ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

Program ID#: 123456

Program Name: ABC Pharmacy

TABLE OF CONTENTS: CURRENT ACCREDITATION CYCLE: 2022 – 2026

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

STANDARD 1: SUPPORT FOR DSMES SERVICES

REQUIRED DOCUMENTS:	PAGE #
☒ Letter of support from sponsor organization dated within 6 months of initial and/or renewal application	/

Support for DSMES Services

[redacted]

[redacted]

Diabetes Education Accreditation Program (DEAP)
125 S. Wacker Dr.
Ste 600
Chicago, IL 60606

March 11, 2022

To Whom It May Concern,

This letter is in recognition that [redacted], a pharmacist employee, is an employee in good standing and is more than capable of rendering and providing diabetes services to [redacted] patients. As the owner of [redacted] **Pharmacy**, I plan to support this program with the needed financial means and administrative support in order to ensure success of this endeavor.

Please feel free to contact me if you have any questions regarding this matter. Thank you for your time and consideration.

Regards,

X

[redacted], *RPh*
Owner, [redacted] **Pharmacy**

1

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

STANDARD 2: POPULATION AND SERVICE ASSESSMENT

REQUIRED DOCUMENTS:	PAGE #
☒ Description of the diabetes related demographics and additional considerations including SDOH and other barriers that impact the target population	2-3

[redacted] Pharmacy Diabetes Education Center

Access and Target Population

Geography of [redacted]

- [redacted] is a semi-urban, semi-suburban town in [redacted] with a total population of 8.27K people **(Source: datausa.io, 2019).**

Demographics of [redacted]

- The largest ethnic group in [redacted] is **White**, consisting of **84.19%** of the population and is primarily English-speaking. **(Source: datausa.io)**
  - Other ethnic groups include Asian (Non-Hispanic) (5.13%), Black or African American (Non-Hispanic) (3.66%), and Other (Hispanic) (2.79%).
- "In 2019, the median age of all people in [redacted] was **44.3** years old. "**(Source: datausa.io)**
- A majority of residents in [redacted] (37.17%) have attained a **high-school graduate education** level. **(Source: worldpopulationreview.com)**
- In addition to diabetes rate, [redacted] also has a **medium-high adult obesity rate** of **25.7%** (Highest obesity rate in the state: 39% in [redacted] County). **(Source: datausa.io)**

Diabetes and Data Trends for [redacted] USA:

- [redacted] County where our facility is located has a **medium-high** diabetes rate of **10.9%**. (Highest rate in the state: 15.6% in [redacted] County). **(Source: datausa.io)**

Target Population for Diabetes Education:

- "**94.9%** of the population of [redacted] has health coverage, with 57.4% on employee plans, 7.38% on Medicaid, 16.3% on Medicare, 13.3% on non-group plans, and 0.556% on military or VA plans." **(Source: datausa.io)**
- The most common first-listed diagnosis and reason for hospitalization in adults with diabetes in [redacted] was **diabetic ketoacidosis**, according to CDC data from 2013.
  - A DSME program such as can directly benefit this population early in a diagnosis of diabetes by teaching appropriate self-management strategies and prevent subsequent hospitalization.

Expected Program Volume: 20 or less participants monthly

Setting Descriptors:

In-person diabetes education will take place at the [redacted], which adjoins the same space occupied by [redacted]. More specifically:

- In-person group classes will be held in the Center's large conference room.
- In-person individual sessions will be held in the Center's smaller patient rooms.

Telehealth education via a HIPAA-compliant web-based platform (eg. Zoom) will be used alternatively if desired by the patient.

Community Site: not applicable

Barriers to Access in Target Population & Solutions:

- **Barrier 1:** Residents in [redacted] have a majority *high-school* education level. This also may reflect a lower health literacy level, which must be accounted for when providing diabetes education.
- **Solution 1:** In addition to using simple, real-life examples to reinforce concepts – our program will aim to provide **different modes of information** to strengthen patient understanding. Modes of information we will supplement our educational sessions with consist of: **visual** (provided via printed brochures/ handouts/slideshows with images) and **written** (eg. worksheets that may assist patients with more complex numerical tasks such as carbohydrate counting). Supplemental modes of information provided can be tailored to individual patient preference and the learning style that is most effective for them.

- **Barrier 2:** Limited accessibility to in-person care during COVID-19 pandemic, including in our area [redacted]
- **Solution 2:** Patients will be given the option to attend classes through a secure, HIPAA-compliant telehealth platform for individual appointments/Zoom for group classes if they are unable or feel unsafe coming to our location for in-person education.

- **Barrier 3:** Lack of access to primary care due to COVID-19. According to census data from datausa.io, **12.8%** of adults in New Jersey have not seen a primary care doctor in 12 months, due to COVID-19.
- **Solution 3:** [redacted] Pharmacy is adjoined at the same address by [redacted] (which has been performing large volumes of COVID-19 testing). The Wellness Center is overseen by a medical director and staffed by a nurse practitioner once a week for adult internal medicine patients and a pediatrician twice a week. This shared location is a perfect segway for our pharmacy patient stream to **reconnect with primary care** and through provider referral, have access to our pharmacy's diabetes education program.

Standard 3.1

[redacted]

Diabetes Education Accreditation Program (DEAP)
125 S. Wacker Dr.
Ste 600
Chicago, IL 60606
03/10/2022

To Whom It May Concern,

I attest that our DSMES Team members are licensed pharmacists with training and experience pertinent to DSMES. Please see copies of their license and Continuing Education pertinent to Diabetes Education as part of our application. I attest that all instructors will maintain their professional license in good standing, in addition to renewing their CE training annually.

Regards,

[redacted] *Pharm.D. RPh*

Program Quality Coordinator

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

STANDARD 3: DSMES TEAM

REQUIRED DOCUMENTS:	**PAGE #**
☒ Description of the Quality Coordinator's role and responsibilities within and outside the DSMES team	4-6
☒ Credentialed DSMES team members provide current licensure, registration and/or certification. (RDN, RN, Pharmacist, CDCES, BC-ADM, etc.)	7
☒ Evidence of at least 15 hours of diabetes-related continuing education each year for all DSMES team members OR evidence of current/unexpired CDCES or BC-ADM credential	8-10
☐ Evidence that Diabetes Community Care Coordinator has the training and/or experience related to their specific role on the team. (If applicable and involved in direct delivery of DSMES)	

Standard 3.2

Instructional Staff Job Responsibilities & Mechanisms for meeting needs outside of scope of practice

Instructional Staff: [redacted] **PharmD**

Policies and Procedures Applicable to Standard 5:

Pharmacy instructors will provide DSME and diabetes self-management support (DSMS). The instructor responsible for designing and planning DSME and DSMS will be a pharmacist with training and experience pertinent to DSME with certification in diabetes care and education.

