ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

Program ID#: 123456

Program Name: ABC Hospital

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| ☒ 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 certificate | 7 |
| ☒ *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)* | 8 |
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| ☐ Every year: One CQI project will be reported to DEAP as part of Annual Status Report | |
| ☒ Two Outcome Measures will be chosen by DSMES team and reported in aggregate as part of Annual Status Report<br>1. Clinical <u>or</u> Behavioral Outcome Measure:<br>2. Clinical <u>or</u> Behavioral <u>or</u> Process Outcome Measure: | 40 |

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## 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 | \ |

## Standard 1

Association of Diabetes Care & Education Specialists
Diabetes Education Accreditation Program (DEAP)
Attn: Sacha Uelmen, RDN, CDCES, Director
125 S. Wacker Dr.
Suite 600
Chicago, IL 60606

March 21/2022

Dear Sacha Uelmen,

I am writing to acknowledge my enthusiastic support for application for Accreditation with DEAP. Our organization is a champion for offering diabetes self-management education and support offered at each of the 4 critical times and the resources necessary to deliver and maintain the highest quality DSMES services as achieved through DEAP Accreditation. We endorse the 4 critical times as identified below.

1. At Diagnosis
2. Annually / and or when not meeting treatment targets
3. When complications develop, and
4. When transitions in life or care occur

We are a Federally Qualified Health Center serving . We serve adult and pediatric patients who are under-insured, uninsured, as well as all others in need of care. We have a mixed population and have identified a priority and a need to offer DSMES services. I acknowledge stakeholder and leadership support for billing and coding, gathering and reporting data and implementing quality improvement projects. Our DSMES team is an integral part of We also support continuing education for our DSMES team to continue to meet and exceed the National Standards for DSMES.

We look forward to receiving accreditation for and will continue to assist our DSMES Quality Coordinator and the team as they begin to implement billing and reimbursement procedures for Medicare and other relevant payers to ensure long term sustainability for this critical standard of care for people with diabetes.

Sincerely,

Director of Nursing

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## 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 | 2-4 |

## Standard 2

a Federally Qualified Health Center (FQHC) located in . The following information is taken from the 2018 , Needs Assessment.

"F / is one of the top 10 richest counties in Florida. According to the Office of Economic and Demographic Research, in 2018, the average per capita personal income for / was $76,059, which is more than $25,000 higher than average per capita income of residents ($50,070). In fact, according to the most recent report available from the Economic Policy Institute examining nationwide county-level data, had the 10th largest income gap between the top 1% and the bottom 99% out of 3,061 counties nationwide. The top 1% in County earn an average of over $2.9 million, and the bottom 99% earn an average of $43,373, representing a top to bottom ratio of 67.2.9 In communities where income inequality is a concern, disparities may exist that primarily affect the quality of life for lower-income residents in a variety of areas, including health, well-being, education, and social mobility. Additionally, such disparity skews the perception of the overall income for , because of the high level of income earned by the top 1 %.

According to the a Office of Economic and Demographic Research and the United States Census Bureau, the median household income in , in 2018 was $52,336 compared to $53,267 for the State of (adjusted for inflation). When considering median household income, levels of earned income at the County and State level now appear comparable (see Economic Opportunity section for more details). According to the MIT Living Wage Calculator, the required annual income before taxes for a family of four (2 adults, 2 children) in , is $ $63,145. This estimate takes into account food, childcare, medical expenses, housing, transportation, taxes, and the cost of living in the location. The Federal Poverty Level (FPL) is a commonly used measure to define poverty. The measure of income is issued annually by the Department of Health and Human Services(HHS)and is regularly used to establish eligibility for public and social services. In 2018, FPL was $24,600 for a family of four. In 2018, it was estimated that 10.7% of residents were below FPL.

When examining the quality-of-life indicators for 2016, approximately 23.3% of residents indicated that they were in poor or fair health, as compared to 19.5% of residents in the state. The counties in the US with the best rates average 12%. With regard to the average number of physically unhealthy days reported in the past 30 days (age-adjusted), residents reported 4.7 days on average, as compared to 4 in the state. A similar pattern was reported with regard to the average number of mentally unhealthy days reported in past 30 days (age-adjusted), residents reported 3.3 days on average, as compared to 3.6 in the state.58 The counties in the US with the best rates average 3.0 and 3.1 days, respectively.

When considering access to food, the USDA defines low food access as living more than ½ mile from sources of healthy and affordable food (e.g., supermarkets; large grocery stores). Within , 43.22% reported low food access, which is higher than both the State of (25.70%) and the United States (22.43%). Although , reported a higher percentage of low food access, percentages of low food access range from 0.00% in tracts 508.08, 504.02, and 507.04 to 100.00% in tract 505.01.

Cancer and heart disease were the leading causes of death for residents of and the state. In , those two diseases were the cause of 49% of all deaths. In addition, Black residents had higher death rates from cancer, heart disease, stroke, and HIV/AIDS than other races and ethnicities."

quality monitors aim to:

a) Reduce percentage of patients with poor diabetes control, those with an A1C >9%. 1/31/2022 results were 28%. National average 21.95%. February 2022 report shows an increase to 43%.
b) Diabetic eye exams. 2020 Goal: 50%. 1/31/2022 was 33%. February 2022 improved to 35%.

Our Corporate office is located ach. We have 7 medical sites that provide care. Each site is wheelchair accessible. A brief description of each of them is addressed below.

| Location | Description |
|---|---|
| 1. | • Located in the southern part of the County. Services a mixed population.<br>• Provides pediatric care, adult care, behavioral health, eye screenings, lab services, dental care and has an on-site pharmacy. On-site health care navigators.<br>• Limited community providers. Has a bus stop. Salvation Army and food pantry nearby.<br>• Has a conference room and large kitchen without a stove. |
| 2. | • Located in central Vero beach along US highway 1. Services a mixed population.<br>• Provides pediatric care, adult care, behavioral health, and lab services. On-site health care navigators.<br>• Has a bus stop and close to local community resources. |
| 3. | • Is more easterly located in along 3 t where the hospital with numerous health care providers. Services a mixed population and the majority are English speaking, and some patients have some form of commercial insurance or MCR.<br>• Provides adult care, women's / gyn care, and lab services. On-site health care navigators.<br>• Has a conference room but is currently being used for medical storage.<br>• Bus stop. |
| 4. | • Located in the same building as and the Provides Behavioral health and nurse manager services.<br>• Bus stop route. |
| 5. | • Centrally located in . Services a mixed population and a significant population is African American.<br>• Provides pediatric care, adult care, behavioral health, eye screenings, lab services, and has an on-site pharmacy. On-site health care navigators.<br>• Limited community providers.<br>• Has a bus stop. Has a large conference room and a mid-size kitchen without a stove. |

| | |
|---|---|
| 6. | • Located in the northern part of the county. Services a mixed population.<br>• Provides pediatric care, adult care, behavioral health, and lab services. On-site health care navigators.<br>• Access to numerous health care services including a hospital. Has a bus stop. Does not have a conference room. |
| 7. | • Located in , the north-west part of the county. Services a primarily Latino/ Spanish speaking population, including seasonal migrant workers.<br>• Provides pediatric care, adult care, behavioral health, eye screenings and glasses, lab services, x-rays, and has an on-site pharmacy. On-site health care navigators.<br>• Limited community providers. Has a large kitchen without a stove that can be used as a conference room.<br>• Has a bus stop best for local transportation. |

Barriers & SDOH:

Diabetes Distress is a leading contributor of poorly managed diabetes self-care. Regime and Interpersonal scores are higher than physician distress and emotional burden. For the most part, patients living with diabetes have confidence with their physicians, including APRNs.

Patient barriers include, but not limited to the following:

a) Unemployment/ lack of ability to maintain employment due to disability or chronic disease, complications, incarceration, obesity and joint pain, language or literacy skills.
b) Running out of diabetes medications often related to expired PAP programs, lack of communication with pharmacists, and costs. Also literacy/ language barriers for understanding prescriptions.
c) Sustaining improved A1C results after diabetes education completed. Appears to occur 6 months later.
d) Completing health care reminders such as diabetic eye exams.
e) Accessing local food resources to reduce food costs and perception that healthier eating is more expensive.
f) Working head of household and limited time to improve lifestyle behaviors such as being more active as well as attending medical appointments.
g) Lack of local resources for support and information in the evenings and on weekends.
h) Patient lack understanding glucose and A1C results as well as not testing BG due to cost of strips.
i) Limited availability of local adult and pediatric endocrinologists.
j) No accredited DSMES services in the county. ( application pending)

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**STANDARD 3: DSMES TEAM**

| REQUIRED DOCUMENTS: | **PAGE #** |
|---|---|
| ☒ Description of the Quality Coordinator's role and responsibilities within and outside the DSMES team | 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 | 7 |
| ☒ 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) | 8 |

## Standard 3 .1

**RN and CDCES Attestation**

March 22, 2022

I, , attest that I possess a current State RN license and am board certification as a Certified Diabetes Care and Education Specialist and that both are in good standing. I have submitted a copy with the DEAP application.

