).

During the initial assessment, any additional participant needs that are identified by the participant, in collaboration with the PQI, will be addressed outside of the Stanford Class individually, but will be an integral part of the entire DSMT process. This plan will also include a personalized follow up plan (Standard 8) for ongoing self-management support, which will be developed collaboratively by the participant and instructor (s). The patient's outcomes and goals and the plan for ongoing self-management support will be communicated and documented. These outcomes and goals may be distinct and in addition to the goal or "action plan" participants develop in the Stanford DSMP program as discussed below. The follow-up plan for ongoing self-management support will focus on long-term self-management that occurs after the Stanford DSMP class ends. Also during this assessment, participant is provided a copy of the attached pamphlet entitled, "Healthy Living with Diabetes: A guide for adults 55 and up" published by the American Diabetes Association. PQI reviews relevant information in the pamphlet, consistent with the assessment, and attaches his/her contact information (telephone and email) to the pamphlet with an invitation for participant to contact PQI with any follow up questions or concerns.

For participants with vision limitations, a card magnifier is provided.

In accordance with Standard 9, the PQI will continue discussions with the participant during the eight- week intervention no fewer than twice in an effort to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The assessment and any follow-up documentation will be provided by the PQI to the PCP and the PQI will be available to discuss the assessment and plan with the PCP.

PQI and group leaders will further engage in regular communication with one another during the six week Stanford intervention to ensure that the participant's plan is appropriate and to address any challenges, questions, lack of information, or other support the participant may need from either the PQI, primary care provider or another professional. The PQI will document regularly all communication with group leaders.

Weeks 2, 3, 4, 5, 6 and/or 7:

In accordance with Standard 9, the PQI will continue discussions with the participant during the eight week intervention no fewer than twice during Weeks 2-7: The Stanford DSMP class is the base curriculum for our DSMT service. During this six (6) week workshop, participants will be provided with an array of tools to improve their ability to self-manage their conditions. The Stanford DSMP class is the primary intervention, to fulfill the participant's need for improved diabetes self-management, but will not be the only intervention and will be coupled with the individualized education plan developed collaboratively based on the initial assessment. The Stanford DSMP class is provided by group leaders, under the supervision of the PQI and includes discussion of all relevant AADE diabetes education benchmarks, including but not limited to the following: overview of diabetes, blood glucose monitoring, nutrition, preventing high and low blood sugar, preventing or delaying complications from diabetes, physical activity, dealing with stress, muscle relaxation, reading nutrition labels, depression management, communication with health care providers, medication usage, foot care, working with the health care system, and planning for the future. The program also requires participants to continue to set individualized weekly goals or "action plans" and to provide follow-up for each action plan achieved. For action plans not achieved, participant engages in problem solving activities with the group to brainstorm potential solutions. At the beginning of each week 2-7, the PQI sends a detailed email to the group leaders outlining the anticipated activities for the week, as well as the availability of the PQI before, during or after sessions. Texts of each email are attached hereto in a Word Document entitled "PQI Communications". The PQI remains available to both the Group Leaders and the Participant to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The primary goal is an improvement in the person's self-management behaviors. Outcomes will be compared to quality indicators to assess the effectiveness of the patients' care plan and the education intervention. Both individualized and aggregate outcomes data will be collected and will include, at a minimum, the following: attainment of participant-defined behavior change goal(s) (intermediate outcomes) and at least one post-intermediate or long term health outcome measure. In a collaborative manner the participant and PQI will define the individualized goals. These individual patient outcome measures are used to guide the intervention and improve care for that participant. The aggregate population outcome measures (program outcome measures) are used to guide programmatic services and CQI activities for the DSME and the population it serves.

During this time period, the success of the Stanford DSMP intervention in meeting the participant's defined goals is measured by the participant's ability to set weekly measurable goals and report back on attainment of these weekly goals in a group setting, with peer involvement. Documentation of the attainment of this goal will be class attendance and participation in the weekly goal setting process with the peer group. Other goals outside of improved self-management behaviors will be addressed as part of the individualized plan and will occur outside of the Stanford DSMP, but remain part of the entire DSMT program and will be directed by the PQI in collaboration with the participant. Methods of attaining these other goals are decided by the participant in collaboration with the PQI. Documentation of class participation, weekly goal setting, and individualized assessment will be maintained in the participant's chart.