Job Descriptions: Primary Qualified Instructors (PQI)

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

REPORTS TO:

- ***DSME/T Program Coordinator:*** [redacted] **PharmD**
- ***Owner:*** [redacted] **RPh**
- ***S*** [redacted] ***e***

SUPERVISES: All diabetes educators named in the organizational chart in Standard 1. Including, but not limiting, all educating pharmacists, educating healthcare professionals, and scheduling techs and billing coordinators.

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.

DUTIES AND RESPONSIBILITIES:

100% (Instruction of program participants):

• Performs DSME/T program participant assessment data, 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.

• 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

• 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 performance to identify areas of strength and area for improvement and to develop a plan for improvement and growth.

• Participates in peer review process to evaluate performance of other professional instructional staff.

• Maintains 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.

• Ability to lead and effectively manage groups.

• Ability to develop a collaborative, therapeutic alliance with individuals.

• Basic computer skills (use of Internet and e-mail).

Standard 3.3

THIS DOCUMENT IS PRINTED ON WATERMARKED PAPER, WITH A MULTI-COLORED BACKGROUND AND MULTIPLE SECURITY FEATURES. PLEASE VERIFY AUTHENTICITY.

State Of New Jersey
New Jersey Office of the Attorney General
Division of Consumer Affairs

THIS IS TO CERTIFY THAT THE
Board of Pharmacy

HAS LICENSED

[redacted]

09/29/2021 TO 04/30/2023
VALID

[redacted]
LICENSE/REGISTRATION/CERTIFICATION #

[redacted]
Signature of Licensee/Registrant/Certificate Holder

ACTING DIRECTOR

Standard 3.4

CPE Monitor Activity Transcript

Participant Name: [redacted]
NABP e-Profile ID:
CPE Activity Date Range: 03/14/2020 to 03/14/2022
Total CPE Hours Earned: 46.75

Recorded CPE activity for the period of 03/14/2020 to 03/14/2022 . Please allow 35 days for the CPE Provider to process your CPE and submit it through the CPE Monitor System. If it has been more than 35 days since you submitted the necessary information for CPE credit, please contact the CPE Provider.

							ACPE/Non-ACPE Credi	
Activity Date	**Activity #**	**Credit Type**	**Source**	**Title**	**Topic**	**Provider**	**Live Hours**	**Hom Hour**
3/8/2022	0207-0000-22-301-H04-P	ACPE	ACPE	Implementing a Social Determinants of Health Program in Community Pharmacy	General Pharmacy Topics	National Community Pharmacists Association	0.00	1.00
3/7/2022	0798-0000-20-093-H01-P	ACPE	ACPE	Diabetes Management A to Z	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
3/7/2022	0798-0000-20-098-H04-P	ACPE	ACPE	Mens Health- Navigating Andropause through Lifestyle and Functional Medicine	General Pharmacy Topics	PharmCon	0.00	1.50
3/7/2022	0798-0000-20-157-H01-P	ACPE	ACPE	GLP-1 Agonists and SGLT2 Inhibitors: Game Changers for Type 2 Diabetes Treatment	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
3/7/2022	0798-0000-20-178-H01-P	ACPE	ACPE	Effective Use of Morbidity- and Mortality-Reducing Agents in Heart Failure	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.25
3/7/2022	0798-0000-20-278-H01-P	ACPE	ACPE	Sugar Youre Going Down - Continuous Glucose Monitoring in the Management of Diabetes	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.50
3/7/2022	0798-0000-20-305-H01-P	ACPE	ACPE	Weighing in on the Obesity Crisis: A Pharmacists Guide to Weight Loss Management	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.25
3/7/2022	0798-0000-21-133-H01-P	ACPE	ACPE	Weighing Our Options: Clinical Implications of Obesity and Pharmacotherapy	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.25

3/7/2022	0798-0000-21-134-H01-P	ACPE	ACPE	Beyond the Classroom: Diabetes Management	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
3/7/2022	0798-0000-21-154-H01-P	ACPE	ACPE	Potential Hazards of Improper Insulin Use and Storage	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
3/1/2022	0798-0000-19-100-H01-P	ACPE	ACPE	Treatment Options in Caring for Older Patients with Diabetes	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.50
1/31/2022	0798-0000-19-181-H01-P	ACPE	ACPE	Cardiac benefits in Diabetes Therapy: Comparing SGLT2 Inhibitors and GLP-1 Agonists	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
1/25/2022	0798-0000-21-094-H01-P	ACPE	ACPE	Herbal and Natural Therapies in Patients with Diabetes	Disease State Mgmt/Drug Therapy	PharmCon	0.00	1.00
1/21/2022	JA4008193-0000-21-054-H01-P	ACPE	ACPE	MDTW Module 1: Diabetes Technology Today: An Overview of the Latest Devices to Help People with Diabetes Optimize Glycemic Management and Improve Outcomes	Disease State Mgmt/Drug Therapy	American Diabetes Association	0.00	1.00
1/20/2022	JA4008193-0000-21-067-H01-P	IPCE	ACPE	Highlights of the 2022 Standards of Care	Disease State Mgmt/Drug Therapy	American Diabetes Association	0.00	0.50
1/16/2022	0036-9999-21-010-H01-P	ACPE	ACPE	Pharmacists on the Frontline of COVID-19: From Testing to Treatment and Prevention	Disease State Mgmt/Drug Therapy	Oregon State University	0.00	1.00
1/12/2022	0202-0000-21-355-H06-P	ACPE	ACPE	Monoclonal Antibodies: Assessment and Administration of COVID-19 Therapy	Immunization Related	American Pharmacists Association	0.00	1.00
10/9/2021	0112-0000-21-112-B04-P	ACPE	ACPE	Pharmacy-based Point-of-Care Testing Certificate Program	General Pharmacy Topics	Michigan Pharmacists Association	4.00	16.00
10/8/2021	0207-0000-20-005-L01-P	ACPE	ACPE	Creating Health: Pharmacist-Led Lifestyle and Weight Management	Disease State Mgmt/Drug Therapy	National Community Pharmacists Association	8.00	0.00