, RN, CDCES

# DSMES Quality Coordinator Position Description

**Position Summary**

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

**Duties and Responsibilities**

1. Oversees the planning, implementation and evaluation of the DSMES service.
2. Arranges and coordinates the activities of the Advisory Group.
3. Liaises between the DSMES team members, the Advisory Group, other departments and administration.
4. Monitors and facilitates maintenance of DSMES team members qualification (CE credits, training, competency, licensures, and registrations).
5. Responsible for maintaining Recognition and participating in the evaluation of the DSMES service's effectiveness.

**Knowledge, Skills, and Abilities:**

1. Knowledge about chronic disease management and disease self-management education.
2. Supervisory abilities.
3. Knowledge about program management.
4. Proficient in various computer and software applications.
5. Marketing and Community Partnership Skills.

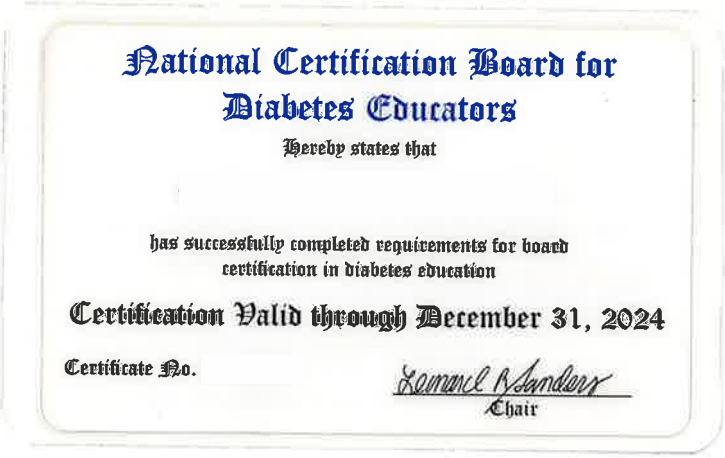
**Qualifications**

1. Licensed Health Care Professional with 5 years supervisory experience in their licensed profession.
2. 3 years' experience in program management and or development in chronic diseases and disease self-management.
3. A certified diabetes care and education specialist or is eligible to become a certified diabetes care and education specialist.
4. Minimum of 15 contact hours within the past year in diabetes and diabetes clinical and educational subjects.

Signature : _____ Date: 3/22/2022

March 22, 2022

## Standard 3.3



National Certification Board for Diabetes Educators

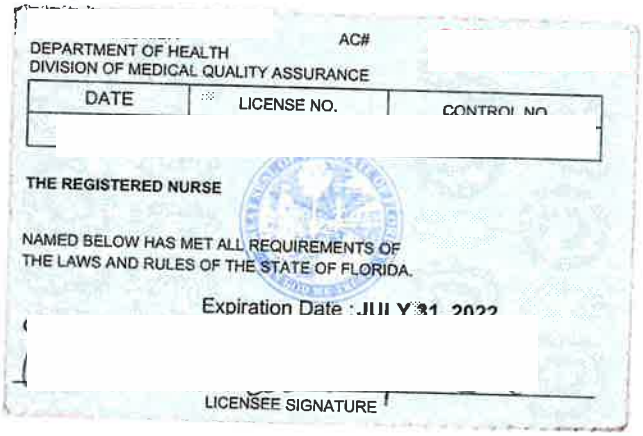
Hereby states that

has successfully completed requirements for board certification in diabetes education

Certification Valid through December 31, 2024

Certificate No.

Chair



DEPARTMENT OF HEALTH
DIVISION OF MEDICAL QUALITY ASSURANCE

AC#

| DATE | LICENSE NO. | CONTROL NO. |
|---|---|---|
| | | |

THE REGISTERED NURSE

NAMED BELOW HAS MET ALL REQUIREMENTS OF THE LAWS AND RULES OF THE STATE OF FLORIDA.

Expiration Date : JULY 31, 2022

LICENSEE SIGNATURE

## Standard 3.4

March 22, 2022

I, , RN. CDCES, attest to the following:

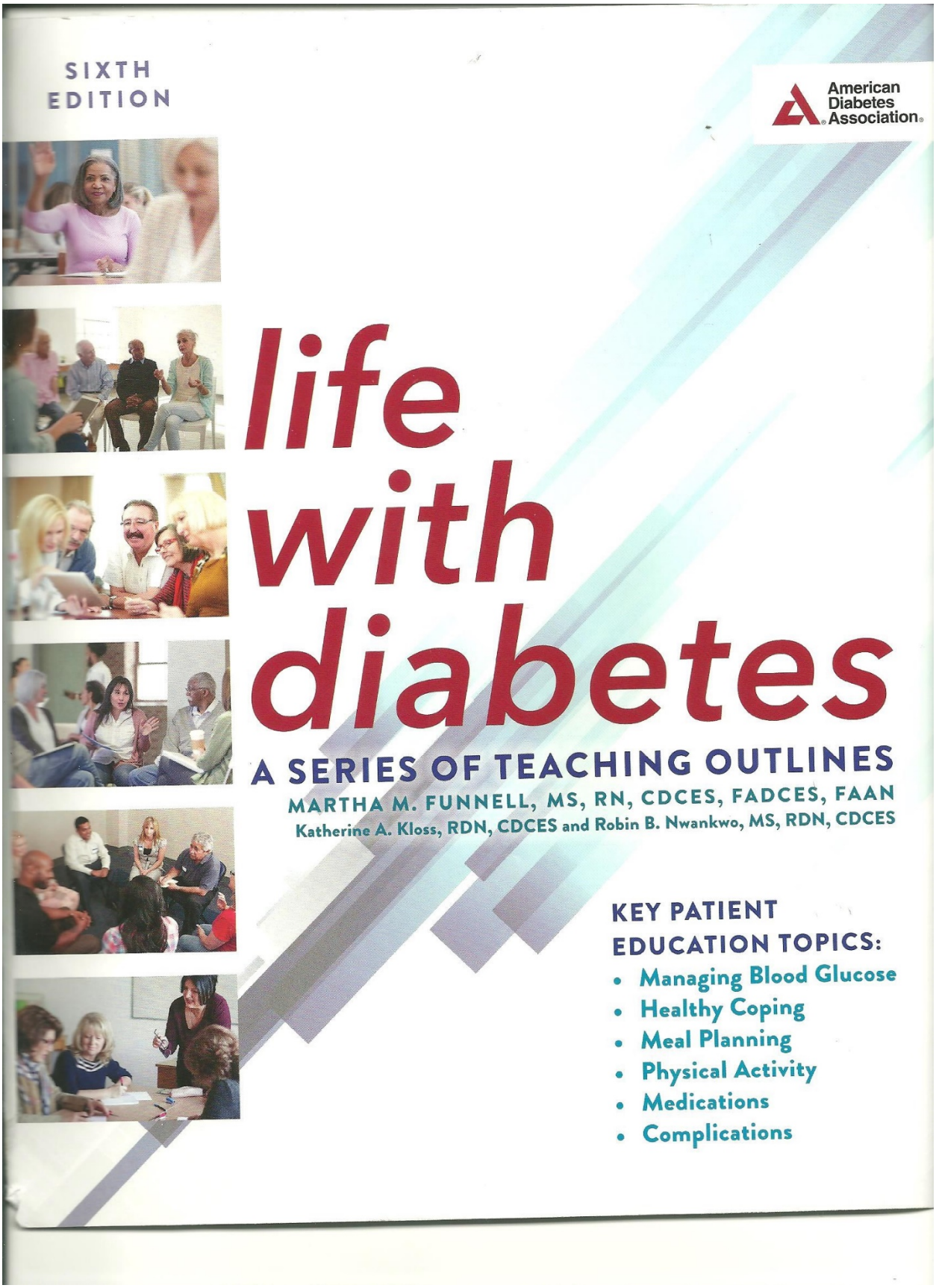
1. All DSMES team members who do not hold the CDCES, or BC-ADM credential will show evidence of at least 15 hours of diabetes-related continuing education each .
2. That the diabetes community care coordinator/s will directly report to a credentialed professional team member and will have of the training and/or experience related to their specific role on the team.
3. Our DSMES team does not currently have the above personnel on the DSMES team.