Week 8:

At the end of the Stanford DSMP intervention, the participant will develop a follow-up plan in a collaborative manner with the PQI. There will be a multidisciplinary approach to completing this process. The multi-disciplinary team works with the participant to develop realistic, individualized goals and an ongoing evaluation plan. The multi-disciplinary team will consist of, at a minimum, the following: PQI, group leaders delivering the Stanford DSMP classes, and participant's primary care provider. Long-term evaluation can include things such as improved HgbA1C values, improved fasting glucose values, improved lipid levels, increased frequency of physical activity, and improved dietary intake. These long-term goals and follow-up should be documented in the participant's record. Resources to support the attainment of these goals will be identified in a collaborative manner. The goals for ongoing self-management, support resources, and ongoing evaluation plan must be communicated to the referring provider. The communication with the referring provider will be documented in the participant's record.

AADE7 Self-Care behaviors

- If participants ask about topics that will not be addressed (such as insulin use, how to use glucometers, etc.), state that they can probably find this information out from different community resources.
- Mention the American Diabetes Association, or their own health care providers. There may also be information in their book, *Living a Healthy Life with Chronic Conditions*.

Chart 2

Workshop Overview						
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6
Overview of self-management and diabetes	Reducing Risk ✓					
Making an action plan	Reducing Risks ✓		✓	✓	✓	✓
Monitoring	Monitoring ✓	✓	✓	✓	✓	✓
Nutrition/Healthy Eating	Healthy Eating ✓		✓	✓		
Feedback/problem-solving	Problem Solving ✓		✓	✓	✓	✓
Preventing low blood sugar	reducing risks ✓					
Preventing complications	reducing risks ✓		✓			
Fitness/exercise	Being Active ✓		✓	✓		
Stress management	Healthy Coping ✓		✓			
Relaxation techniques	Healthy Coping ✓		✓	✓		
Difficult emotions	Healthy Coping ✓			✓		
Monitoring blood sugar	Monitoring ✓			✓		
Depression	Healthy Coping ✓				✓	
Positive thinking	Healthy Coping ✓				✓	
Communication	Healthy Coping ✓				✓	
Medications	Taking medication ✓				✓	
Working with your health care professional	Reducing Risk ✓					✓
Working with the health care system	Reducing Risk ✓					✓
Sick days	Healthy Coping ✓					✓
Skin and foot care	Monitoring ✓					✓
Future plans	Reducing Risk ✓					✓

2. SAY / PARAPHRASE:

- We will be discussing goals that you want to work towards during the next few weeks.
- Later today we will be setting short-term goals, so you may want to start thinking about what you might want to do between now and next week.
- In order to benefit from this workshop, there are certain responsibilities each of us in this group must be willing to do. Let's look at the following guidelines.

(Chart 3 on the next page)

Workshop Overview – Activity	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Overview of self-management and diabetes -Reducing Risk	✓					
Making an action plan -Reducing Risk	✓	✓	✓	✓	✓	✓
Monitoring -Monitoring	✓	✓	✓	✓	✓	✓
Nutrition/Healthy Eating -Healthy Eating	✓	✓	✓	✓		
Feedback/problem-solving -Problem Solving		✓	✓	✓	✓	✓
Preventing low blood sugar -Reducing Risk		✓				
Preventing complications -Reducing Risk			✓			
Fitness/exercise -Being Active			✓	✓		
Stress management -Healthy coping			✓			
Relaxation techniques- -Healthy coping			✓	✓		
Difficult emotions -Healthy coping				✓		
Monitoring blood sugar -Monitoring					✓	
Depression -Healthy coping					✓	
Positive thinking -Healthy coping					✓	
Communication -Healthy coping					✓	
Medication -Taking medication					✓	
Working with healthcare professional -Reducing Risk						✓
Working with healthcare system -Reducing Risk						✓
Sick days -Healthy coping						✓
Skin and foot care -Monitoring						✓
Future plans -Reducing Risk						✓

Standard 7:

An individual assessment and education plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.