Disclaimer:
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STANDARD 4: DELIVERY AND DESIGN OF DSMES SERVICES

REQUIRED DOCUMENTS:	PAGE #
☑ Evidence that Quality Coordinator and team has access to - and is familiar with - a published and up to date curriculum applicable to their target population. Attestation that QC and all team members have reviewed for content and application to current organizational practices.	11-12
☒ New applicants will include an overview of the DSMES services that includes a description of the modes of delivery that are offered (in person, virtual, telephone, group, one on one), the types of sessions offered in each mode (Type 1, Type 2, Gestational, etc) and a brief description of how interaction, discussion, and individual questions are addressed in each mode of delivery. Programs who have renewed their accreditation will also maintain evidence that the DSMES team has reviewed overall service offerings each year.	13

Standard 4.1

Association of Diabetes Care & Education Specialists

125 S. Wacker Dr. Suite 600
Chicago, IL 60606

Phone: (312) 601-4800

Invoice No. [redacted]

INVOICE

Sold To: [redacted]

Ship To: [redacted]

Account No.	Purchase Order No.	Order Date	Order Number	Terms	Invoice Date
[redacted]		03/08/2022	[redacted]		03/08/2022

Qty	Item Code	Description	Unit Price	Extended Price
1	E996	eBook: ADCES Diabetes Education Curriculum: A Guide to Successful Self-Management, 3rd Edition	$130.00	$130.00

Line item Total	Shipping	Tax	Subtotal	Amount Received	Amount Due
$130.00	$0.00	$0.00	$130.00	$130.00	$0.00

03/10/2022 02:48:14 PM

11

[redacted]

[redacted]

Diabetes Education Accreditation Program (DEAP)
125 S. Wacker Dr.
Ste 600
Chicago, IL 60606

To Whom It May Concern,

I attest that as DSMES Quality Coordinator, I have reviewed curriculum content and understand how to apply it to our DSMES program. I further attest that all future team members will review the curriculum and understand its content.

Regards,

[redacted]

[redacted], *Pharm.D. RPh*

Program Quality Coordinator

Pharmacy Diabetes Education Center

Support for DSMES Services

The Pharmacy Diabetes Self-Management Education program will primarily take place at the W[redacted], which is located at the same physical address as the pharmacy and has small patient rooms and a large conference room to accommodate individual and group education classes. Classes will also be accessible through a video conferencing platform such as Zoom for patients who opt in and prefer to participate in classes virtually.

Our main referral stream will be through [redacted]er's medical director, Dr. and her internal medicine practice, The Institute for Medicine and Aesthetics which sees patients at [redacted]r on a regular basis. Currently, we have a nurse practitioner onsite at [redacted]r once a week who sees adult internal medicine patients and will refer eligible patients to our program. We also plan to advertise our diabetes self-management education program to our local physicians of diabetic patients at Pharmacy. Other referral avenues include advertising directly to patients of Pharmacy and of our three other mutually-owned pharmacy locations: Pharmacy, Pharmacy, and The Pharmacy at.

STANDARD 5: PERSON-CENTERED DSMES

REQUIRED DOCUMENTS:	PAGE #
☒ Description of how the assessment process is administered and informs a collaborative person-centered plan for the DSMES intervention. Include how the participant is involved throughout the DSMES plan and overall intervention.	14-17
☒ Provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record. ☒ DSMES Assessment ☒ DSMES Plan ☒ Each DSMES Visit including date/time and topic areas covered with plan for follow up ☒ Behavior Goal (ADCES7) and progress ☒ Outcomes of intervention communicated to referring physician/qualified healthcare professional	18-35

Standard 5.1

DIABETES SELF-MANAGEMENT EDUCATION ASSESSMENT

Patient Information: [redacted]

Patient's Last Name **First Name** **Middle Name**

Date of Birth [redacted] **Gender:** ☒ Male ☐ Female

[redacted]

Street Address **City** **State** **Zip Code**

[redacted]

Email Address

Primary Language: ☒ English ☐ Spanish ☐ Other: _____

Ethnicity: ☐ Hispanic ☒ Non-Hispanic

[redacted]

Referring Provider: [redacted]

Prior Diabetes Education: ☒ Yes ☐ No If yes, please specify _____

Family Environment and Support:

Do you live alone? ☐ Yes ☒ No If no, how many people live with you? _____

Who is your primary caregiver if not self? n/a - caregiver is self.

Do you prepare your own meals? ☒ Yes ☐ No If no, who does? _____

Do you have support from family or others to deal with your diabetes? ☒ Yes ☐ No

Other psychosocial factors impacting diabetes management: (lack of time)

- Work schedule (meal prep/planning issues)
- Need to study w/ free time - pharmacy intern preparing for NAPLEX.
- Meal planning trouble w/ time
- Access to care/healthy food
- Time to exercise
- Issues w/ insurance approving meds

(Ideal - 6/7 d healthy eating, 1/7 - cheat day Situation)

14

DIABETES SELF-MANAGEMENT EDUCATION ASSESSMENT

Medical Information:

Type of Diabetes: T2DM **Age:** 28 **Height:** 5'11" **Weight:** 205

Medication Allergies: n/a NKA

Food Allergies: n/a NKA

Environmental Allergies: NKA

Exam Results:

Labs

Labs-

Test	Result	Date
HgbA1C	~~7779~~ 7.9	3/1/22
Fasting Blood Glucose	173	3/8/22
LDL-C	154	3/1/22
	Yes	**No**
Annual Foot Exam		X
Annual Eye Exam	X	

	Yes	No
Are you currently taking oral medications for diabetes?		X
If no, Have you ever taken oral medications to control your diabetes?	X	
Are you taking insulin to control your diabetes?	X	
If no, Have you ever taken insulin to control your diabetes?	n/a	
Have you ever taken steroids, such as prednisone to control your diabetes?	X	