RN, CDCES

## 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. | 9 |
| ☒ 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. | 11 |

[Standard 4.1]


SIXTH EDITION
American Diabetes Association.
life with diabetes
A SERIES OF TEACHING OUTLINES
MARTHA M. FUNNELL, MS, RN, CDCES, FADCES, FAAN
Katherine A. Kloss, RDN, CDCES and Robin B. Nwankwo, MS, RDN, CDCES
KEY PATIENT EDUCATION TOPICS:
• Managing Blood Glucose
• Healthy Coping
• Meal Planning
• Physical Activity
• Medications
• Complications

## Standard 4.2

Curriculum Review Attestation

March 22, 2022

I, RN. CDCES, attest as the Quality Coordinator, that I reviewed the ADA's Life with Diabetes curriculum's content and application to our current organizational practices. Our Director of Nursing, approved purchase of said curriculum which is in our possession and will be utilized in our DSMES program

RN, CDCES

## Standard 4.3

**Standard # 4 Delivery and Design of DSMES Services**

DSMES services utilize a curriculum to guide evidence-based content and delivery; to ensure consistency of teaching concepts, methods, and strategies within the team; and to serve as a resource for the team. DSMES teams have knowledge of and are responsive to emerging evidence, advances in education, strategies, pharmacotherapeutics, technology enabled treatment, local and online peer support, psychological resources and deliver strategies relevant to the population we serve.

We connect patients living with diabetes to technology enabled solutions, such as mobile apps, digital therapeutics, online programs, and peer support groups within our local or online community that encourages practical integration of diabetes self-management and psychological support into the existing daily routine between and beyond DSMES sessions.

Process:

1. Utilize the ADA's written curriculum, Life with Diabetes, learning objectives and criteria for methods of delivery and evaluating successful learning outcomes as the framework for the DSMES.
2. Education process is guided by the curriculum with content, learning objectives, methods of delivery and criteria for evaluating learning for the populations served (including pre-diabetes, type 1 diabetes, type 2 diabetes, secondary diabetes, gestational diabetes, or pregnancy complicated by diabetes) in the following 9 content areas.
    a. Diabetes pathophysiology and treatment options
    b. Healthy eating
    c. Physical activity
    d. Medication usage
    e. Monitoring and using patient-generated health data (PGHD)
    f. Preventing, detecting and treating acute complications including hypoglycemia, hyperglycemia, diabetes ketoacidosis, sick day guidelines, and severe weather or situation crisis and diabetes supplies management
    g. Preventing, detecting and treating chronic complications including immunizations and preventive eye, foot, dental, and renal examinations as indicated per the individual participant's duration of diabetes and health status
    h. Healthy coping with psychosocial issues and concerns
    i. Problem solving
3. Review curriculum and/or course materials for requirements and updates as needed or at least annually.
4. Provide patients with support resources for needs that can also be met outside of the organization.

Addendum: Copy of Purchase receipt and Curriculum Cover

**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. | 12 |
| ☒ Provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record.<br>☒ DSMES Assessment<br>☒ DSMES Plan<br>☒ Each DSMES Visit including date/time and topic areas covered with plan for follow up<br>☒ Behavior Goal (ADCES7) and progress<br>☒ Outcomes of intervention communicated to referring physician/qualified healthcare professional | 13-38 |

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## 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.** | 13 |
| ASSESSMENT | ☒ | **Assessment:**<br>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 | 13-14 |
| | ☒ | 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 | 13-14 |
| | ☐ | 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:***<br>How (group, individual)<br>What (Assessment of ADCES7 Self Care Behaviors and needs – to be determined collaboratively between participant and DSMES team)<br>When (how many visits anticipated and how often they will come for DSMES)<br>Where (in person, telehealth (audio or audio-video) combination)<br>Why: Purpose for DSMES, diagnosis, complications, etc. | 14-16 |
| DSMES INTERVENTION | ☒ | ***Document for each participant at every session:***<br>When: Date of Service and Plan for Follow Up (timing for next DSMES session)<br>Who: DSMES Instructor/Team and Participant/family in attendance<br>What: Topics Covered (ADCES7 Self Care Behaviors)<br>How: Participant's progress with learning<br>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. | Communicated through EHR |

## Standard 5.1

**Standard #5 : Person -Centered DSMES**

Person-centered DSMES is a recurring process over the life span for a person with diabetes (PWD). Each person's DSMES plan is unique and' based on the persons' concerns, needs, and priorities collaboratively determined as part of the DSME assessment. The DSMES team monitors and communicates the outcomes of the DSMES to the diabetes care team and or referring physician or other qualified health care profession.

Process:

1. Obtain a referral from primary physician or provider over-seeing patient's diabetes care.
2. Conduct and document a participant comprehensive assessment, including baseline diabetes self-management knowledge and skills, and readiness for behavior change. To include:
    a. Diabetes disease, nutritional management, physical activity, taking medications, monitoring blood glucose, preventing, detecting and treating acute complications, preventing, detecting and treating chronic complications
    b. Clinical (diabetes and other pertinent clinical history)
    c. Cognitive (knowledge of self- management Skills and functional health literacy)
    d. Psychosocial (emotional response to diabetes)
    e. Diabetes distress and support system
    f. Behavioral (readiness for change, lifestyle practices, and self-care behaviors)
3. If parts of the complete initial assessment are deferred document the rationale.
4. Assess, develop and document the education participants concerns, needs, and self-management skills and knowledge.
5. Document on-going education planning and behavioral goal-setting.
6. Document in the participant's health record the DSMES professional team member's assessment of the participant's intervention and outcomes of education provided.
7. Engage and document patient's unique needs, goals, and changes that are important to them and assist them for living longer and healthier with diabetes.
8. Provide patients with written information that is available on the S drive as well as videos.
9. Provide referring physician updates and progress. This can be documented in sources such as care planning, patient chart updates, verbally, or tasks.

Addendum: T1 and T2 DDS scale

**Patient:**
**DOB:**
**SSN:** ******

**Date:** 10/22/2021 12:00
**Provider:** Diabetes, Educator
**Encounter:** Nurse Education Visit

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
DSMT: Initial Comprehensive Assessment.

## REFERRED HERE

## HISTORY OF PRESENT ILLNESS
is a 54 year old male.
- Allergy list reviewed • Problem list reviewed • Medication list reviewed

## PREVIOUS TESTS
- Test: Hemoglobin A1C Report Date: 10/21/2021
  Hemoglobin A1C 12.0 Abnormal
- Test: Microalbumin/Creatinine Report Date: 10/21/2021
  Albumin 30 Normal
  Creatinine 100 Normal
  Creat/Alb Ratio 30 Normal

## NOTES
Subjective / Objective:
Patient was diagnosed with diabetes in October 2021. He went to the ER and was admitted to Longwood Hospital on 10/18/2021 with a blood sugar value of 627. States he has a blood

glucose monitor and his significant other who is a registered nurse showed him how to use it. He brought it with him this visit. Significant other and her child. He also has children from a previous marriage. He states he has financial resources for care and medical supplies and medications.
Weight: 306.6

Coping and Problem Solving Skills
Patient states he was surprised to get diagnosis of diabetes however his significant other and family are supportive of him. He feels confident with glucose monitoring which will be discussed below. He states he had /has some visual loss but believes it was related to hyperglycemia. He doe not have any literacy challenges. No social barriers of health have been identified at this visit. Patient states his major stresses are work and being diagnosed with diabetes and that he does not really have a method to manage his stress at this time. His stress level is 3 out of a 5. Reports that his employer and work colleagues are supportive. States he is motivated as he wants to be around his grandbabies for a long time.
Education & Discussion:

- How stress and cortisol raises blood glucose.
- Importance of methods to reduce stress such as deep breathing exercises, listening to music, embracing personal spiritual or religious activities or engaging in a hobby.
- Importance of mindfulness and making time for self-care.
- Setting SMART goals, not setting goals that are too high, and importance of positive self-feedback and recognition when goals are achieved.

Medication
Patient's medications were reviewed and reconciled. He is taking Metformin 1 gm twice a day and he denies any GI distress from it. He is also taking glimepiride and denies any hypoglycemia at this time.
Education & Discussion:

- Take medications as prescribed and report side effects.
- Action and side effects medications for diabetes.
- Biguanides such as Metformin: Helps lower blood glucose levels primarily by decreasing the amount of glucose produced by the liver. ° Helps lower blood glucose levels by making muscle tissue more sensitive to insulin so glucose can be absorbed. May cause GI distress/diarrhea, but this is improved when taken with food and slowly titrated up to full dose. Does do not usually cause hypoglycemia. Free at many pharmacies.
- Sulfonylureas: Glimepiride or glipizide or glyburide. Such as but not limited to stimulates the pancreas to squeeze out some extra insulin. Can take once or twice daily before meals. Low cost. Can cause hypoglycemia.

