REFER TO DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT PROGRAMS

Patients are referred to an American Diabetes Association (ADA) Education Recognition Program or an American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program. The program emphasizes collaboration with patients to develop their own educational plan to promote self-management skills that facilitate behavior change. The program also offers resources and/or referrals for community services.

More than any other chronic condition, effective diabetes treatment is dependent on patient self-awareness, self-management, self-motivation, and ultimately self-care. Research shows the positive impact DSME can have on people with Type 2 diabetes, including improved HbA1c, enhanced self-efficacy, decreased presence of diabetes-related distress and depression, and reduced onset and/or advancement of diabetes complications.

Diabetes self-management education (DSME) is the process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. Such programs offer quality education that meet the National Standards for Diabetes Self-Management Education and Support, and are eligible for third-party insurance reimbursement (including Medicare and many Medicaid). Currently, two organizations, ADA and AADE, are CMS-designated national accreditation organizations.

TIPS FOR REFERRING PATIENTS

- Create and implement a communications plan to educate providers about the availability and effectiveness of DSME programs and how to effectively refer patients.
- Determine if your organization currently offers or refers to a DSME program.

If your organization does not offer a DSME program:

- Identify DSME programs in your area using search tools offered by ADA and AADE (refer to Appendix E: Suggested Readings for links). If programs exist, collaborate to create a referral process that includes a formal feedback loop to track attendance.
- Consider creating a recognized program.

If your organization offers or refers to a DSME program:

- Focus initial DSME referrals on four critical time points:
  1. New diagnosis of Type 2 diabetes
  2. Annual health maintenance and prevention of complications
  3. New complicating factors that influence self-management (e.g., prescribing a new medication)
  4. Transitions in care occur (e.g., transitioning into adulthood, hospitalization, and moving into an assisted living facility, skilled nursing facility, correctional facility, or rehabilitation center)
- Develop a streamlined, systematic referral process to DSME programs. For reimbursement, referrals must be generated by the physician or qualified non-physician practitioner managing the individual's diabetes condition.

My Self-Care Success

Northeast Georgia PHYSICIANS GROUP

Name: _____ **DOB:** _____ **Date:** _____

Instructions: By setting self-care goals you can take an active role in helping yourself feel better more quickly. Choose **one** of the areas below and **set a goal**. Make sure the goal is clear and reasonable.

Eat a Healthy Diet

Be Physically Active

Take My Medicine

Spend time with people that support you

Monitor My Blood Sugar and Blood Pressure

Cope with Stress

Limit Alcohol

Stop Smoking

One way I want to improve my health is (e.g., be more active):

_____

My goal for this week is (e.g., walk 4 times):

_____

When I will do it (e.g., mornings before breakfast): _____

Where I will do it (e.g., at the park): _____

How often I will do it (e.g., Monday through Thursday): _____

How likely are you to follow through with these activities prior to your next visit? *circle one*

Not Likely 1 2 3 4 5 6 7 8 9 10 **Very Likely**

What might get in the way of your completing these activities prior to your next visit?

