

Policy and Procedure Manual
Diabetes Self-Management Education and Support
Services

(Revised February 2021)

ABC Community Based Organization (CBO)
Anywhere, USA

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Introduction

The ABC CBO Diabetes Self-Management Education and Support (DSMES) services is based on the ten (10) National Standards for Diabetes Self-Management Education and Support. Our program secures stakeholder input, at least annually, to ensure continuous quality improvement. The ABC DSMES services has an advisory committee as our method of securing stakeholder input. The advisory committee reviews the policies and procedures for the ABC CBO DSMES program at least annually and makes recommendations to the quality coordinator on ways to improve the delivery of DSMES to the target population.

When changes are made to the ten (10) National Standards, the policies and procedures will be amended to reflect those changes.

Initial Implementation Date for the ABC CBO Policy and Procedure Manual:

Date of Initial Approval	Quality Coordinator Signature
[Put Date Here]	Ms./Mr. First Name Last Name

Policy Update Log (sample entries. The update log should be amended every time there is a change to the policy and procedure manual):

Date Approved	Section/Paragraph Amended	Change
October 5, 2018	Section 3, Paragraph 1	Revised section relating to CHW supervision
November 18, 2018	Section 2, Paragraph 4	Changed the page heading
Etc.	Etc.	Etc.

The Ten 2017 DSMES National Standards

STANDARD 1. Internal Structure

The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization -- large, small, or independently operated.

STANDARD 2. Stakeholder Input

The provider(s) of DSMES services will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.

STANDARD 3. Evaluation of Population Served

The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services.

STANDARD 4. Quality Coordinator Overseeing DSMES Services

A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement.

STANDARD 5. DSMES Team

At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDCES) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.

STANDARD 6. Curriculum

A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.

STANDARD 7. Individualization

The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES team member(s) will develop an individualized DSMES plan.

STANDARD 8. Ongoing Support

The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will best maintain their self-management needs.

STANDARD 9. Participant Progress

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

STANDARD 10. Quality Improvement

The DSMES services quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.

Policies and Procedures Specific to the Ten National Standards

[Here you repeat each of the standards, with the policies and procedures applicable to each standard, as shown below]

Standard 1. Internal Structure

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

Policies and Procedures Applicable to Standard 1:

Mission Statement:

The ABC Area Agency on Aging is committed to improving the quality of life and maintaining the dignity of older adults in our region. We achieve this mission by providing leadership and support, developing community partnerships, establishing comprehensive services, and disseminating accurate information.

The Vision of ABC CBO is to be a(n):

- Leading innovator in developing programs that meet the changing needs of the area's aging and disabled population
- Catalyst in collaborating with other organizations to develop a comprehensive network of services for older adults and persons with disability in our community
- Expert in securing adequate funding to serve the growing and diverse aging and disabled population
- Leader in promoting the well-being of older adults and persons with disability by empowering them through high-quality information and programs

Diabetes Education is Part of ABC CBO's Mission:

As part of ABC CBO's core services and mission, we provide services funded in part through the Older Americans Act (OAA). These services include health promotion and disease prevention (Title IIID of the Older Americans Act). As a result of this focus on health, we expanded our core services to provide the Chronic Disease Self-Management Program (CDSMP) and the Diabetes Self-Management Program (DSMP) developed at _____ [here you list the name of the evidenced-based program, e.g., originally developed at Stanford University, as applicable]. ABC CBO targets older adults and persons with disability with a diagnosis of diabetes. We specifically target older adults and persons with disability that are community dwelling and could benefit from disease self-management education and support. To meet the needs of the target population, our Diabetes Self-Management Education and Support classes focus on reaching older adults in minority groups who are most affected by diabetes and diabetes-related complications in our service area.

Diabetes Self-Management Education and Support Program Mission Statement:

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

education and disease management strategies.