Essential Elements Checklist:

- Collaborative participant assessment
- Education process policy
- Plan of care based on assessment and meets the individual's needs
- Integration of AADE7
- Intervention per plan provided and outcomes evaluated
- Collaborative development of education goal, objectives and plan

The Professionally Qualified instructor is responsible for the overall delivery of course content. Each participant will have an initial assessment done by the professional instructor. At this time a customized education plan will be developed. The education plan will identify areas of need that are particular to the condition of the participant.

After the initial assessment, the participant will begin attending the group sessions. The group sessions provide general diabetes information about diabetes that is publicly available and the delivery of this information in the group setting is overseen by the professional instructor and is delivered by the community health workers. The professional instructor is always available to the CHWs and provides additional individualized instruction based on the education plan that was developed at the time of the initial assessment.

Each participant has subsequent individual educational sessions with the professional instructor, during the delivery of the course content. The frequency of the individual educational sessions is based on the clinical needs of the participant. The individual educational sessions provide an opportunity for the instructor to provide detailed clinical content that applies the general diabetes educational material to the specific clinical needs of the participant.

Most of the participants that complete the course will have a minimum of three (3) meetings with the professional instructor on an individual basis. These individualized educational sessions have an objective to deliver individualized instruction to the participant in a one-on-one setting with the professional instructor. However, the number of individualized sessions is

dependent upon the clinical and educational needs of the participant and is at the discretion of the professional instructor that is leading the course.

The CHWs role is the deliver the general diabetes information content, under the supervision of the professional instructor. The general information is then reviewed with the participant in a manner that addresses their specific clinical presentation and educational needs as determined by the professional instructor and the education plan that is completed by the professional instructor.

The Professional instructor and CHWs work in a collaborative manner to address the educational needs of the participant by presenting each person with general diabetes educational content with individualized education sessions that are delivered by the professional instructor on a one-on-one basis. The professional instructor oversees the entire educational process, monitors the delivery of the general diabetes information, and provides individualized instruction based on the needs of the participant and documents the delivery of the educational content in the education plan.

Policy: Development of Individualized Education Plan and Physician Communication

(Standard 7)

An individual assessment and education plan will be developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record. Please see enclosed curriculum.

REFERRAL AND MANAGEMENT

1. Upon referral from their primary care provider or by self-referral, participants enter the program and receive consultation with a PQI. If an individual is a self-referral and does not have a primary care physician, he or she will be referred to a family practice physician in the Hebrew Senior Life system or an appropriate local system. The completion of an outpatient referral form is requested from the physicians, and includes diagnosis, complications, laboratory tests, current diabetes medication management, and other conditions. Participants are asked to complete an initial history, which includes demographics, medical information, nutrition and lifestyle facts and a psychosocial assessment. An appointment is then arranged for participants members to come to one of the diabetes education sites where they will meet individually with a PQI (RD or RN) and, where appropriate will be referred to additional

individual and or group interventions. After each appointment, whether group or individual, the RN and the RD notify the physician of the visit through a progress note form. This form outlines education received, meal plans, activity/exercise plan, and participant's selected behavior change goals. An outcomes and educational objectives sheet is also completed by the second visit by the RN/RD. If phone contact is made with the patient between appointments, a chart note is written on the progress note form, with a copy going to the physician. If oral medication/insulin adjustments are recommended, a letter and physician order form is also sent to the referring physician.

2. The basic education programs for Type 2 Diabetes, whether individually or in a group, consist of an initial consult and follow-up sessions as deemed appropriate. After the completion of the program at 8 weeks, patients are scheduled for follow-up sessions as needed annually or biannually. Follow-up appointment reminders may be provided in the form of a written postcard encouraging patients to come in for annual follow-ups. Phone call follow-ups may also be utilized if patients are unable to come in. Data collection spreadsheets will be used to determine when the patient is due for an annual follow-up appointment.