How often do you measure your blood sugar?	Continuously measured (Dexcom)
What does your blood sugar usually range?	120-220'
How often are physically active on average?	very rarely
What are some examples of physical activity you enjoy?	Soccer
Do you follow a meal plan? If yes, describe your meal plan:	NO
Do you currently smoke? Yes or No What do you smoke? Vape How often? Sometimes	
Do you drink alcohol? Yes or No How much do you drink and how often?	
Do you have High Blood Pressure? Yes or No (109/71 Current) (150/88 two d ago)	
Do you have pain from your diabetes? Yes or No If yes, please describe the pain: Just pain - chronic neck/back muscle (6-6-5 severity up to 8)	

cigarettes - used to smoke mildly. (quit 3yrs ago)

15

DIABETES SELF-MANAGEMENT EDUCATION ASSESSMENT

Cultural Factors:

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

Other than time/work schedule – no.

Do your cultural beliefs influence your ability to manage your diabetes?

No.

Are there certain types of foods important to your culture? no

Does having diabetes or having a serious illness cause you stress? Yes.

Are there any religious or cultural factors that affect how you eat? no

Maybe social.

How do you feel about having diabetes (for example, OK, anxious, depressed or overwhelmed)?

Sad hungry

Other cultural factors that impact the management of your diabetes:

Individual Educational Plan:

Would you like help with any of the following? (Check all that apply)

- ☑ Communicate better with my doctor
- ☑ Eating healthier/following meal plan
- ☐ Giving myself injections correctly
- ☐ Increase blood sugar monitoring
- ☐ Increase my exercise/physical activity
- ☐ Increase support from family/friends
- ☐ Manage my depression
- ☑ Setting achievable weight loss goals
- ☐ Treat complications from diabetes
- ☐ Understanding my diabetes

Identify the top three (3) problems that you struggle with related to your diabetes:

Carb Craving
Carb Counting
Time management relating to healthy meal prep

Identify barriers to managing your diabetes successfully:

Busy life style not enough time.
Not enough time to go to gym/other exercise
~~Insurance Denying~~ my sensors/~~transmitter~~ for high copays CGM Sensor/Transmitter and Ozempic.

16

DIABETES SELF-MANAGEMENT EDUCATION ASSESSMENT

Medication List: (can attach patient medication profile)

Medication	Dose	Frequency	Ordering Provider
Humalog (~~Dexcom Sensor~~ Device)	Via Insulin pump		
Ozempic	0.5 mg	Q week	
Dexcom Sensor (~~Insertion~~)/Transmitter			
Lisinopril	5 mg	QD	
Lantus (in case of pump failure)	→ (if needed)		
Tandem TSlim X2			

PA ← $300/mo PA

← Insulin pump device

Individual Problems/Needs/Goals:

Participant's Readiness for Change: will be ready to implement after taking the NAPLEX.

☐ Action ☐ Preparation ☐ Contemplative ☐ Pre-Contemplative ☐ Maintenance ☐ Relapse

Participant's Initial Goals: 1) Making time / planning healthy meals.

2) Learn how to count carbs appropriately / strategies to manage carb cravings

3) Incorporating basic regular physical activity (a doable plan)

Accommodation for Participant's Individual Education Needs (i.e. Visual, Learning, Mobility, Other Disability)

no disabilities

Summary of Plan: We will work on learning ways to better manage condition using meds - starting with ↑ accessibility to meds after seeing PCP - will review carb counting methods to increase med adherence, and guidelines for safe exercise.

[redacted] 3/8/22

DSME Staff (Print) **DSME Staff Signature** **Date**

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 educator. During the initial assessment, any additional participant needs outside the scope of practice for the educator will be appropriately referred will be an integral part of the entire DSMT process.

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

DEAP CHART REVIEW TOOL: STANDARD 5

LABEL YOUR CHART ACCORDING TO TOOL BELOW

		Standard 5: Person Centered DSMES	Notes:
	☒	**Referral for DSMES** in chart: see diabeteseducator.org/referdsmes for template & guidelines for **Medicare – reviewed by DEAP auditors to support programs to ensure they are being reimbursed for DSMT appropriately.**	18
ASSESSMENT		**Assessment:**	19-34
	☒	Health Status: type of diabetes, clinical needs, health history, disabilities, physical limitations, SDOH and health inequities (e.g., safe housing, transportation, access to nutritious foods, access to healthcare, financial status, and limitations), risk factors, comorbidities, and age	
	☒	Psychosocial Adjustment: emotional response to diabetes, diabetes distress, diabetes family support, peer support (e.g., in-person or via social networking sites), and other potential promotors and barriers	
	☐	Learning Level: diabetes knowledge, health literacy, literacy, numeracy, readiness to learn, ability to self-manage, developmental stage, learning disabilities, cognitive/developmental disabilities (e.g., intellectual disability, moderate-severe autism, dementia), and mental health impairment (e.g., schizophrenia, suicidality)	
	☐	Lifestyle Practices: self-management skills and behaviors, health service or resource utilization, cultural influences, alcohol and drug use, lived experiences, religion, and sexual orientation	
DSMES PLAN	☒	***Document at least once throughout DSMES intervention:*** How (group, individual) What (Assessment of ADCES7 Self Care Behaviors and needs – to be determined collaboratively between participant and DSMES team) When (how many visits anticipated and how often they will come for DSMES) Where (in person, telehealth (audio or audio-video) combination) Why: Purpose for DSMES, diagnosis, complications, etc.	19-34
DSMES INTERVENTION	☒	***Document for each participant at every session:*** When: Date of Service and Plan for Follow Up (timing for next DSMES session) Who: DSMES Instructor/Team and Participant/family in attendance What: Topics Covered (ADCES7 Self Care Behaviors) How: Participant's progress with learning Why: Participant's current progress with SMART goal and action plan; then next steps (what will participant work on between now and next DSMES session)	Documented in each encounter
	☒	**Communication back to referring provider** that includes summary of DSMES provided, participant outcomes and plan for follow up.	35

and Medical Nutrition Therapy Services Order Form

Patient Information

[redacted]

Patient's Last Name | First Name | Middle

Date of Birth [redacted] Gender: ☑ Male ☐ Female

[redacted]