Diabetes Education Process and Self-Management Support:

The DSMES services is an eight-week intervention, which begins with each participant undergoing a detailed individual assessment conducted by the licensed instructor, a registered dietician (RD). Based on the results of the individual assessment, the licensed instructor develops a comprehensive education plan. A key component of the individual assessment and education plan is the establishment of individualized goals and self-management support strategies. This initial session is week 0 and occurs prior to the implementation of a group intervention.

After completion of week 0, the participant participates in the six (6) week Diabetes Self-Management program. Two trained lay leaders, under the supervision of the licensed instructor, facilitate the group workshops from a highly detailed manual. Participants, in the group education sessions make weekly, individualized action plans, share experiences regarding their achievement of individualized goals, and help each other solve problems they encounter in creating and carrying out their individualized self-management program. The DSMES education will document the individualized outcomes of the program for each participant.

The lead instructor ensures that all members of the DSMES education team are properly trained to deliver the curriculum and possess the ability to deliver the educational content as intended. In addition, the group instruction occurs in a setting that allows for interaction between the participants and the trained group leaders. The lead instructor maintains responsibility for ensuring that they are accessible to the trained members of the education team during each group session.

ABC CBO implements an evidence-based curriculum to deliver DSMES. The instructional materials have been provided to our program's Advisory Council as part of our continual quality improvement review process. Workshops are conducted in a manner to encourage full participation by all members of the group. The group learning process increases participants' ability to learn self-management behaviors in an environment of mutual support enabling them to build on the success of their peers.

At the completion of the six-week group training sessions, each participant will complete a follow up assessment with the lead instructor to review their effectiveness in achieving the goals of their individualized education plan. This review provides the lead instructor with an opportunity to augment and modify the participant's disease self-management plan, if necessary. All follow up is communicated by members of the DSMES education team to both the participant and the referring primary care provider.

This review constitutes the 8th week in the eight-week intervention.

Link to Self-Management Resource Center:

<https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/>

Standard 2. Stakeholder Input

The provider(s) of DSMES will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.

Policies and Procedures Applicable to Standard 2:

The ABC DSMES program will establish and maintain a diabetes self-management education advisory group to provide ongoing external input to achieve improvements in program quality.

The diabetes self-management education advisory group will meet as needed, but no less than annually to review and analyze the diabetes self-management education program. Membership shall include, but is not limited to, the following:

Advisory Group Member Name	Position/Title/Professional Credentials
List Members Here	List position/title/professional credentials here. Be sure to include: <ul style="list-style-type: none">- Medical Director/PCP- PQI- Community member/former participant with diabetes- Community Health Center Educator, Certified Diabetes Educator- Others, as determined applicable- Etc.

Advisory Committee functions:

- Actively reviews the DSMES program and outcomes (process and clinical outcomes)
- Actively reviews the CQI data reports developed by the quality coordinator
- Makes recommendations to help improve and maintain the program
- Reviews the annual program plan and evaluation
- Reviews the continuous Quality Improvement Plan
- Annually reviews the current policy and procedure manual
- Assess for the impact of social determinants on the target population and seek solutions to address perceived or real barriers to disease self-management
- Identify best practices to improve provider referrals to the DSMES program

Standard 3. Access

Evaluation of population served:

The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population’s need for DSMES services.

Policies and Procedures Applicable to Standard 3:

Target Population

Geographic Region: South East Metro, Anywhere USA

Expected Volume: 21-100 monthly

Settings: (Fill in type of sites) Older adult activity centers

Community Site: Older Adult Activity Centers in South East Metro area

Setting Descriptors: (Describe population served) Low-income Latino population

Target Population's unique characteristic: Older Adults (generally age 60+) and persons greater than 18 with a disability.

Tailoring to target population: To meet the needs of this older adult population, the DSMES program will be particularly tailored to address challenges that include, but are not limited to low vision, hearing loss, limited mobility. In order to increase participant compliance with our DSMES program, we will continually assess for the impact of social determinants on our target population. We will seek solutions to overcome real or perceived barriers to participation to facilitate referrals and increase the percentage of program participants that complete the defined DSMES program curriculum (completers). Educational material using large print will be utilized when necessary. Hearing assistance devices will be available. All site locations will accommodate walkers, wheelchairs and other devices designed to improve mobility.