Various instructional approaches are used throughout individual and/or group sessions. Lecture, discussion, demonstration, return demonstration and educational materials handouts are utilized for all programs. If the patient has medical needs on follow-up that has not been taken care of with the patient's physician, this is addressed at this point. Any interventions are to be documented in the patient's chart in the progress notes with copies to the physician. The RD will also meet with each individual patient at the scheduled session times and review their meal plans, and various other aspects of nutritional counseling. If the participant fails to keep a follow-up appointment, he or she will be contacted with a letter indicating the appointment was missed and that continual follow-up is important in the self-management of diabetes. The participant is encouraged to reschedule. If the participant fails to do this within four weeks, the diabetes educator will call the participant to discuss achievement of behavior change goals and answer any questions the participant might have or address any difficulties in coming back for follow-up visits. After unsuccessful attempts to achieve compliance with the education plan by the diabetes educator, the participant is then considered "lost to follow-up" and it should be noted in the patient's record. A letter is also sent to the referring physician detailing each patient contact.

DSMT Intake Form

Section 1: PARTICIPANT INFORMATION:

Name _____

Address: _____

Home phone: _____ Cell/other phone: _____

Best time to call: _____ Birth Date: _____ Male Female

Participant's primary language: _____

Race/ethnicity: _____ Latino/Latina

Workshop Site Assigned: _____

Workshop Start Date: _____

Class Zero Intake Site: _____

Section 2: BILLING INFORMATION:

Medicare number: _____

Supplement/Advantage plan: _____

Prior diabetic education: Yes No

If yes, what was the class? _____

Where? _____ When? _____ (within a year)

Is Medication Nutrition Therapy recommended by your physician? Yes___ No___

Referring Physician: _____

Address: _____

City/State: _____

Phone: _____ Fax: _____

Referral Source: _____

Section 3: MEDICAL INFORMATION:

Type of Diabetes_____ Age____ Ht_____ Wt_____ BMI____

Most Recent Fasting Blood Glucose (date/result): _____

Most Recent HgbA1c, if available (date/result):_____

Most Recent LDL-C, if available (date/result): _____

1. Are you taking oral medications to treat your diabetes? Yes No

Have you ever taken oral medication to treat your diabetes? Yes No

Name(s) of medication and dosage(s): _____

2. Are you currently taking insulin to control your diabetes? Yes No

Have you ever taken insulin to control your diabetes? Yes No

Name(s) of medication and dosage(s): _____

3. Have you taken any steroids such as prednisone which impacted your diabetes? Yes No

How did it impact your diabetes?_____

4. How often do you measure your blood sugar level?

Never Rarely 1-3 times per month 1 – 3 times per week;

4 – 6 times per week 1-2 times per day 3+ times per day

If you keep a log of your blood sugar level what is your usually range? _____

5. How often are you physically active (e.g., walking, exercise?)

Never Rarely 1–3 times per month Once a week,

Two or more times per week Daily

Please share examples of the types of physically activity

6. Do you follow a specific meal plan? Yes No

If yes, what is your meal plan?

7. Do you use tobacco? Yes___ No___

If yes, what type? Cigarettes_____ Chew_____ Snuff___ Pipe_____ Cigar_____

If you stopped smoking, when was your last use?_____

8. Do you have pain from your diabetes or any other condition? Yes__No__

If yes, describe how this affects you_____

9. Have you been in the emergency room or hospitalized for a condition related to your diabetes in the last 12 months? Yes No

Details:

8. Have you had your eyes checked by a specialist in the last 12 months? Yes No

Results: _____

9. Have you had a foot examination in the last 12 months? Yes No

Results: _____

10. Do you have high blood pressure? Yes No

Name(s) of medication and dosage(s):

11. Do you have pain from your diabetes or any other condition?

If yes, please briefly describe how this affects you: _____

Section 4 - SOCIAL FACTORS

Family Environment and Support:

1. Do you live alone? Yes If no how many people live with you _____
2. Are there relatives or others caring helping you on a regular basis? Yes No
3. Do you prepare your own meals? Yes If no, who prepares them for you?

4. Do you have support from family or others to deal with your diabetes? Yes No
5. Other psychosocial factors impacting diabetes management

Cultural Factors:

1. Is there anything specific to your culture that you think influences your ability to manage your diabetes?

2. "Do your cultural beliefs influence your ability to manage your diabetes?"