Address | City | State | Zip Code

[redacted]

Home Phone | Other Phone | E-mail address

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested

☑ Initial group DSME/T: ☑ 10 hours or ____no. hrs. requested

☐ Follow-up DSME/T: ☐ 2 hours or ____no. hrs. requested

☑ Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision ☐ Hearing ☐ Physical

☐ Cognitive Impairment ☐ Language Limitations

☐ Additional training ☐ additional hrs requested _____

☐ Telehealth Other _____

DSME/T Content

☐ Monitoring diabetes ☐ Diabetes as disease process

☐ Psychological adjustment ☐ Physical activity

☐ Nutritional management ☐ Goal setting, problem solving

☑ Medications ☐ Prevent, detect and treat acute complications

☐ Preconception/pregnancy management or GDM

☐ Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

DIAGNOSIS

Please send recent labs for patient eligibility & outcomes monitoring

☑ Type 1 ☐ Type 2

☐ Gestational Diagnosis code _____

Complications/Comorbidities

Check all that apply:

☐ Hypertension ☐ Dyslipidemia ☐ Stroke

☐ Neuropathy ☐ PVD

☐ Kidney disease ☐ Retinopathy ☐ CHD

☐ Non-healing wound ☐ Pregnancy ☐ Obesity

☐ Mental/affective disorder Other _____

Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested

☐ Initial MNT ☐ 3 hours or ____ no. hrs. requested

☐ Annual follow-up MNT ☐ 2 hours or ____ no. hrs. requested

☐ Telehealth ☐ Additional MNT services in the same calendar year, per RD

Additional hrs. requested _____

Please specify change in medical condition, treatment and/or diagnosis:

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Definition of Diabetes (Medicare)

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

- a fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;
- a 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or
- a random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.

Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register.

Other payors may have other coverage requirements.

Signature and NPI # [redacted] Date 3/1/22

Group/practice name, address and phone: [redacted]

Revised 8/2011 by the American Association of Diabetes Educators and the American Dietetic Association.

(C2)

Patient Class Intake Form

[redacted] Patient Name

[redacted] DOB

Today's Date: 3/10/22 Class Topic: Reducing risks, Meds.

Weight	Blood Pressure	A1C/Date	FSBG
~~205~~ lbs 210	136/80	7.9 (3/1/22)	131

Have you had any medication changes since your last class? Yes or No

If yes, what changed? NO

One thing I will change after this class is: _____

I will start this goal by doing the following: following up w/ MD + (Eye Dr) for checkup + medication

I know if I can make this change it will have the following impact on my health/life: ↓ A1C ↓ Diabetes related side effects on eye

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? NO

For Instructor Use Only:

Did patient report being successful in making their desired change? Yes (Partially) No

Document any additional interventions recommended here: Visiter Changes - Start wearing eyeglasses you had previously + follow up + get an eye checkup.

[redacted] Instructor Signature

3/10/22 Date

19

(C3)

Patient Class Intake Form [redacted] Patient Name [redacted] DOB

Today's Date: 3/15/22 Class Topic: Coping, Healthy Eating, Meds (Statins)

Weight	Blood Pressure	A1C/Date	FSBG
206	132/80	7.9	127

Have you had any medication changes since your last class? Yes or No

If yes, what changed? No

One thing I will change after this class is: Medication compliance

I will start this goal by doing the following: following up w/ MD regarding Ozempic PA

I know if I can make this change it will have the following impact on my health/life: Decrease portion sizes = ↓ HbA1c

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? No

For Instructor Use Only:

Did patient report being successful in making their desired change? (Yes) Partially No

Document any additional interventions recommended here: No retinopathy observed at a prior eye appt as reported by patient - wearing eyeglasses helped + he is following up to make appt w/ both primary + opthalmologist.

[redacted]
Instructor Signature

3/15/22
Date

20

C4

Patient Class Intake Form

[redacted] Patient Name

[redacted] DOB

Today's Date: 3/17/22 Class Topic: Meds.

Weight	Blood Pressure	A1C/Date	FSBG
212	128/74	7.9	147

Have you had any medication changes since your last class? Yes or No

If yes, what changed? No

One thing I will change after this class is: Pursuing MD's intended Drug Regimen.

I will start this goal by doing the following: Follow up w/ MD office. Call ins compy.

I know if I can make this change it will have the following impact on my health/life: ↓A1c

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? No

For Instructor Use Only:

Did patient report being successful in making their desired change? Yes (Partially) No

Document any additional interventions recommended here: Delays in starting Ozempic - which MD prescribed for weight loss/better BG control. Educated regarding diet/carb counting (pt verified understanding) + encouraged follow up w/ medications to start therapy.

[redacted]

Instructor Signature

3/17/22

Date

21

C5

Patient Class Intake Form

[redacted] Patient Name

[redacted] DOB

Today's Date: 3/21/22 Class Topic: Monitoring, Healthy Eating, Meds. (cont'd)

Weight	Blood Pressure	A1C/Date	FSBG
208	144/79	7.9	110

Have you had any medication changes since your last class? (Yes) or No

If yes, what changed? Vyvanse - Binge Eating Treatment
Vitamin D2, Crestor 5 mg

One thing I will change after this class is: Improve Carb counting for Bolus Calculation

I will start this goal by doing the following: Using Apps such as Bitesnaps and other nutrition Based websites

I know if I can make this change it will have the following impact on my health/life: Lower peaks during hyperglycemia

Are there any providers I need to see at this time? Eyes, (Feet), PCP, (Dentist), Other _____

Are there any labs I need to ask my doctor about? NO

For Instructor Use Only:

Did patient report being successful in making their desired change? (Yes) Partially No

Document any additional interventions recommended here: Patient saw PCP & followed up to start Vyvanse for binge eating + Statin for cholesterol. Discussed easier methods of carb counting eg. Apps — bitesnap. Takes a picture of what you eat + helps estimate calories — Re-emph importance of carb counting.