Program instructors will have particular experience in working with older adults so as to have a heightened ability to recognize other needs of the population. While the majority of the target population is English speaking, educational material will be available in the other languages prevalent in the geographic areas served (Spanish, Cambodian, Creole, etc.) and translation services will be made available when necessary. Further, some segments of the target population have incomes at or below the federal poverty limits. Populations that live at or below the poverty line are often disproportionately impacted by social determinants of health. Our program delivery model will continually assess for the impact of social determinants and incorporate solutions to social determinants in the education process.

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

At least annually, an assessment of the target population will be performed to address access to

healthcare services, cultural influences, barriers to education, and appropriate allocation of resources. Resources allocated include funding for program intervention and assessment, physical space, transportation costs, social determinants impacting the population and other factors as determined from the stakeholder group.

Standard 4. Quality Coordinator Overseeing DSMES Services

A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement.

Policies and Procedures Applicable to Standard 4:

The ABC CBO Diabetes Self-Management Program will maintain the services of a Quality Coordinator. The Quality Coordinator has the responsibility of providing oversight of the DSMES program, including planning, measuring program quality, conducting continuous quality improvement, implementation, and evaluation of education services. A key task of the Quality Coordinator is the collecting and evaluation data to identify gaps in DSMES providing feedback on performance to all DSMES team members, sharing program quality with referring providers and the organizational leadership.

Quality Coordinator Job Description

<Insert the Quality Coordinator Job Description Here (Sample Below)>

TITLE: DSMES Quality Coordinator

REPORTS TO: Quality Coordinator (manager, administrator, CEO, etc.)

SUPERVISES: DSMES program staff (licensed instructors, group leaders, community health workers, etc.)

POSITION OVERVIEW: Provides oversight for planning, implementation, and evaluation of the DSMES program and ensures the systematic and coordinated delivery of diabetes educational services.

DUTIES AND RESPONSIBILITIES:

- Provides direction for the selection, and ongoing review, of the curriculum and educational materials to ensure they meet the needs of the population targeted.
- Monitors program quality, using a data-driven approach, and reports program quality outcomes to external and internal stakeholders.
- Monitors DSMES referral patterns and makes recommendations to increase referrals.
- Develops and directs the implementation of an annual program evaluation plan and

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

KNOWLEDGE, SKILLS, AND ABILITIES:

- Knowledge about chronic disease management and disease self-management educational processes.
- Supervisory abilities.
- Knowledge about program management and the ability to analyze program data to drive quality outcomes.
- Proficiency in various computer applications, including spreadsheets.
- Marketing skills.

EXPERIENCE/EDUCATION:

- Education and/or experience in program management.
- Education in, and/or experience with, chronic diseases and disease self-management.
<Insert Quality Coordinator resume here>

<Insert copy of Quality Coordinator’s license/certification here (if applicable)>

<Insert documentation of Quality Coordinator’s pertinent training here (if applicable)>

Standard 5. DSMES Team

At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDCES) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.

Policies and Procedures Applicable to Standard 5:

The ABC CBO Diabetes Self-Management Education Program will have one or more instructors providing DSMES that constitutes the DSMES team. At least one of the instructors will be a registered dietitian (RD) [if applicable to your program]. The Licensed Instructor will be a licensed professional and hold a current license in one of the following professions – Registered Nurse, Registered Dietitian, or Registered Pharmacist, in the State that the DSMES program is

providing services to participants.

The ABC CBO Diabetes Self-Management Education and Support Program uses paraprofessionals (lay leaders/community health workers) in the provision of diabetes self-management education. Lay leaders/community health workers provide assistance with diabetes self-management education and support, under the supervision of the Licensed Instructor or other affiliated licensed professional instructor for the program. Paraprofessionals contribute by providing participant instruction, reinforce self-management skills, support behavior change, facilitate group discussion, provide psychosocial support, and ongoing self-management support. Paraprofessionals operate as an essential member of the DSMES team. When there are clinical issues that exceed the scope of practice of the paraprofessional, the paraprofessional is trained to escalate the issue to the licensed instructor on the DSMES team.