Monitoring
Patient states he is monitoring twice a day. He is performing fasting and a 2-hour postprandial dinner blood glucose test. His usual FBS is 140. He is using the bionime glucometer.
Education & Discussion:

- Pretesting blood glucose fingerstick procedures such as gathering equipment, washing hands,

inserting test strips, and preparing lancet device.
- Fingerstick procedure and collection of blood on testing test.
- Target goals, meaning of FBS versus 2- hour postprandial from time of meal.
- Cleaning meter, storage of strips, checking expiration dates, and keeping blood glucose log. Don't use strips from other meters.
- Proper disposal of lancets and not to re-use them.
- Importance of not using multiple meters for testing and not allowing others to check their blood glucose on patient meter.
- Glucometer settings and functions available and how to utilize results.
- Use blood glucose results to make healthier decisions.
- Importance of blood glucose monitoring, record results, and to bring results , meter and testing supplies to appointments.

Healthy Eating
Patient states he used to drink lots of Gatorade and sweet tea and have breakfast and lunch which was usually obtained from Arby's or McDonald's or similar fast foods. Missing teeth which makes chewing certain foods difficult and also voices self-consciousness over it.
Education & Discussion:
- Healthy plate method and portion sizes information given to patient. Reviewed in detail.
- Basics of fats, proteins, and carbohydrates.
- Importance of reading nutritional labels and what they mean.
- Importance of meal planning, easy preparation, and eating less drive-through foods.
- Read nutritional information on restaurant websites to make better decisions when dining out.

Physical Activity:
He does not have a physical activity routine. He usually works 60 to 70 hours a week and goes into work around 9 AM and sometimes does not get home until 830 or 9 PM. He is a mechanic and supervisor at an auto body repair shop. He also has animals/farm that he tries to help his significant other with.
Education & Discussion:
- Benefits of mild to moderate physical activity on blood glucose and overall health.
- Increase physical activity even in 10-minute increments 3 times a day.
- Aim for at least 150 minutes of moderate physical activity such as walking, riding a bike, and or swimming.

Risk Reduction / Prevention of Complications:
Had not maintain medical care especially during Covid. States he is also uninsured and this has been a factor in medical care. However he did need dental care and was able to seek that through TCCH last year.
Education & Discussion: Health reminders and importance of completing them.
- COVID and other common vaccine benefits.
- Weight reduction of 7 -10 % and benefits to overall health.
- Foot care, daily feet inspections, to inspection soles of shoes, and good footwear. Avoid going barefoot.
- Importance of annual eye and dental care.

**Patient:**
**DOB:**
**SSN:** *-----

**Date:** **10/22/2021 12:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **Nurse Education Visit**

Plan / Patient Centered Goals:

- Patient to walk Rosie, a horse every day for 30 minutes or 10 minutes 3 times a day.
- Short-term goal fasting blood sugar between 120 and 130. Postprandial glucose between 140 and 180.
- After eating lunch or dinner take a 10-minute walk.
- Continue blood sugar as a FBS and 2-hour postprandial.
- Seek healthier options for meal planning
- Follow-up DSMES visit October 29, 2021.

Face to Face time: 60 min.

## CARE TEAM

Educator Diabetes

**Patient:**
**DOB:**
**SSN:** *****

**Date:** 10/29/2021 12:30
**Provider:** Diabetes, Educator
**Encounter:** Nurse Education Visit

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
diabetes education follow-up

## REFERRED HERE
Dr. A. Pham

## PHYSICAL FINDINGS
- Vitals taken 10/22/2021 12:17 pm

| | |
|---|---|
| Height | 67 in |
| Weight | 306 lbs 9.6 oz |
| Body Mass Index | 48.0 kg/m2 |
| Body Surface Area | 2.42 m2 |

- Vitals taken 10/29/2021 12:39 pm

| | |
|---|---|
| Weight | 308 lbs |

## NOTES
Subjective / Objective:
1:1 DSMES
Patient states he is doing well. He brought his glucometer with him.

Coping and Problem Solving Skills & Education & Discussion:

**Patient:**
**DOB:**
**SSN:** *****

**Date:** **10/29/2021 12:30**
**Provider:** **Diabetes, Educator**
**Encounter:** **Nurse Education Visit**

Patient denies any coping challenges and none identified this visit. He denies problem solving challenges and states he is able to work on his goals at this time with the help of his family and DSMES diabetes educator.

Medication & Education & Discussion:
Medications reviewed and reconciled. Patient denies side effects and states he is taking medications as ordered.

Monitoring
FBS this morning was 162. Last night his 2-hour postprandial after dinner was 144. At 7:11 PM after having a banana his blood glucose was 189. His 7-day average is 169 and he is trending higher in the a.m. Is able to demonstrate proper technique as well as navigate results in his glucometer settings.
Education & Discussion:

- Importance of not using multiple meters for testing and not allowing others to check their blood glucose on patient meter.
- Glucometer settings and functions available and how to utilize results.
- Use blood glucose results to make healthier decisions.
- Importance of blood glucose monitoring, record results, and to bring results , meter and testing supplies to appointments.

Healthy Eating
States they are ordering ever fresh meals for dinner and his daughters are preparing his lunch meals. He has not eaten at any fast food restaurants and has increased his water intake. He had his bottom teeth removed about 1 year ago and is waiting to get dentures. States he is doing better than he thought with not eating fast food. He is feeling satisfied with meals and believes his portion sizes are definitely smaller than they used to be. States lunches and dinners align with the Healthy Plate method.
Education & Discussion:

- Healthy plate method and portion sizes and basics of fats, proteins, and carbohydrates.
- Importance of reading sugar content and to divide by 4 to determine # of teaspoons in drinks. As well as choose low carbohydrate fruits versus eating a large banana.
- Importance of staying hydrated and options other than water. Such as un- sweet teas, low sodium broths, and fruits and vegetables high in water content.
- Importance of meal planning, easy preparation, and eating less drive-through foods.
- Read nutritional information on restaurant websites to make better decisions when dining out.

Physical Activity
States he has not met his physical activity goals due to plantar fasciitis on his left foot and hurts when walking. Walked Rosie maybe once or twice. Is considering purchasing new work boots. Not receptive to foot exam this visit, states work boots are too difficult to get off and back on. Patient states he usually is tired when he comes home from work and then he assists with care of animals.
Education & Discussion:

**Patient:**
**DOB:**
**SSN:** *******

**Date:** **10/29/2021 12:30**
**Provider:** **Diabetes, Educator**
**Encounter:** **Nurse Education Visit**

- Benefits of mild to moderate physical activity on blood glucose and overall health.
- Increase physical activity even in 10-minute increments 3 times a day.
- Aim for at least 150 minutes of moderate physical activity such as walking, riding a bike, and or swimming.
- Negative influences of being sedentary such as higher blood glucose, weight gain, muscle loss.

Risk Reduction / Prevention of Complications
Needs full exam, eye exam, and vaccinations. He has not been vaccinated for Covid 19 and declines at this time.
Education & Discussion:

- Eye exam scheduled for 11/5/2022
- Foot care and foot wear, States he does inspect his feet daily and denies any sores on feet.

Plan / Patient Centered Goals:
Reduce A1C from 12.0 to 7.5 -8.0%
Reduce weight from 308 pounds to 299

- Walk 30 min. everyday, can be in 10 or 15 min increments
- FBS every morning and 2 hr. post prandial dinner. Use results for decision making.
- Limit sugary drinks / ice tea- is now mixing 50-50.
- Continue progress on healthy eating.

Follow- up visit 11/5/2022

Face to Face time: 60 min.

## CARE TEAM

Educator Diabetes

**Patient:** 1
**DOB:**
**SSN:** ******

**Date:** 11/05/2021 12:30
**Provider:** Diabetes, Educator
**Encounter:** [Patient Encounter]

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
DSMES follow-up

## REFERRED HERE

## NOTES
Subjective / Objective:
Patient is here for follow-up 1:1 DSMES. Patient newly diagnosed with type 2 diabetes in October. He brought his lunch since he is on his lunch break from work. Works across the street so it does not take long for him to get here. Focus for session today will be on his progress and behavior changes so that he can meet his goals.

Coping and Problem Solving Skills
States he is coping well although he feels like he has a lot to learn about diabetes and gets confused searching the Internet for additional information. Daughters are supportive and continued to make his lunch. Significant other is also supportive.Patient states his employer has been great with letting him have time off and will continue to let him have time off from needed appointments. Patient voices frustration that he is used to working 60 to 70 hours a week and is also trying to make up loss of work hours.
Education & Discussion:
- Pathophysiology of type 2 diabetes
- Meaning of self-management and with the creation of habits living with diabetes can be

easier and result in long-term behavior changes that are beneficial.
- Importance of setting smart goals and our next session will specifically focus on breaking his goals into meaningful bite-size steps to achieve.
- Provided patient with established and reputable Internet resources to access versus random searches.