3. Are there certain types of foods important to your culture?

4. Does having diabetes or having a serious illness create culture stress?

5. Are there any religious or cultural factors that affect how you eat?

6. Emotional symptoms associated with diabetes (stress, anxiety, depression): “How do you feel about having diabetes?”

Okay	Anxious	Angry
Afraid	Sad	Depressed
Overwhelmed	“Unsure of what to do, alone”	
Additional Comments		

Other cultural factors that impact the management of diabetes _____

Section 5 -- Individual Educational Plan:

Paraphrase: The Take Charge of Your Diabetes workshop meets for 6 weeks range of topics. Participants learn in the workshop to work on their own goals related to managing their diabetes. Now, we’re going to create an individual educational plan for you so that you can get the most out of the workshop.

1. Would you like help with any of the following things (Check as many as applicable?)

- Eating healthier meals/following a healthier meal pattern
- Increase my level of physical activity/exercise
- Increase my monitoring of blood sugar
- Increase the support from family or friends
- Set an achievable weight lose goals
- Increase my understanding of diabetes
- Improve my ability to manage stress and/or emotions that effect my diabetes
- Improve my ability to manage my depression
- Increase my ability to work with complications from diabetes (such as medical issues like neuropathy, vision problems, low energy, mobility problems)

___ Increase my ability to use the medical system effectively (for example: better communication with doctors)

___ Increase my ability to give myself injections at appropriate/regular time

2. Identify the top three problems or issues which impact your ability to managing your diabetes: (for example, blood sugar fluctuations; poor diet; depression; or other factors)

3. Identify barriers to managing your diabetes successfully: (physical barriers; language; literacy; appropriateness for self-management)

INDIVIDUAL PROBLEMS/NEEDS/GOALS:

4. Participant’s readiness for change (Pre-contemplative; contemplative; preparation; action; maintenance; relapse)

Participant’s initial goals:

ACCOMMODATION FOR PARTICIPANT’S INDIVIDUAL EDUCATIONAL NEEDS:

Visual/Learning/Mobility/other disability that needs an accommodation:

Summary of Plan

Instructor’s Signature_(RN, RD, PharmD, RPh)_____

Date_____

Section 5: Individual and Collaborative Education Plan

Introduction: *The [Fill in Name of Workshop] Diabetes workshop will meet for 6 weeks and cover a range of topics. Participants will learn about nutrition, exercise, managing stress, communicating with health professionals, managing blood glucose, and skills for goal setting and problem solving. Participants typically use the workshop to work on their own goals related to managing their diabetes.*

If participant is appropriate for and willing to attend the workshop, PQI adds: *Now we're going to create an individual education plan for you so that you can get the most out of the workshop.*

1. Would you like help with any of the following things? (Circle as many as applicable)

- a. Eating healthier meals / following a healthier meal pattern
- b. Increasing / being consistent with exercise
- c. Increasing monitoring of blood sugar
- d. Giving injections at appropriate / regular times
- e. Managing medication usage
- f. Increasing support from family and friends
- g. Losing weight
- h. Understanding more about diabetes
- i. Working with stress and/or other difficult emotions from diabetes
- j. Working with complications from diabetes (medical issues such as neuropathy, vision, low energy, foot, mobility)
- k. Using the medical system with more success and effectiveness
- l. Improving Communication Skills

2. Participant's current problems or issues with managing diabetes: (blood sugar fluctuations, poor diet, depression, other complications)

3. Barriers to learning / coping successfully with diabetes (physical barriers, language, literacy, appropriateness for self-management):

At each follow-up visit, the participant meets with a RD or other diabetes educator who assesses the participant's current health status, knowledge, skills, attitudes and self-care behaviors. The blood glucose results are reviewed; quality control checks are done on the participant's blood glucose meters along with assessment of the patient's ability to perform their own blood glucose testing with their blood glucose meter. At this time behavior change goals are evaluated and, if needed, new goals are developed. The patient is given a copy of his behavior change goals. The RD or other diabetes educator also evaluates the patient's continuity of care to make sure all areas are being addressed appropriately. Outcomes are also measured by tracking the following clinical measures: Participant's HGB A1c testing results, Frequency of pre-and post-program participants obtaining an annual dilated eye exam, and Frequency of participants that obtain required foot screening.