Job Descriptions: Licensed Instructors and Paraprofessional Group Leaders

<Insert the Licensed Instructor and Paraprofessional Group Leader Job Descriptions Here (Samples Below)>

TITLE: Professional Diabetes Program Licensed Instructor

REPORTS TO: DSMES Quality Coordinator

SUPERVISES: Paraprofessional instructional staff, Group Leaders

POSITION OVERVIEW:

- Provides individualized diabetes self-management education and support (DSMES) to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators.
- Provides supervision and oversight of the participating paraprofessional instructional staff and group leaders (i.e., community health workers / lay leaders) that assist in delivering the diabetes self-management education and support program to class participants. The primary qualified instructor is responsible for selecting community health workers, monitoring their performance, ensuring that they are properly trained and monitoring their ability to provide DSMES services to the target population. Direct and General supervision occurs during program instruction and entails: 1) oversight of the instructional material, 2) fidelity checks to ensure that approved material is being delivered as intended, 3) direct observation of community health worker-led instruction, and 4) continual availability to paraprofessional staff during all individual and group DSMES sessions.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Performs DSMES program participant assessment data, using an evidence-based DSMES framework, in a collaborative and ongoing manner.
- Collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSMES 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 DSMES program services, using outcome measures using an evidence-based framework.
- Documents assessment data, educational plan, educational services provided and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.
- Communicates relevant participant information to primary care provider.
- Participates in the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSMES program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other professional instructional staff.
- 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).

EXPERIENCE/EDUCATION:

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

<Insert Licensed Instructor's Resume here>

<Insert copy of Licensed Instructor's license here>

<Insert documentation of Licensed Instructor's relevant training here>

TITLE: Paraprofessional Group Leader/Community Health Worker

REPORTS TO: DSMES Quality Coordinator and Primary Qualified Instructor

SUPERVISES: Non-Supervisory Position

POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators. Paraprofessionals operate as a member of the DSMES team. Paraprofessional Community Health Workers will participate in facilitating group education, reinforce self-management skills, support behavior change, provide psychosocial support, and ongoing self-management support to DSMES participants.

DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Under the supervision of a licensed program instructor, collects DSMES program participant assessment data, in a collaborative and ongoing manner.
- Under the supervision of a licensed program instructor, collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSMES program participants.
- Provides non-technical educational interventions that utilize primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods.
- Collaboratively with the licensed instructor, develops an individualized follow-up plan with each program participant.
- Collaboratively with the licensed instructor, evaluates effectiveness of services provided by measuring the attainment of learning objectives.
- Collaboratively with the licensed instructor, conducts a follow-up assessment upon completion of DSMES program services, using evidence-based outcome measures.
- Documents assessment data of the licensed instructor developed educational plan, educational services provided, and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the paraprofessional's scope of practice and expertise, and alerts the licensed instructor of any situation that exceeds the scope of the paraprofessional instructor.

20% (Other duties):

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

professional instructional staff.

- 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.
- Able to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).
- Completion of training in the DSMES program curriculum.

EXPERIENCE/EDUCATION:

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

<Insert resume of each Paraprofessional>

<Insert any training for each Paraprofessional>

Standard 6. Curriculum

A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.

Policies and Procedures Applicable to Standard 6:

DSMES Curriculum:

<Insert a copy of your program curriculum here. This is a sample, below.>

The Eight (8) week DSMES curriculum set forth below is designed to provide each participant with an individual assessment and education plan that has been developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions, and self-management support strategies. An essential component of our DSMES program is the development of participant action plans. Each consumer will participate in an action planning process where they will develop individualized goals related to diabetes self-management. The DSMES team will document the participant action plans and provide recommendations on how the participant can achieve their self-defined goals. DSMES staff will also document

individual achievement or lack of achievement of defined individualized goals. The individual action planning process is a core component in the delivery of individualized DSMES to program participants.