[redacted]
Instructor Signature

3/21/22
Date

22

(C6) Patient Class Intake Form

[redacted] Patient Name

[redacted] DOB

Today's Date: 3/23/22 Class Topic: Healthy Eating, Meals, (and) Reducing Risks

Weight	Blood Pressure	A1C/Date	FSBG
205	130/80	7.9	110

↳ pump Target

Have you had any medication changes since your last class? Yes or (No)

If yes, what changed? _____

One thing I will change after this class is: Further improving portion size and Carb Counting

I will start this goal by doing the following: Medication Compliance. New Hypoware decreases Binge eating and therefore pt Size

I know if I can make this change it will have the following impact on my health/life: ↓A1C Further Reduce Changes of long term Diabetic Side effects or neuropathy.

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? No

For Instructor Use Only:

Did patient report being successful in making their desired change? Yes (Partially) No

Document any additional interventions recommended here: Discussed following up w/podiatrist + effects of diabetes on nerves - no complaints on tingling / loss of sensation this fun. Improved on being able to carb count + accurately estimate bolus insulin dose post meal

[redacted] Instructor Signature

3/23/22 Date

23

(C7)

Patient Class Intake Form

[redacted] Patient Name

[redacted] DOB

Today's Date: 3/25/22 Class Topic: Monitoring, Meds (cont'd) / Problem Solving

Weight	Blood Pressure	A1C/Date	FSBG
203	139/79	7.9	110 (Target)

Have you had any medication changes since your last class? Yes or No

If yes, what changed? Ozempic

One thing I will change after this class is: Making Sure to take new medications on time: Crestor, Vyvanse, Ozempic

I will start this goal by doing the following: Using Alarms Setting timers on phone to Remind me Vit D & Weekly Crestor - nightly Ozempic - weekly Vyvanse - Morning

I know if I can make this change it will have the following impact on my health/life: ↓ Carb Craving ↓ Cholesterol & TG ↓ A1c, ↓ weight and BMI

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other No

Are there any labs I need to ask my doctor about? _____

For Instructor Use Only:

Did patient report being successful in making their desired change? Yes (Partially) No

Document any additional interventions recommended here: Alarms to remember medication doses - technology has helped w/ compliance in the past. Now has more meds after MD visit so remembering doses w/ reminders on phone can help.

[redacted]

Instructor Signature

3/25/22

Date

(C8)

Patient Class Intake Form [redacted] Patient Name [redacted] DOB

Today's Date: 3/28/22 Class Topic: Problem Solving, Meds, Healthy Eating

Weight	Blood Pressure	A1C/Date	FSBG
207	135/70	7.4	110

Have you had any medication changes since your last class? Yes or (No)

If yes, what changed? _____

One thing I will change after this class is: Portion Control

I will start this goal by doing the following: eating more regularly so during day so I dont eat all at one at night - eating breakfast

I know if I can make this change it will have the following impact on my health/life: ↓ A1C, weight/BMI, cholesterol

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? A1C

For Instructor Use Only:

Did patient report being successful in making their desired change? (Yes) Partially No

Document any additional interventions recommended here: Alarm reminders helped remember to take doses of new meds - Patient reports trouble + binge eating - will work on eating more regular meals earlier in day to prevent eating a large amount at once a night. Breakfast alarm reminders in AM.

[redacted]
Instructor Signature

3/28/22
Date

25

(C9)

Patient Class Intake Form [redacted] Patient Name [redacted] DOB

Today's Date: 3/30/22 Class Topic: Being Active

Weight	Blood Pressure	A1C/Date	FSBG Pump
205	135/80	7.9	110 (Target)

Have you had any medication changes since your last class? Yes or No

If yes, what changed? _____

One thing I will change after this class is: Working out + recording how many minutes of exercise makes blood sugar drop.

I will start this goal by doing the following: Monitoring blood sugar during workout observing types of exercise that makes sugar go low

I know if I can make this change it will have the following impact on my health/life: ↑ exercise ↓ cholesterol, weight / BMI

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other _____

Are there any labs I need to ask my doctor about? NO

For Instructor Use Only:

Did patient report being successful in making their desired change? (Yes) Partially No

Document any additional interventions recommended here: Discussed previous experience w/ exercise + how to consider re-incorporating physical activity as a daily routine. Previously mentioned exercising was difficult due to BG dropping mid workout. Will monitor + look for types of exercise that might be safe. 3+ x per week.

[redacted]
Instructor Signature

3/30/22
Date

26

(CU)

Patient Class Intake Form

[redacted]
Patient Name

[redacted]
DOB

Today's Date: 4/1/22 Class Topic: Healthy Eating, Meds, Staying Active

Weight	Blood Pressure	A1C/Date	FSBG
204	132/80	7.9	110 target

Have you had any medication changes since your last class? Yes or No

If yes, what changed? VYVase switched to Adderall

One thing I will change after this class is: Start working out more regularly while paying attention to BG.

I will start this goal by doing the following: Light warm up → wait + check sugar. couple min then continue / break based on numbers.

I know if I can make this change it will have the following impact on my health/life: ↑ activity ↑ mood ↓ weight/BMI

Are there any providers I need to see at this time? Eyes, Feet, PCP, Dentist, Other

Are there any labs I need to ask my doctor about? NO

For Instructor Use Only:

Did patient report being successful in making their desired change? Yes Partially No

Document any additional interventions recommended here: Encouraged light-moderate activity + waiting & checking blood sugar midway to ensure activity does not cause hypoglycemia - also making sure albuterol inhaler is close but in case of asthma - Said it sometimes bothers him.