Medication & Education & Discussion:
Reviewed and reconciled. Patient states he is taking them as ordered. Action and purpose of medications were previously addressed. Patient denies side effects and does not have questions at this time.

Monitoring & Education & Discussion:.
Patient is meeting his goals of testing FBS and 2-hour postprandial.
- Patient understands the differences between FBS, 2-hour postprandials and random blood sugars.
- A1c results and the difference between fingersticks.
- Meeting fasting blood glucose and 2-hour postprandial goals and the difference between them. Work on these goals slowly for sustainablity.
- Importance of recognizing achieving lower blood glucose results

Healthy Eating & Education & Discussion:
Patient states they have been continuing to use ever meals for dinner which makes meal planning easier since both he and his significant other work full time. He is eating the lunches that his daughter prepares for him. which follow the healthy plate method. He is feeling confident with the support of his children and significant other. He is meeting his goal of not eating at fast foods and reducing the sugar content of his iced tea. Patient states he has reduced his portion sizes and is feeling satisfied with his meals.

Physical Activity & Education & Discussion:
This area is a particular challenge for patient. He did not have a physical activity routine prior to diagnosis and felt the activity he did at work and not at was sufficient. States his employer is also supportive of him developing a physical activity routine and and possibility of him joining a gym or doing some type of formal workouts. He states he is also tired when he gets home. He is also cautious not to flare-up plantar fasciitis, He is not gotten new work boots yet.
- Relationship and association of high A1c's energy level and overall sense of wellbeing and that as he begins to lower his A1c he will most likely have more energy.
- Start slowly with 10-minute increments. Begin with walking for 10 -15 minutes after he has lunch at work.

Risk Reduction / Prevention of Complications & Education & Discussion:
Had diabetic eye exam this morning. Declines vaccinations at this time including Covid.

Plan / Patient Centered Goals:
No changes in established goals this visit. Patient will walk for 10 to 15 minutes after lunch while he is at work.

**Patient:**
**DOB:**
**SSN:**

**Date:** **11/05/2021 12:30**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

Is to continue his healthy eating and the changes that he has made with the support of his family. Follow-up visit 11/11/2021 with the main focus on reviewing and assessing his goals and understanding the importance of smart goals for better results

Face to Face time: 60 min.

## CARE TEAM

Educator Diabetes

**Patient:**
**DOB:**
**SSN:** *****

**Date:** **11/11/2021 22:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
diabetes education follow-up

## REFERRED HERE

## NOTES
Subjective / Objective:
Here for a DSMES follow-up visit to specifically address smart goals. Initial goals expressed by patient are:
Will walk for 10 to 15 minutes after lunch while at work.
Continue healthy eating and the changes that he has made with the support of his family.

Problem Solving Education and discussion:
How to develop smart goals:
Patient was given copy of my SMART goals work sheet in each section was reviewed to assist patient with creating his smart goals.
We addressed in detail the components of a SMART goal:
- Specific
- Measurable
- Achievable
- Realistic
- Timely

**Patient:**
**DOB:**
**SSN:** ******

**Date:** **11/11/2021 22:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

We included the benefit / motivators of achieving his goals, potential obstacles with potential solutions and who is available to assist patient in achieving them.
Present during this visit was University echo project diabetes peer support coach who is purpose is to available to people living with diabetes. She is able to assist patients with local resources, listening to patient's challenges and assisting them with that, possibly attending appointments with them. She does not provide any medical advice. Is also available to be ongoing support after patient's complete DSMES.

Plan / Patient Centered Goals:
Patient short-term goal is to lose 25 pounds and will be at a weigh close to 285 pounds, he states he will do this through eating healthier and being more physically active. Walk 10 to 15 minutes during his lunch break at work 5 days a week. His motivation is to spend time with his grandchildren. He would like to accomplish this by 1/13/2022. He would also like to take less medications and lower his A1C to less then 8 by 1/13/2022. A significant challenge for patient was drinking sweet teas and drinks. He states he is no longer eating at fast foods and this has not been a problem with his co-workers who often chose this option. He is okay with eating lunch that his daughters prepare. He is happy to announce that he is no longer drinking sweet teas since last week. Patient reinforces that his support system consists of his significant other, daughters, and coworkers as well as DSMES appointments.
Follow- up appt. scheduled for 12/2/2022 Libre Freestyle CGM.

Face to Face time: 60 min,

## CARE TEAM

Educator Diabetes

**Educator Diabetes**
**Electronically signed by:**

**Electronically approved by:**

**Patient:**
**DOB:**
**SSN:** *****

**Date:** 12/02/2021 16:25
**Provider:** Diabetes, Educator
**Encounter:** [Patient Encounter]

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
diabetes education follow-up and Libre Freestyle CGM

## REFERRED HERE

## HISTORY OF PRESENT ILLNESS
is a 54 year old male.
- Allergy list reviewed • Problem list reviewed • Medication list reviewed

## NOTES
Subjective / Objective:
Focus of this visit is education and insertion of libre freestyle CGM. Patient states he is doing well and has been able to work on his goals. Libre freestyle rep is present during this visit to provide support information.

Detailed information and education including but not limited to the following :
- Monitoring of BG using a CGM and fingersticks
- insertion, care and the use of the libre
- how it differs from the glucometer requiring fingersticks for hypo and hyperglycemia alarms
- Target goals
- Trends and how to address them

**Patient:**
**DOB:**
**SSN:** *****

**Date:** **12/02/2021 16:25**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

- How to enter food and activity events notes
- Does not replace fingersticks particularly for hypo and hyperglycemic events
- How to access the various information such as time in range, percentage of time spent in target, lows and highs.
- Signs and symptoms of hypoglycemia and how to treat using the 15 -15 rule

University of Florida diabetes support coach was present and provided patient with a CGM skin patch to support and reinforce the sensor remaining intact for 14 days. Reinforced to patient that he may reach out to her for support in between visits and when he completes DSMES.
In addition libre freestyle representative present during this visit to provide information to patient on company's patient support services and contact information. Written information also given to patient.

Plan / Patient Centered Goals:

- Patient to successfully use libre CGM to assist in accomplishing goals and improved glycemic results.
- Return 12/16/2022 to review CGM results and obtain patient feedback on use of CGM

Face to Face time: 60 min

## CARE TEAM

Educator Diabetes

**Educator Diabetes**
**Electronically signed by:**

**Electronically approved by:**

**Patient:**
**DOB:**
**SSN:** ******0017

**Date:** 12/09/2021 09:00
**Provider:** Diabetes, Educator
**Encounter:** Nurse Education Visit

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Atorvastatin Calcium 80 MG Oral Tablet Take 1 tablet once a day for CHOLESTEROL, 90 days, 1 refills
- Carvedilol 6.25 MG Oral Tablet twice a day 0 days, 0 refills
- Glimepiride 4 MG Oral Tablet once a day 0 days, 0 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime 0 days, 0 refills
- metFORMIN HCl 1000 MG Oral Tablet Take 1 tablet twice a day for DIABETES, 90 days, 1 refills
- metFORMIN HCl 500 MG Oral Tablet twice a day 0 days, 0 refills
- Pioglitazone HCl 30 MG Oral Tablet Take 1 tablet once a day for DIABETES, 90 days, 1 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
diabetes education follow-up : review / discuss Libre

## REFERRED HERE
Dr. A. Pham

## HISTORY OF PRESENT ILLNESS
ı is a 54 year old male.
- Allergy list reviewed • Problem list reviewed

## PHYSICAL FINDINGS
- Vitals taken 12/09/2021 09:24 am

| | |
|---|---|
| Height | 67 in |
| Weight | 298 lbs 12.8 oz |
| Body Mass Index | 46.8 kg/m2 |

**Patient:**
**DOB:**
**SSN:**

**Date:** **12/09/2021 09:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **Nurse Education Visit**

| | |
|---|---|
| Body Surface Area | 2.40 m2 |

## NOTES

Subjective / Objective:
Patient is here to discuss libre functionality such as alarms and connectivity concerns as well as discuss hypoglycemia.Patient's weight this visit is 298.8 pounds on 10/21/2021 his weight was 310. Patient A1c is 8.2 which is down from 12.0 in October.

Coping and Problem Solving Skills Education & Discussion:
Patient family remains supportive as well as his coworkers are supportive. Patient is a bit frustrated with low alarms alerts and if his sensor is working properly. He states his medications were changed and he has concerns about the increase in Metformin and the addition of pioglitazone.