Week 1: Individual Assessment with the DSMES Licensed Instructor:

Each new participant will undergo a 1:1 in person assessment with either a Registered Dietitian, or Registered Nurse with particular training in diabetes. The assessment will include information about the individual's relevant medical history, age, cultural influences, health beliefs and attitudes, social determinants of health, diabetes knowledge, self- management skills and behaviors, readiness to learn, health literacy level, physical limitations, family support, and financial status.

The current assessment tool is attached and subject to modification as part of our ongoing quality improvement efforts.

During this assessment, educational goal(s) and learning objectives, and the plan for educational content and method/s will be developed collaboratively between the participant and instructor(s). This plan will include, where appropriate, ongoing assessment with the Registered Dietitian, or Registered Nurse and/or referral to the Group DSMES program.

During the initial assessment, any additional participant needs that are identified by the participant, in collaboration with the licensed instructor, will be addressed outside of the group classes individually, but will be an integral part of the entire DSMES process. This plan will also include a personalized follow-up plan for ongoing self-management support, which will be developed collaboratively by the participant and instructor (s). The participant's outcomes and goals and the plan for ongoing self-management support will be communicate, to all members of the DSMES team and documented in the clinical record. These outcomes and goals may be distinct and in addition to the goal or "action plan" participants develop in the group DSMES program, as discussed below. The follow-up plan for ongoing self-management support will focus on long-term self- management that occurs after the DSMES class ends.

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

In an effort to provide an ongoing evaluation of the consumer's attainment of educational goals, the licensed instructor will continue discussions with the participant during the eight-week intervention no fewer than twice in an effort to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The assessment and any follow-up documentation will be provided by the licensed instructor to the Primary care provider (PCP) and the licensed instructor will be available to discuss the assessment and plan with the PCP.

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

with paraprofessional group leaders.

Weeks 2, 3, 4, 5, 6 and/or 7: The licensed instructor will continue discussions with the participants during the eight-week group intervention no fewer than twice during Weeks 2-7.

The group education class is the base curriculum for our DSMES service. During this six (6) week workshop, participants will be provided with an array of tools to improve their ability to self-manage their conditions. The group class is the primary intervention, to fulfill the participant's need for improved diabetes self-management, but will not be the only intervention and will be coupled with the individualized education plan developed collaboratively based on the initial assessment. The group class is provided primarily by paraprofessional group leaders, under the supervision of the licensed instructor and includes discussion of all relevant evidence-based diabetes education benchmarks, including but not limited to the following:

- overview of diabetes, (diabetes pathophysiology and treatment options),
- blood glucose monitoring, nutrition, healthy eating,
- preventing high and low blood sugar, monitoring, and using patient-generated health data (PGHD),
- preventing or delaying complications from diabetes,
- physical activity,
- dealing with stress,
- muscle relaxation,
- reading nutrition labels,
- depression management, psychosocial issues and concerns,
- communication with health care providers,
- medication usage,
- foot care,
- working with the health care system, and
- planning for the future and problem solving.

The program also requires participants to continue to set individualized weekly goals or "action plans" and to provide follow-up for each action plan achieved. For action plans not achieved, participant engages in problem solving activities with the group to brainstorm potential solutions. The implementation of individualized action planning exercises, supports the individualization of the DSMES process for each participant.

During weeks 2-7, the licensed instructor remains available to both the Paraprofessional Group Leaders and the participant to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The primary goal is an improvement in the participant's self-management behaviors to support their ability to overcome real or perceived barriers to self-management of disease. Outcomes will be compared to quality indicators to assess the effectiveness of the participant's care plan and the education intervention.

Both individualized and aggregate outcomes data will be collected and will include, at a minimum, the following: attainment of participant-defined behavior change goal(s) (intermediate outcomes) and at least one post-intermediate or long-term health outcome

measure. In a collaborative manner, the participant and licensed instructor will define the individualized goals. These individual participant outcome measures are used to guide the intervention and improve care for that participant. The aggregate population outcome measures (program outcome measures) are used to guide programmatic services and CQI activities for the DSMES and the population it serves.