The appropriate forms for eye care and foot care are filled out and sent to the referring physician. If the patient has medical needs on follow-up that have not been taken care of with the patient's referring physician, this is addressed at this point. Any interventions are to be documented in the patient's chart with a progress note with copies submitted to the referring physician. The RD will also meet with the patient at the scheduled session times and review their meal plans, and various other aspects of nutritional counseling. If the participant fails to keep a follow-up appointment, he or she will be contacted with a letter indicating that the appointment was missed. The letter will highlight the importance of adhering to the recommended follow-up schedule as this is an integral part of the diabetes self-management learning process. The participant is encouraged to reschedule any missed appointments. If the participant fails to comply with the follow-up schedule within four weeks, the diabetes educator will call the participant to discuss achievement of behavior change goals and answer any questions the participant might have or address any difficulties in coming back for follow-up visits. After two phone calls from the diabetes educator, the participant is then considered "lost to follow-up" and it should be noted in the patient's record. A letter is also sent to the referring physician documenting all care provided and attempts made to adhere to assist the participant with maintaining the follow-up schedule.

The follow up plan form is attached next:

Name: _____

Date: _____

Follow Up PlanRecommendations: Dentist Foot Doctor Eye Doctor Quit Smoking Dietitian FluVaccination Pneumonia Vaccination Diabetes ID Public Health/Visiting Nurse Support Group _____ Social Worker Other _____ A1c Cholesterol HDL LDL Triglycerides Microalbuminuria

Other _____

Behavior Change Goal:

Specific behavior to be changed _____

How will you change the behavior? _____

How will the behavior change improve your health or quality of life?

Signature _____

Follow Up Assessment

How successful are you with your behavior change goal?

 Never Sometimes Usually Always

If you are not successful, why not? _____

Did you follow through with recommendations? (see above) Yes No

If not, why not? _____

How is your current health? Poor Fair Good Excellent

How frequently do you check your blood sugar? _____

What does it range? _____ Do you like the blood sugars you're seeing? _____

How often do you follow your meal plan? N/A Rarely or never Occasionally Often Always

How often do you do a self foot exam? _____ How often are you physically active? _____

How well do you feel you are able to do the following?

Oral medication/Insulin use: N/A Poor Fair Good ExcellentBlood Sugar meter use: N/A Poor Fair Good ExcellentFoot Exam: N/A Poor Fair Good ExcellentHow sure are you that you can manage diabetes? Not sure Somewhat sure Very sure

Date(s) of any hospital stays for diabetes since class: _____

My diabetes is a(n): Disaster Burden Problem Challenge Opportunity Other

Write one example of how you used what you learned about diabetes in your class: _____

What has changed in your diabetes care since the classes? _____

FOR INSTRUCTIONAL STAFF ONLY

Additional interventions provided/follow-up needed _____

 See Education Record: _____

Signature: _____

Standard 9:

The DSME entity will measure attainment of patient defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.

Essential Elements Checklist:

- Individual and aggregate achievement of behavior change goals
- Policy required that outcomes data include appropriate measures
- Reason for chose of outcome measures
- Effectiveness of interventions is based on data

Performance Measurement Plan/QI Plan (Standard 9):

The Diabetes Self-Management Training (DSMT) program will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of educational interventions. The performance measurement plan will commence upon the initial assessment between patient and PQI and may be augmented and modified during the 8-week intervention based on collaborative input from patient, PQI, and the multidisciplinary team.

Patient-defined Goals and Patient Outcomes

1. Data Collection

a. Individualized Data

- i. Participant-defined behavior change will be measured using individualized spreadsheets based on the AADE7 self-care behavior framework. This self-care framework is based upon the belief that behavior change can be most effectively achieved using the following 7 behaviors as a framework: healthy eating, being active, monitoring, taking medication, problem solving, reducing risks and healthy coping. SMART goal sheets will be utilized for patient motivation and program documentation. The individualized spreadsheets will be linked to a global spreadsheet that tracks overall participant behavior change. The global database will be used to identify CQI measures and will be reported to the advisory committee at least annually.
- ii. Long-term health outcomes measurement will be determined by guidance of the Diabetes Advisory Group and tracked individualized spreadsheets. Among these long-term health outcomes will be the measurement of

mean hemoglobin A1C decrease and data collected will include, at a minimum:

- Weight
- Hemoglobin A1C
- Medication Compliance
- Age
- BMI

Each of the long-term outcomes measures will be stored in a database that captures data on each participant. The resulting data will provide the program coordinator with a data set to perform CQI. The results of this program data analysis will be reported to the advisory committee at least annually by the program coordinator.

b. Aggregate Data

- i. Participant-defined behavior change will be measured using a database, based on the AADE7 self-care behavior framework.
- ii. At least one long-term health outcomes measurement will be determined by guidance of the Diabetes Advisory Group based on influence of Diabetes Self-Management Education Core Outcomes Measures," Mulcahy, et al, Diabetes Educator, September/October 2003) and tracked using the participant outcome measures database.

2. Frequency of Measurement

- a. Individual self-care behavior change data and selected health outcomes will be documented in the database at each patient encounter
- b. Individual self-care behavior change data will guide the education/training process. Program staff will have "read-only" access to the database to obtain participant level data and to run reports to determine trends.

3. Evaluation

Aggregate data will guide the Diabetes Advisory Group in determining CQI projects, annually. The Advisory group will define the outcome measures that they want to review and will submit these to the program coordinator to complete. The Advisory group will provide quality benchmarks for the program. Lastly, the Advisory group will work with the program coordinator to determine interventions to improve program quality benchmarks.

Diabetes Self-Management Support Plan

Name: _____

Date: _____

This is your Diabetes Self-Management Support Plan. You are being asked to commit to activities that will give you access to educational or motivational support in managing your diabetes.

Choose one or more activities from the options below.

- Subscribe to a diabetes magazine
 - Diabetes Forecast (www.diabetes.org)
 - Diabetes Self-management (www.diabetesselfmanagement.com)
 - Diabetes Health (www.diabeteshealth.com)

- Access diabetes informational websites
 - [American Association of Diabetes Educators](#)
 - [American Diabetes Association](#)
 - [Diabetes Life](#)
 - [American Heart Association](#)
 - [American Dietetic Association](#)
 - [National Diabetes Education Program](#)
 - [Better Choices, Better Health Online Workshop](#)

- Visit with a Registered Dietitian
- Join a fitness center, gym or YMCA
- Meet with a Personal Fitness Trainer
- Contact your health insurance company to ask about their Diabetes Management Programs
- Join a weight loss program
- Attend a healthy cooking class
- Other _____

Standard 10:

The DSME entity will measure the effectiveness of the education program and determine opportunities for improvement using a written CQI plan that describes and documents a systematic review of the programs' process and outcome data.

Essential Elements Checklist:

- Systematic process for implementing a CQI process/plan
- Program improvement, if applicable, is based on data deficiencies that have been analyzed
- CQI results are shared with the advisory group annually

CQI Plan (Standard 10)

The DSMT program will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement (CQI) plan that describes and documents a systematic review of the entities' process and outcome data. Please see sample CQI measure below:

Continuous Quality Improvement Process

Identified Problem: A number of patients with Type 2 diabetes are referred to our DSME Program without having a recent HgbA1c.

PLAN:

Improve the percentage of patients referred who have a current (within the past 3 months) Hgb Alc.

DO:

- Each patient enrolled in classes or individual track will be entered into participant tracking spreadsheet. At the end of each quarter, a report will be compiled of the percentage of patients enrolled last quarter who have recent Hgb Alc values on enrollment.
- Participants will be aggregated by their referring provider.
- Referring providers that have a high number of clients without a current Hgb Alc will be informed of the number of clients that report not having a HgbAlc.
- Information will be provided to the referring provider's staff of the importance of obtaining HgbAlcs at required intervals and literature will be provided that can go in the provider's waiting room for patients.

- Identify barriers to drawing and reporting HgbA1c values by discussion with referring offices and with participants that do not have a current HgbA1c.
- Initiate a plan to increase the percentage of patients who are referred with a recent HgbA1c.

STUDY:

Monitor percentage of patients who are referred with a recent HgbA1c every quarter. Analyze the effect of the plan to increase the percentage of patients who are referred with a recent HgbA1c. Utilize spreadsheet to track data.

ACT:

Use strategies that are effective and create new ones as needed. Report results to Quality and Risk Management, and the advisory committee annually.

Repeat cycle.