[redacted]
Instructor Signature

4/1/22
Date

27

DSMT Individualized Plan of Care and Progress Report

Name: [redacted] **Date of Birth** [redacted]

	Session 1	Session 2	Session 3	Session 4	Session 5
Date	3/8/22	3/10/22	3/15/22	3/17/22	3/21/22
Scale 1-3 (1-never, 2-in progress, 3-always)	Session 1	Session 2	Session 3	Session 4	Session 5
States guidelines for safe exercise	1 1	1 1	1 1	1 1	1 1
Understands action and use of oral medications/insulin	1 2	2 3	2 3	2 2-3	2 3
Identifies symptoms/treatment of hyperglycemia and hypoglycemia	1 2-3	2 2-3	2 2-3	2 2-3	2 3
Understands the effects of illness on diabetes management	1 1	1 2	2 2	2 3	2 3
Verbally describes proper meal planning and goals	1 1	1 2	2 2	2 2	2 2
Understands how to plan for travel	1 1	1 2	2 3	2 3	2 3
Verbalizes proper hygiene in preventing complications (skin, foot & dental)	1 1	1 1	1 1	2 2	2 2
Properly identifies complications (neuropathy, eye, urinary, etc.)	1 1 1	1 1	1 1	2 2	2 2
Understands diabetes-related lab values (A1c, etc.)	1 2-3	2 3	2 3	2 3	2 3
Displays proper glucose testing technique (on cGM)	1 n/a	1	1	1	1
Makes healthy food choices and can verbalize best choices for substitutions	1 1	1 1	2 2	2 2	2 2

1 - never , 2 - in progress
3 - always

DSMT Individualized Plan of Care and Progress Report

Name: [redacted] **Date of Birth:** [redacted]

	Session 6	Session 7	Session 8	Session 9	Session 10
Date					
Scale 1-3 (1-never, 2-in progress, 3-always)	**Session 6**	**Session 7**	**Session 8**	**Session 9**	**Session 10**
States guidelines for safe exercise	1	1	1	2	3
Understands action and use of oral medications/insulin	3	3	3	3	3
Identifies symptoms/treatment of hyperglycemia and hypoglycemia	3	3	3	2-3	3
Understands the effects of illness on diabetes management	3	3	3	3	3
Verbally describes proper meal planning and goals	2	2	2	2	3
Understands how to plan for travel	3	3	3	3	3
X Verbalizes proper hygiene in preventing complications (skin, foot & dental)	2	3 (eye)	2	2	2 follow up dental/foot
Properly identifies complications (neuropathy, eye, urinary, etc.)	2	3	3	3	3
Understands diabetes-related lab values (A1c, etc.)	3	3	3	3	3
Displays proper glucose testing technique (on cGM) n/a	~~1~~	1	1	1	1
X Makes healthy food choices and can verbalize best choices for substitutions	2	2-3	2-3	2-3	2-3

1 never

2 in progress

3 always.

[illegible] quiz

This quiz was taken ____ pre-education 4 post education

Patient Name: [redacted] Date: 4/1/22

Please circle your level of confidence on a scale from 1 (not confident) to 5 (very confident).

Not Confident ⟶ Very Confident

I know how to check my blood sugars. (monitoring)	1	2	3	4	5
I know where to find the resources I need to manage my diabetes. (coping)	1	2	3	4	5
I know how to eat right as a diabetic. (healthy eating)					✓
I know how to safely exercise. (being active)			✓		
I understand how to take my medications the right way. (medications)					✓
I know what to do when I'm sick in order to appropriately manage my diabetes (problem solving)					✓
I know what healthcare screenings are recommended for diabetics and how often to complete them. (reducing risks)					✓

1. Do you know your current A1c? Yes or No If yes please write it here: 7.9
2. When I first wake up my fingerstick blood sugar should be 110 mg/dL
3. Two hours after a meal my fingerstick blood sugar should be 110 mg/dL
4. I do / do not have a blood glucose monitor. List name of meter here: ~~Dexcom G6~~ + One touch Verio
5. My next PCP Doctor's appointment is on TBD.

30

[redacted]

Patient Name DOB

Progress Tracking Form

	Class 1	Class 2	Class 3	Class 4	Class 5
Date	3/8/22	3/10	3/15	3/17	3/21
Class Topic	*see below 3, 5	5, 7	2, 3, 5	5	1, 3, 5
Weight	~~205~~ 210 lbs	~~205~~ 210 lbs	~~205~~ 210 lbs	212 lbs.	208 lbs
Blood Pressure	109/71	136/80	~~143/84~~ 132/80	128/74	144/79
A1c/date	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)
FSBG	173	131	~~147~~ 122	147	110
Individual or Group	Individual	Individual	Individual	Individual	Individual
Session Time	1 hr	1 hr	1 hr	1 hr	1 hr.
					At the end of Class 5, which selfcares were achieved?

*1 Monitoring, 2 Coping, 3 Healthy Eating, 4 Being Active, 5 Medications, 6 Problem Solving, 7 Reducing Risks

- Carb counting/ dietary consciousness/ healthy eating
- Med management.

2

[redacted] [redacted]

Patient Name DOB

Progress Tracking Form

	Class 6	Class 7	Class 8	Class 9	Class 10
Date	3/23	3/25	3/28	3/30	4/1
Class Topic	*see below 3, 5, 7	1, 5, 6	3, 5, 6	4	3, 4, 5
Weight	205 lbs	203 lbs.	207 lbs.	205 lbs.	204 lbs.
Blood Pressure	130/80	139/79	135/70	135/80	132/80
A1c/date	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)	7.9 (3/1/22)
FSBG	110 (target)	110 (target)	110 @ pump target	110 target	110 - target
Individual or Group	Individual	Individual	Individual	Individual	Individual
Session Time	1 hr	1 hr.	1 hr	1 hr	1 hr.

*Monitoring, 2 Coping, 3 Healthy Eating, 4 Being Active, 5 Medications, 6 Problem Solving, 7 Reducing Risks

22

[redacted]

[redacted] Pharmacy: Diabetes Education Center

[redacted]

March 8, 2022

Attention: [redacted], NP

Re: Follow up to Referral for Diabetes Self-Management Education

Patient Name: [redacted] DOB [redacted]

This letter is to update your patient was seen and evaluated on 03/08/2022. Thank you for the referral and order that you authorized. After initial consultation with the patient, the following items will be focused on in educating this patient specifically:

1. Carbohydrate counting
2. Healthy meal prep/managing carb cravings
3. Incorporating a regular physical activity routine

In addition to this focus, we will begin this patient's education in our small group classes this month, which will further provide a general education covering the seven self-care behaviors including eating healthy, being active, monitoring, taking medication, problem solving, healthy coping, and reducing risks. I will send another follow up letter after this patient's small group education is complete.

Please let us know if we can help with anything further.

[redacted]

Pharmacist Signature

03/08/2022
Date

[redacted] Pharm.D. RPh

33

This quiz was taken X pre-education _____post education

Patient Name: [redacted] Date: 3/8/22

Please circle your level of confidence on a scale from 1 (not confident) to 5 (very confident).