During this period, the success of the group intervention in meeting the participant's defined goals is measured by the participant's ability to set weekly measurable goals and report on attainment of these weekly goals in a group setting, with peer involvement. Documentation of the attainment of this goal will be class attendance and participation in the weekly goal setting process with the peer group.

Other goals outside of improved self-management behaviors will be addressed as part of the individualized plan and will occur outside of the group intervention but remain part of the entire DSMES services and will be directed by the licensed instructor in collaboration with the participant. Methods of attaining these other goals are decided by the participant in collaboration with the licensed instructor. Documentation of class participation, weekly goal setting, and individualized assessment will be maintained in the participant's chart.

Week 8: At the end of the group intervention, the participant will develop a follow-up plan in a collaborative manner with the licensed instructor. There will be a multi-disciplinary approach to completing this process. The multi-disciplinary team works with the participant to develop realistic, individualized goals and an ongoing evaluation plan.

The multi-disciplinary team consists of, at a minimum, the following:

- Individual program participant
- Licensed instructor,
- Paraprofessional group leaders delivering the diabetes self-management classes, and
- Participant's primary care provider.

Long-term evaluation can include elements such as improved HgbA1C values, improved fasting glucose values, improved lipid levels, increased frequency of physical activity, and improved dietary intake. These long-term goals and follow-up will be documented in the participant's record. Resources to support the attainment of these goals will be identified in a collaborative manner. The goals for ongoing self-management, support resources, and ongoing evaluation plan will be communicated to the referring provider. The communication with the referring provider will be documented in the participant's record.

See Summary Table on the following page.

Summary Table

Workshop Overview - Activity	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6
Overview of self-management and diabetes - Diabetes pathophysiology and treatment options - Reducing Risk	✓					
Making an action plan - Reducing Risk	✓	✓	✓	✓	✓	
Monitoring diabetes and blood sugar - Monitoring	✓	✓	✓	✓	✓	✓
Nutrition/Healthy Eating - Healthy Eating	✓	✓	✓	✓		
Feedback/Problem-solving - Problem Solving		✓	✓	✓	✓	✓
Dealing with stress - Healthy Coping		✓				
Preventing low blood sugar - Reducing Risk			✓			
Preventing complications - Reducing Risk			✓			
Making decisions - Problem solving			✓			
Physical activity/exercise - Being Active			✓		✓	
Difficult emotions - Healthy coping				✓		
Relaxation - Healthy coping					✓	
Depression - Healthy coping					✓	
Positive thinking - Healthy coping					✓	
Communication - Healthy coping					✓	
Medication - Taking medication						✓
Working with your healthcare professional and system - Diabetes pathophysiology and treatment options - Reducing Risk						✓
Sick days - Healthy coping						✓
Foot care - Monitoring						✓
Future plans - Diabetes pathophysiology and treatment options - Reducing Risk						✓

Standard 7. Individualization

The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES team member(s) will develop an individualized DSMES plan.

Policies and Procedures Applicable to Standard 7:

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

During the group intervention, participants will engage in the implementation of weekly action plans. The action planning process provides individualized instruction to participants on appropriate goal setting and a review of achievement of stated goals. In order to meet the National Standard requirement, this process must be documented on an individual basis. Therefore, programs have to establish a process to document each person's weekly goals and then the subsequent achievement, or lack of achievement, of the stated individual goals. The documentation of the individual action plans is for the education record and not meant to be distributed to the participants or shared with persons that are not directly participating in teaching the workshop.

After the initial assessment (week 1), the participant will begin attending the group sessions. The group sessions provide general diabetes information about diabetes that is publicly available and the delivery of this information in the group setting is overseen by the professional instructor and is delivered by the community health workers. The licensed instructor is always available to the paraprofessional DSMES staff and provides additional individualized instruction based on the education plan that was developed at the time of the initial assessment. The group sessions extend beyond the delivery of static lecture content. The group sessions incorporate group dynamics in the education process. Participants are encouraged to actively engage other members of the group and conduct meaningful action planning. Participants are also encouraged to incorporate patient-generated health data (PGHD), especially blood glucose and/or continuous blood glucose monitoring data into decision making and individualized action planning.