_____

Solutions to the above barriers: _____

_____

TOOL: DIABETES REPORT CARD

BILLINGS CLINIC

Your Diabetes Report Card

Name: _____
Date: _____

"A-B-Cs"	Risk Factor	Your Goals
A Is for "A1c"	**Diabetes Control** ***My Hemoglobin A1c is _____= average glucose of _____.*** *This measures how your sugars (glucose) have been running in the past 3 months.*	❑ Hemoglobin A1c goal is _____. ❑ Pre-meal blood sugar target is 80 to 130 mg/dl ❑ Peak blood sugar target (2 hrs after a meal) is less than 180 mg/dl ❑ Have your A1c checked every 3-6 months
B Is for "Blood Pressure"	**Blood Pressure** ***My blood pressure is _____*** *This blood pressure control is very important in preventing the complications of diabetes.*	❑ Blood pressure goal is less than **140/90** ❑ Have your blood pressure checked at every office visit or as directed by your health care provider
C Is for "Cholesterol"	**Cholesterol** • ***Total Cholesterol level is*** _____ • ***Triglyceride level is*** _____ • ***HDL (good) level is*** _____ • ***LDL (bad) level is*** _____	❑ Total Cholesterol less than 200 ❑ Triglycerides less than 150 ❑ HDL greater than 50 ❑ LDL less than 100 (if high risk heart disease <70) ❑ Diabetics aged 40-75 should be on a statin
D Is for "Diet"	**Diet and Weight** *Eat a healthy diet moderate in calories to help you maintain a healthy weight* ***My weight today is _____*** ***My BMI today is _____***	❑ If you are overweight, losing 5-10 % of your current weight can improve your blood sugar , blood pressure, cholesterol and overall well-being **5 – 10 % = _____ pounds**
E Is for "Eyes"	**Unrecognized Diabetic Eye Disease** *Diabetes is the leading cause of blindness in the U.S.* ***Date of Last eye exam_____***	❑ Get a dilated eye exam by an eye care provider **ONCE A YEAR** or as directed.
F Is for "Feet"	**Unrecognized Diabetic Foot Disease** *Diabetes causes loss of sensation in the feet and poor circulation.* ***Date of last foot exam: _____***	❑ Get a foot exam in your doctor's office **ONCE A YEAR** or as directed. ❑ Check your feet daily.
G Is for "Get Active"	**Lack of Physical Activity** *Increased activity is a natural way of improving your diabetes control and overall health.*	❑ 30 to 60 minutes of moderate activity per day can improve your blood sugar and weight. ❑ Reduce the amount of time you are sitting.
H Is for "Heart & Stroke"	**Risk of Heart Disease and Stroke** *People with diabetes have an increased risk of heart attack and stroke.*	❑ Daily aspirin therapy may be of benefit and is recommended for men > 50 and women > 60. Check with your provider.
I Is for "Immunizations"	**Influenza Immunization** **Pneumococcal Vaccination** **Hepatitis B Vaccination** (ages 19-59) *Getting these vaccines can prevent serious illness or even death*	❑ Influenza Immunization annually ***Last influenza immunization _____*** ❑ Pneumococcal Vaccination ***Last Pneumo-13 vaccination _____*** ***Last Pneumo 23 vaccination _____*** ***Last Pneumo-unknown vaccination_____*** ❑ Hepatitis B Vaccinations 1) _____ 2) _____ 3) _____
J, K Is for "Kidneys"	**Unrecognized Kidney Disease** *My microalbumin to creatinine ratio is: _____* (Normal is less than 30) *Diabetes is the most common cause of kidney failure in the U.S.*	❑ Get a yearly urine test to check if diabetes may be affecting the kidneys. ❑ Your provider may prescribe a blood pressure medication called an ACE Inhibitor or ARB to help keep your kidneys healthy.

TOOL: DSME PROGRAM REFERRAL LIST

INTERMOUNTAIN HEALTHCARE

We recommend AMGA members implementing this plank create a similar program referral list for your area. The program list included below is intended to serve as an example.

Diabetes educators and diabetes education programs

Diabetes education and medical nutrition therapy are covered by most commercial insurance providers and by Medicare. For help locating diabetes educators in the area of your practice, call Intermountain's Primary Care Program at 801-442-2990.

Salt Lake Valley Area

Salt Lake City, UT

Salt Lake Clinic
389 South 900 East — 385-282-2600 *option 2*

Murray, UT

Intermountain Medical Center
5121 Cottonwood Street — 801-507-3366

Intermountain Medical Group Comprehensive Care Clinic
5171 Cottonwood Street — 801-507-9369

Cottonwood Endocrine and Diabetes Center
5770 South 250 East, Suite 310 — 801-314-4500

Internal Medicine Associates
9844 South 1300 East, #200
(Alta View Hospital Campus) — 801-572-1472

Bountiful, UT

Bountiful Health Center
390 North Main Street — 801-294-1000

Taylorsville, UT

Taylorsville Health Center
3845 West 4700 South — 801-840-2000

Central Utah

Heber, UT

Heber Valley Medical Center
1485 South Highway 40 — 435-657-4311

American Fork, UT

American Fork Hospital
98 North 1100 East, Suite 302 — 801-492-2200

Provo, UT

Utah Valley Regional Medical Center
1034 North 500 West — 801-357-7546

Mt. Pleasant, UT

Sanpete Valley Hospital
1100 South Medical Drive — 435-462-2441

Fillmore, UT

Fillmore Community Hospital
674 South Highway 99 — 435-743-5591

Richfield, UT

Sevier Valley Medical Center
1000 North Main — 435-893-0371

Southern Utah

Panguitch, UT

Garfield Memorial Hospital
200 North 400 East — 435-676-8811

Cedar City, UT

Valley View Medical Center
110 West 1325 North, Suite 100 — 435-868-5576

St. George, UT

Dixie Regional Diabetes Clinic
348 East 600 South — 435-251-2888

Southern Idaho & Northern Utah

Burley, ID

Cassia Regional Medical Center
1501 Hiland Avenue — 208-677-6035

Tremonton, UT

Bear River Valley Diabetes Education
440 West 600 North — 435-716-5310

Logan, UT

Logan Regional Hospital
500 East 1400 North — 435-716-5310

Budge Diabetes Clinic
1350 North 500 East — 435-792-1710

Ogden, UT

McKay-Dee Hospital
4401 Harrison Blvd — 801-387-7520

McKay-Dee Endocrine and Diabetes Clinic
4403 Harrison Blvd, #3630 — 801-387-7900

North Ogden Clinic
2400 North 400 East (Washington Blvd) — 801-786-7500

This CPM presents a model of best care based on the best evidence available at the time of publication. It is not a prescription for every patient, and it is not meant to replace clinical judgment. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Wayne Cannon, MD, Intermountain Healthcare, Primary Care Medical Director (Wayne.Cannon@imail.org).

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