Medication Education & Discussion:
Medications reviewed with patient. States the glimepiride was discontinued and pioglitazone was ordered. Also states Metformin was increased to 1000 mg twice a day. Patient states that he is still having GI distress from 500 mg twice a day. Patient has appointment with primary care physician next week and wants to discuss with physician his medication regime before he initiates his new therapies.

Monitoring Education & Discussion:
Libre sensor is intact and covered with CGM patch. Denies any insertion site discomfort or pain. Patient does not always have his phone on hand when he is at work and gets notifications that he has lost connection. Also states some places in the work environment does not have the best reception. Explained to patient that it is best that he keep his phone on him or nearby and that this might help with some of the connection issues he is experiencing. Review of libre shows that he is having lows and patient states even in the 70s he feels hypoglycemic and it is usually waking him up from sleep due to the alarms. Reviewed signs and symptoms of hypoglycemia and that patient may feel lows even above 70 because his A1c was so high previously. Patient states he is going to start having a snack before going to bed to minimize lows and the alarm going off. He is going to start with a half a peanut butter sandwich. Also discussed other options that are easy for patient to chew. Explained to patient that the low alarm cannot be turned off due to safety reasons. He should check his blood glucose with a fingerstick using his glucometer when he reads low to obtain an accurate current reading. Reinforced the difference between the CGM and glucometer. Patient has a little over a week left on libre CGM and discussed the benefits of looking at time in range versus one-time readings with a glucometer. Discussed the benefits of being able to add notes and see what pre and post meal glucose are as well as pre and post activity. Also discussed that occasionally there will be excursions in blood glucose that cannot be explained. Recognized patient's accomplishment with weight loss and reduction of A1c. Lowered upper target range since patient is doing well and is capable of staying below one 170. Patient is aware that this may cause some additional alarms but to use these notifications to make healthier decisions and correlate results with lifestyle habits. Patient voices understanding..

**Patient:**
**DOB:**
**SSN:** ******

**Date:** **12/09/2021 09:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **Nurse Education Visit**

Healthy Eating Education & Discussion:
Patient states he continues to eat healthy and is watching portion sizes. Is no longer drinking sodas or sweetened drinks. Daughters and significant other are supportive. They are also continuing buying meals from a E-Z Prep order site; states foods are fresh and good. And that it also makes mealtime i.e. dinner time easier especially since significant other works and sometimes has long days just as patient might have.

Physical Activity Education & Discussion:
Patient states he does not feel as strong as he used to feel and is wondering about that and if it is a side effect of medications. He will discuss with his physician. Patient has not really established a physical activity regime due to long work hours. Discussion and education on the importance of daily walking and exercise and how it benefits glycemic results. Patient voices understanding.

Risk Reduction / Prevention of Complications Education & Discussion:
Focus this visit was hypoglycemic symptoms and treatment. Patient is maintaining appointments and is progressing on meeting his goals.

Plan / Patient Centered Goals:

- Follow-up with MD appointment on December 15, 2021. Discuss with MD side effects of medication and new regime and other concerns.
- Follow -up DSMEs December 16, 2021
- I will discuss with Dr. Pham patient progress, hypoglycemic events and medication concerns.

Face to Face Time: 50 min.

## CARE TEAM

Educator Diabetes

**Educator Diabetes**
**Electronically signed by:**

**Electronically approved by:**

**Patient:**
**DOB:**
**SSN:** *****

**Date:** **12/16/2021 22:28**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Atorvastatin Calcium 80 MG Oral Tablet Take 1 tablet once a day for CHOLESTEROL, 90 days, 1 refills
- Carvedilol 6.25 MG Oral Tablet twice a day Take 1 tablet twice a day for blood pressure, 90 days, 2 refills
- Glimepiride 4 MG Oral Tablet once a day Take 1 tablet daily for DIABETES, 90 days, 3 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime Take 1 tablet daily for BLOOD PRESSURE, 90 days, 3 refills
- metFORMIN HCl 1000 MG Oral Tablet Take 1 tablet twice a day for DIABETES, 90 days, 1 refills
- Pioglitazone HCl 30 MG Oral Tablet Take 1 tablet once a day for DIABETES, 90 days, 1 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
diabetes education follow-up

## REFERRED HERE
Dr. A. Pham

## HISTORY OF PRESENT ILLNESS
-- :l is a 54 year old male.
- Allergy list reviewed • Problem list reviewed

## PREVIOUS TESTS
- 10/21/2021 Hemoglobin A1C 12.0 Abnormal
- 12/07/2021 CHOLESTEROL, TOTAL 206 mg/dL High
- 12/07/2021 GLUCOSE 127 mg/dL High
- 12/07/2021 HEMOGLOBIN A1c 8.2 % of total Hgb High

**Patient:**
**DOB:**
**SSN:** *******

**Date:** **12/16/2021 22:28**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

## NOTES

Subjective / Objective:
Patient states he saw Dr. l yesterday. States he is doing well. Please see the notes below regarding patient progress.

Coping and Problem Solving Skills & Education & Discussion:
Patient reports he is doing well significant other in children as well as employer and coworkers remains supportive. He also has a friend who is a chef in a restaurant not far from where he works who will customize patient's meals.

Medication & Education & Discussion:
Per patient and per review of MD notes patient can take Metformin 500 mg or at 1000 mg in a.m. and 500 mg in p.m. and then titrate up as tolerated. Patient states he will reduce the 1000 mg to 500 and then slowly titrate back up to avoid GI hypoglycemia. Physician has requested patient continue all other medications as prescribed.

Monitoring & Education & Discussion:
Patient A1c on 12/15/2022 was 8.2 this is reduced from 12.0% on 10/21/2021. Patient is pleased to see this improvement in glycemic results and his getting close to reaching his goals. Is using his glucometer.

Healthy Eating & Education & Discussion:
Patient will continue with meal planning as established. He will also reach out to his friend who is a chef with diabetes who has agreed and is supporting patient that he will make him meals that patient can order. Patient is pleased to have this additional support.

Physical Activity & Education & Discussion:
Patient states he is walking for 10 to 15 minutes on his lunch break at work. States his employer is supportive and encouraging him to also join a gym to be more physically active. Patient will consider however he states he long work hours and when he gets home He needs to help around the house and he is tired.

Risk Reduction / Prevention of Complications & Education & Discussion:
Patient had his eye exam.
needs foot exam which is declined this visit Needs dental appointment.
Patient's weight is now down to 298.4. His weight on 10/22/2021 was 306.6 pounds

Plan / Patient Centered Goals:
Patient to return on 1/26/2022 to review progress on his goals and to determine what support services he will need for sustainablity.
Recognition on patient's progress celebrated this visit.

**Patient:**
**DOB:**
**SSN:** *******0817

**Date:** **12/16/2021 22:28**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

Face to Face time: 60 min,

## CARE TEAM

Educator Diabetes

**Patient:**
**DOB:**
**SSN:** *****

**Date:** **01/26/2022 10:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

## ACTIVE PROBLEMS
- Diabetes Mellitus Type 2
- Essential Hypertension
- Gout
- Hyperlipidemia Due To Type 2 Diabetes Mellitus
- Obesity Morbid Due To Excess Calories

## CURRENT MEDICATION
- Atorvastatin Calcium 80 MG Oral Tablet Take 1 tablet once a day for CHOLESTEROL, 90 days, 1 refills
- Carvedilol 6.25 MG Oral Tablet twice a day Take 1 tablet twice a day for blood pressure, 90 days, 2 refills
- Glimepiride 4 MG Oral Tablet once a day Take 1 tablet daily for DIABETES, 90 days, 3 refills
- Losartan Potassium 25 MG Oral Tablet 1 every bedtime Take 1 tablet daily for BLOOD PRESSURE, 90 days, 3 refills
- metFORMIN HCl 1000 MG Oral Tablet Take 1 tablet twice a day for DIABETES, 90 days, 1 refills
- Pioglitazone HCl 30 MG Oral Tablet Take 1 tablet once a day for DIABETES, 90 days, 1 refills

## ALLERGIES
- No Known Allergies

## REASON FOR VISIT
DSMES: 1:1 review and follow-up

## REFERRED HERE
Dr. A. Pham

## PHYSICAL FINDINGS
- Vitals taken 01/26/2022 10:10 am

| | |
|---|---|
| with work boots on | |
| Height | 67 in |
| Weight | 297 lbs 6.4 oz |
| Body Mass Index | 46.6 kg/m2 |
| Body Surface Area | 2.39 m2 |