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

The assessment and education plan, intervention, and outcomes will be documented in the participant's health record and communicated to all members of the care team.

Standard 8. Ongoing Support

The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will best maintain their self-management needs.

Policies and Procedures Applicable to Standard 8:

Successful self-management of diabetes requires lifelong behavior change. Sustaining behavior change requires the provision of interventions and support that extends beyond the DSMES program. DSMES team members must continually assess the local community for resources and services that could support DSMES participants beyond the DSMES class. Participants will receive individualized referrals to community resources that will support ongoing behavior change to participants.

Each participant will be provided with a list of resources that are customized to their individual needs and goals to facilitate ongoing effective self-management. The resources should be locally available and will help the participant implement and sustain the ongoing skills, knowledge, and behavior changes needed to manager their condition. The participant should select the resources that they are most likely to engage in to sustain behavior change and support the concepts presented during the DSMES program.

Examples of Ongoing support services includes, but not limited to, the following items:

- Group exercise programs
- Support groups
- Walking clubs
- Fitness programs
- Fall prevention programs
- Online resources
- Virtual chat/support groups
- Community gym programs
- Team sport activities

Each resource provided to a participant should be documented in the educational record and shared with the care team.

Standard 9. Patient Progress

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

Policies and Procedures Applicable to Standard 9:

Performance Measurement Plan/QI Plan:

The Diabetes Self-Management Education and Support program will measure attainment of

participant-defined goals and outcomes to evaluate the effectiveness of educational interventions. The DSMES team will help participants establish SMART goals (specific, measurable, achievable, realistic, and time-bound). The DSMES team will monitor the individual participant's ability to attain their individualized SMART goals. During the action planning process, the DSMES staff will document participant attainment or lack of attainment of defined SMART goals.

In addition, the DSMES staff will monitor the following elements for each participant:

- Knowledge,
- Behavior change
- Goal setting ability
- Self-assessment
- Quality of life
- Participant satisfaction

The performance measurement plan will begin at the initial assessment between the participant and licensed instructor. The DSMES team will track and communicate individual outcomes at appropriate intervals that are established by the licensed instructor, with paraprofessional input.

Patient-Defined Goals and Patient Outcomes:

1. Data Collection

- Individualized data provided in initial assessment with licensed instructor.
- Participant-defined behavior change will be measured based on the evidence-based self-care behavior framework spreadsheet. This self-care framework is based upon the belief that behavior change can be most effectively achieved using the following 7 behaviors as a framework: healthy eating, being active, monitoring, taking medication, problem solving, reducing risks and healthy coping. The SMRC's DSMP compliments the AADE7 framework with participant-created weekly action plans.
- Paraprofessionals will be provided a SMART goal sheet for each participant to monitor the weekly focus of action plans. The multidisciplinary team will review progress to identify opportunities for participant motivation and program documentation. Participants will be asked to provide progress in the following health outcomes areas: weight, hemoglobin A1C, and medication compliance and monitoring during the follow-up session conducted on week 8 of the intervention. Data will be indicated on the participant's SMART goal sheet as part of their overall educational record.

Results will be evaluated, and program changes will be made based on the analysis of:

- Aggregate data.
- Participant-defined behavior change, measured using a database, based on the AADE7 self-care behavior framework.
- Long-term health (will be reviewed with newly hired RD/ licensed instructor; it is a long-term outcome measurable in our program model.)

2. Frequency of Measurement

- a. Individual self-care behavior change data and selected health outcomes will be documented in the database at three points during the eight-week intervention. Those

times are:

- Prior to beginning the [Fill in, e.g., group intervention] program.
 - Midway through the workshop during session three (3).
 - Week 8 will be a follow-up session by the licensed instructor. Major changes in health outcomes occurring outside of this timeline will also be noted.
- b. Individual self-care behavior change data will guide the education/training process. PQI and instructors will work with the participant if data analysis suggests self-care improvements are not made by a participant.