Not Confident		Very Confident

I know how to check my blood sugars. (monitoring)	1	2	3	4	5
I know where to find the resources I need to manage my diabetes. (coping)	1	2	3	4	5
I know how to eat right as a diabetic. (healthy eating)					5
I know how to safely exercise. (being active)			3		
I understand how to take my medications the right way. (medications)					5
I know what to do when I'm sick in order to appropriately manage my diabetes (problem solving)					5
I know what healthcare screenings are recommended for diabetics and how often to complete them. (reducing risks)					5

1. Do you know your current A1c? Yes or No If yes please write it here: 7.4
2. When I first wake up my fingerstick blood sugar should be 110 mg/dl
3. Two hours after a meal my fingerstick blood sugar should be 110 mg/dl
4. I do / do not have a blood glucose monitor. List name of meter here: ~~Dexcom G6~~ Sensor
5. My next PCP Doctor's appointment is on 3/10/22.

34

[redacted] Pharmacy: Diabetes Education Center

[redacted]

April 1, 2022

Attention: [redacted] **NP**

Re: Follow up to Referral for Diabetes Self-Management Education

Patient Na[redacted] **DOB:** [redacted]

This letter is to update you that ten hours of diabetes education has been completed with your patient. Thank you for the referral and order that you authorized.

Upon referral the patient presented with a history of A1C of 7.9, based on lab results your office provided from 3/1/22 - will follow up to observe for any improvements/changes from baseline when next A1C is taken. Patient presented weighing 210 lbs and finished our program weighing at 204 lbs.

Education was focused on optimizing use of medications, carb counting, preventing diabetes-related complications, and incorporating regular activity. The patient had a high baseline level of knowledge about diabetes and how medications worked due to his background as a pharmacy intern. However, his main obstacle was adherence and getting his medications/cGM supplies since he had not seen a primary care practitioner for the past year. Other areas he needed assistance with were dietary control (type/portion of food consumed), carb counting, and staying active. Since starting diabetes education, he has been able to follow up with primary care and has become more adherent to medications with the help of technology and use of alarms/reminders. He has also become more motivated to incorporate dietary changes and learned ways to monitor himself for safe physical activity on a regular basis.

Please let us know if we can help with anything further.

[redacted]

Pharmacist Signature

4/1/2022

Date

[redacted], Pharm.D. RPh

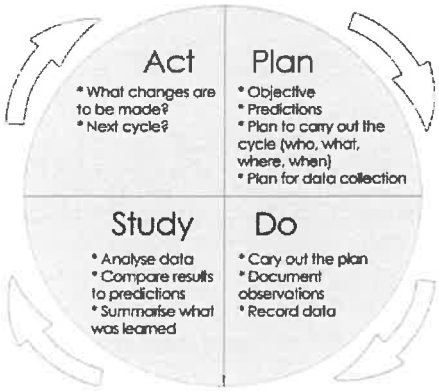
ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

STANDARD 6: MEASURING AND DEMONSTRATING OUTCOMES OF DSMES SERVICES

REQUIRED DOCUMENTS:	PAGE #
☒ Initial applicants will provide a plan for collecting outcome data for evaluation and improvement of overall DSMES services and reporting to ADCES as part of Annual Status Report.	36-37
☐ Existing programs will provide a minimum of one program level clinical or behavioral outcome aggregated and reported to ADCES as part of **Annual** Status Report	
☒ Minimum of one other program level outcome (can be part of CQI) will be aggregated and reported to ADCES **annually**	36-37
☐ One CQI project will be reported with related outcomes each year as part of **Annual** Status Report	

CONTINUOUS QUALITY IMPROVEMENT PROJECT

The PDSA cycle



Your Organization [redacted]

Date 03/14/2022

Three fundamental questions should be answered by the CQI project:

1. What are we trying to accomplish?
2. How will we know a change is an improvement?
3. What changes can we make that will result in an improvement?

Plan (This is the section to complete for new plan each year)

What change are you testing (what problem are you trying to solve)? Explain the current situation and what you hope to change about it.

Improvement in diabetes-specific patient outcomes (such as A1c, blood pressure, or weight) before and after a patient undergoes 10 hours of diabetes self-management education.

What do you predict will happen and why?

A patient's diabetes-specific markers should improve (lower A1c and blood pressure) following 10 hours of diabetes self-management education. Improvement in markers, if seen can reflect the degree to which the patient learned and implemented lifestyle changes (dietary and physical activity) and enhanced medication management/adherence after undergoing diabetes self-management education.

Who will be involved?

Patient will report outcome data at each class using their progress tracking form. If participating remotely, patient will be responsible to take measurements such as blood pressure and report them during their visit.
Program instructor will collect data initially and at the program conclusion for each patient.
If necessary, labs such as A1c will be ordered by the patient's provider to measure for changes/improvement.

When will the change happen and how long will it take to implement? (timeline)

We will measure for a change in outcome before and after 10 hours of diabetes self-management education (DSME). This may take 1.5-2 months based on how quickly the patient is able to complete their full 10 hours of education.

What resources will be needed?

- **Blood pressure monitor (Available onsite)**
- **Labs (Phlebotomy services available onsite – can be sent out to lab)**

(Note: If participating remotely, patient will need to use a home cuff to measure blood pressure. If A1C needs to be retaken, they will need to come in-person to our facility or a local lab to get blood drawn.)

What data need to be collected and when? (timeline) - **Outcome Measures:**

1. **Blood pressure (initial / each class/ final)**
2. **A1C (initial / final)**

36

Do (Complete this section as you are doing your test of change)

Carry out the change on a small scale. Collect data you identified in your plan. Explain here what you did and how you did it. Document observations, including any problems and unexpected findings here.
Study (Complete this section once you have completed your test of change and have your data) Analyze the data. Did the change result in the expected outcome? Were there implementation lessons? Summarize what was learned. Were there any unintended consequences, surprises, successes, failures?
Act (Complete this section AFTER you have evaluated your data and are deciding what to do with the results, i.e. next steps) Based on what was learned from the test, select one of the following and elaborate: ☐ Adapt – modify the changes and repeat PDSA cycle. ☐ Adopt – consider expanding the changes in your organization. ☐ Abandon – change your approach and repeat PDSA cycle.