## PREVIOUS TESTS

**Patient:**
**DOB:**
**SSN:** ******

**Date:** **01/26/2022 10:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

- 10/21/2021 Hemoglobin A1C 12.0 Abnormal
- 12/07/2021 HEMOGLOBIN A1c 8.2 % of total Hgb High

## NOTES

Subjective / Objective Review and DSMES discussion of goals and plans includes coping and problem-solving skills, medications, monitoring, healthy eating, physical activity, risk reduction and prevention of complications.:

- Patient weight with new work boots on is down to 297.4 pounds. At home was 294.3. Patient weight on 10/21/2021 was 310. His BMI was 48.6 on 10/21/21 and as of today his BMI is 46.6. States he believes his weight loss is due to healthier lifestyle choices and healthier eating. He is pleased with these results and will continue to work on them. Patient goal was reduce his weight to 299 pounds and to weigh himself daily which he has been doing.
- Patient is pleased to report that he is testing his blood sugar 2-3 times a day via fingersticks and that his average blood sugar is 113. Reports that change in food choices and avoidance of fast foods and sweet drinks has been a change in behavior and will continue with these measures. Is also using these results to continue healthier lifestyle choices. Patient states that the libre CGM helped him discover how much time in range and outside of his target goals he was and that information was beneficial for the 14 days. He does not want to continue it and will use fingersticks for glucose monitoring.
- Patient states he saw MD on 12/15/2021 and instructed patient to decrease Metformin to 500 mg twice a day or take 500 mg in the p.m. and 1000 mg in the a.m. due to GI distress ; patient states he is taking 500 mg twice a day without difficulty.
- A1c this visit is 6.8. Patient's goal was to reduce A1c from 12.0 to 7.5 to 8.0% by this time. Patient is pleased that his A1c at this visit is 6.8 and he attributes to behavior changes and improved health. His lipids are also better. Patient voices success is to behavior and lifestyle changes and having manageable goals.
- Patient states that not eating fast foods and sugary drinks has made a difference. He also attributes this to the fact that his daughters have been making his lunches and that in the evening he and his significant other are eating healthy portioned meals close to the natural sources. Patient will transition from his daughters making lunches to ordering lunch meals from a local chef who owns a restaurant nearby who will make patient his meals for lunch. He will continue the meal delivery for dinner time.
- Have foot exam and other health reminders completed to prevent complications.
- Patient states he is able to walk 10 to 15 minutes every day while at work and tries to be more active once he gets home. This is a difficult area for patient and he may consider accessing additional resources such as local community physical activity events or joining a gym. We readdressed the benefits of physical activity and how to gradually increase them throughout the day a week. Purchased new work boots which has made a difference and he feels like he has less foot pain.
- Patient states he is pleased that he has met his goals and is feeling confident that he can continue his progress. He feels like his barriers have been addressed and that he has support systems and resources available.

**Patient:**
**DOB:**
**SSN:** *******

**Date:** **01/26/2022 10:00**
**Provider:** **Diabetes, Educator**
**Encounter:** **[Patient Encounter]**

Plan / Patient Centered Goals:

- To schedule a follow-up appointment with MD.
- To request / schedule follow-up with diabetes educator for additional support and adjustment of goals. I will reach out to patient to schedule an appointment if I do not hear from him so that patient does not regress or get frustrated with living with diabetes.
- Follow-up for dental care so that he has less difficulty chewing foods.
- Patient is uninsured however he has resources inside and outside of that he is able to access and is accessing.

Face to Face time: 60 min.

## CARE TEAM

Educator Diabetes

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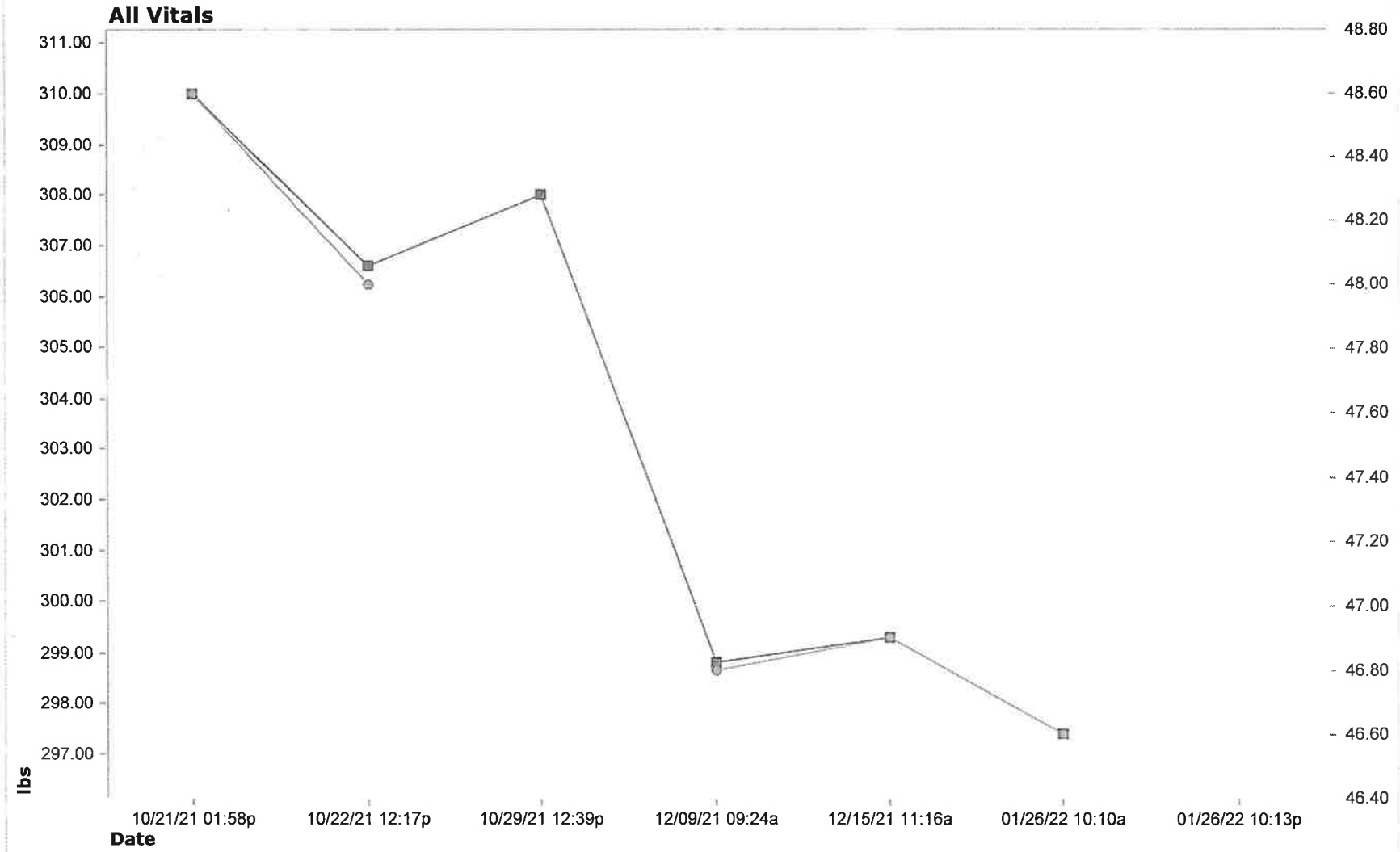


| | 10/21/21 01:58p | 10/22/21 12:17p | 10/29/21 12:39p | 12/09/21 09:24a | 12/15/21 11:16a | 01/26/22 10:10a | 01/26/22 10:13p |
|---|---|---|---|---|---|---|---|
| Weight (lbs) | 310.00 | 306.60 | 308.00 | 298.80 | 299.31 | 297.40 | |
| Body Mass Index | 48.60 | 48.00 | | 46.80 | 46.90 | 46.60 | |