Ongoing Diabetes Self-Management Support:

Each participant will receive diabetes self-management support materials. In addition, an ongoing diabetes self-management support plan will be developed and reviewed with the participant and the referring provider. The Ongoing Diabetes Self-Management Support (DSMS) Plan will be documented on the program form.

See the following page for a sample Ongoing DSMS Plan form.

SAMPLE

Ongoing Diabetes Self-Management Support (DSMS) Plan

Name:

Date:

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

Recommendations:

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

- Access diabetes informational websites
 - www.diabeteseducator.org (American Association of Diabetes Educators)
 - www.diabetes.org (American Diabetes Association)
 - www.dlife.com (Diabetes Life)
 - www.americanheart.org (American Heart Association)
 - www.eatright.org (American Dietetic Association)
 - www.ndep.nih.gov (National Diabetes Education Program)

- Visit with a Registered Dietitian

- Join a Fitness center, Gym or YMCA

- Contact your health insurance company to ask about their diabetes management programs

- Join a weight loss program

- Attend a healthy cooking class

- Other _____

Written Support Materials Given

- Diabetes Brochures (List title, author, and date given)
- _____
- _____

- Living a Healthy Life with Chronic Conditions*

Clinician Signature/Date _____

Standard 10. Quality Improvement

The DSMES services quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.

Policies and Procedures Applicable to Standard 10:

Continuous Quality Improvement Process:

The Quality Coordinator will monitor the following areas of the DSMES program on an ongoing basis. CQI reports will be shared with the Program Advisory Council at each meeting. The Quality Coordinator will assess individual participant and aggregate program data. The aggregate program data will be used to monitor overall program performance. The CQI process will support the implementation of interventions that work to meet the needs of the defined population to achieve maximum success in disease self-management.

The continuous quality improvement process should incorporate elements that address the following three essential elements:

- 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 improvement?

Evaluation:

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

1. Low participant registration levels in workshop

Items to Monitor

- Number of participants registered two weeks prior to workshop start date.
- Outreach done prior to workshop start date.
- Number of physician groups and healthcare providers informed of workshops.

Corrective Action Plan

- Physicians and healthcare providers located within 10 miles of DSME site which will receive quarterly outreach contacts.
- Physicians who consistently refer participants to DSME sites will receive a thank you. They will be asked to provide an endorsement that can be included in outreach materials to other healthcare providers.

2. Participant compliance to intake process

Items to Monitor

- DSMES workshop participant intake forms will be reviewed by PQI for

completeness of information.

Corrective Action Plan

- A log will be maintained by the PQI identifying areas that are incomplete.
- Findings from the log will assist in improvements marketing materials.

3. Level of progress on participant identified SMART goals based on action plans

Items to Monitor

- Participant DSMES SMART goal sheet will be reviewed to identify progress in action plans on weekly basis.

Corrective Action Plan

- PQI and quality coordinator will conduct a fidelity visit of community health workers to ensure Stanford DSMP is being facilitated as required.
- Additional training will be available to community health workers in forms of webinars or individualized training specific to noted knowledge deficits. The training of community health workers or lay leaders will be performed by the licensed instructor for the program.

4. Frequency of participant glucose monitoring

Items to Monitor

- Participant initial intake form.
- Number of participants who respond to the general monitoring question during SMRC's DSMP Session 1, Activity 4 Monitoring.
- Participant Follow-up Form.

Corrective Action Plan

- Licensed Instructor will quarterly review the number of participants who increase their frequency of glucose monitoring.
- An assessment will be made to determine obstacles participants indicate in increasing their frequency of glucose monitoring.
- The findings will guide inclusion of additional resources provided to participants by the Licensed Instructor throughout their eight-week intervention.

Overall corrective action plan:

Use strategies that are effective and create new ones as needed. Report all problems to the Program Advisory Council.