M XXX-XX-

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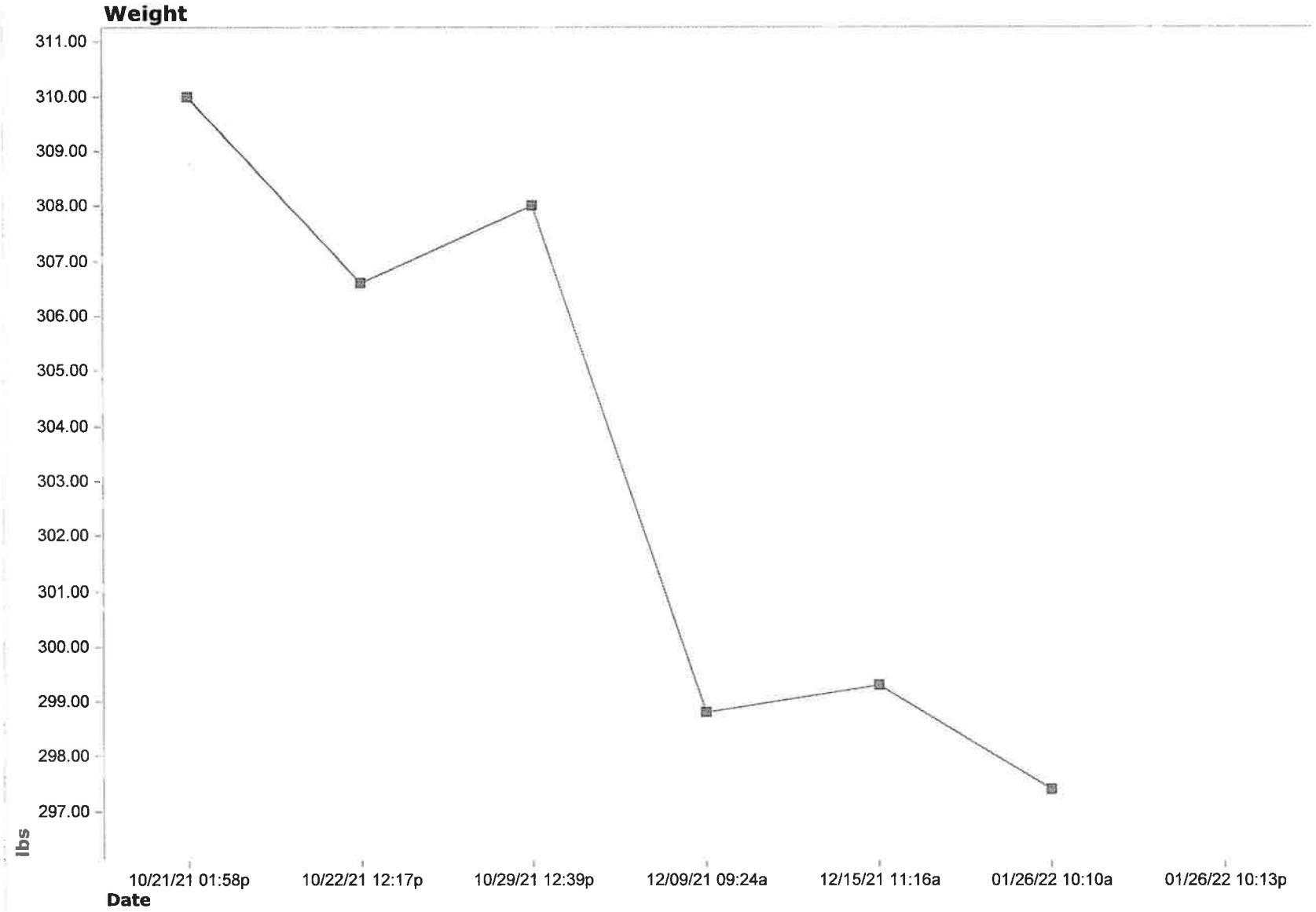

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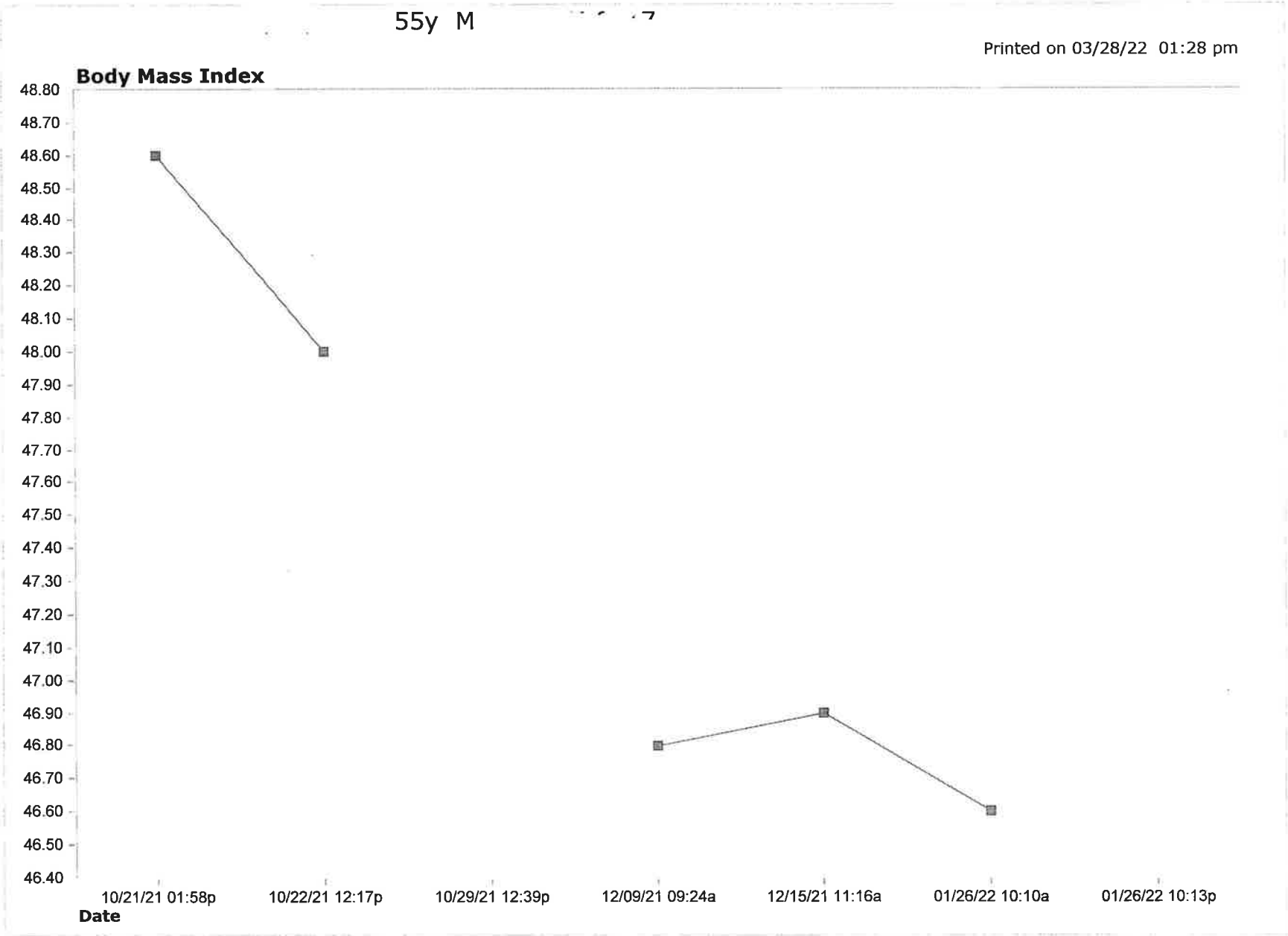

**STANDARD 6: MEASURING AND DEMONSTRATING OUTCOMES OF DSMES SERVICES**

| 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. | 39 |
| ☐ 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** | 40 |
| ☐ One CQI project will be reported with related outcomes each year as part of **Annual** Status Report | |

## Standard 6

**Standard 6: Measuring and Demonstrating Outcomes of DSMES Services**

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

Outcome measures can include but not limited to A1C results, blood pressure improvement, BMI improvement, number of referrals, number of patients completing DSMES. Outcome measures will also include input from stakeholders and TCHH improvement measures.

Process:

1. Maintain a quality improvement process and plan to evaluate the education process and service outcomes. We use the PDCA process. ( Plan, Do , Check, Act)
2. Document evidence of aggregation of the following participant outcomes:
    a. At least one clinical/behavioral goal outcome
    b. At least one clinical, behavioral or process outcome
3. Include in the Continuous Quality Improvement (CQI) project
    a. Opportunity for DSMES service improvement or change.
    b. Baseline project achievement
    c. Project target outcome
    d. Outcome assessment and evaluation.
4. Base CQI on regular aggregation of DSMES outcomes data and application of results to enhance quality of the DSMES and address gaps in service. Document an ongoing quality improvement project and implementation of new projects when applicable.
    a. Quality improvement outcomes must be documented and evaluated every 6 months at a minimum.
    b. Maintain documentation of plans and actions based on project outcome.

Addendum: CQI Process. DSMES 2022-2023 target goals

TCCH DEAP 2022 -2023 Target Goals

1. Reduce patient A1C's above 9.0 from 35.5 % to 31.94 %.
2. Identify 2021 and first quarter 2022 benchmarks, trends, and QI measures for baseline data for on-going DSMES CQI process.
3. Sustain our DSMES accreditation program annually through 2030 and beyond.