

Procedures and Forms Used in the Operation of the Diabetes Self Management Program at the Bay Clinic, Inc.

There are two types of items we will describe here: *Calendar Events* occur regularly through the year and those related to *Class Procedures* that follow the class cycles. These will be followed with the *Forms* used, starting on page 9.

Calendar Events

Annual Meeting of the Advisory Board The American Diabetes Association (ADA) requires that each program have an advisory board that includes key staff, community members and patients. There is a standard template covering items the ADA feels are important.

There are many ways that the ADA checks on their certified programs. They can make a surprise visit. They might want the minutes for the most recent annual meeting. They might want job descriptions. They could visit. Stacy Haumea said “We’re ready for whatever they want to do.”

Forms include the one-page summary form **Annual Status Report for Recognized Diabetes Education Programs** on page 9 and the extended version, the **Annual Program Review and Plan** on page 10 that was sent to the ADA in 2007.

Annual Event at Prince Kuhio Plaza

The Prince Kuhio event coincides with the annual National Health Center Week that is promoted by the National Association of Community Health Centers in Washington, D.C. The first event was held in 2008 at the largest shopping mall in the Hilo area and was very

successful. There were about 20 health providers who participated. There was a good program at the microphone balanced between health providers and entertainment headlined by perhaps the most popular comedian in Hawaii, Frank De Lima, who also has diabetes. Hundreds of people participated over a four-hour period. Because it went so well, the Bay Clinic decided to make it an annual event.

Included is a more detailed summary of the event and its costs. Page 25.



Other annual events The Bay Clinic participates in the annual “Take It Off Hawaii” event. This is an annual community-wide anti-obesity program.

The Clinic staff and some patients also participate in the annual “Relay for Life,” a cancer survivor event where people gather contributions for sponsorship and walk around a track throughout the night.

Monthly Meetings in the Park

Planning the event usually takes place during one of the Warriors Against Diabetes sessions. Participants will toss around ideas. “We usually try to get what the patients want to see.” Haumea said.

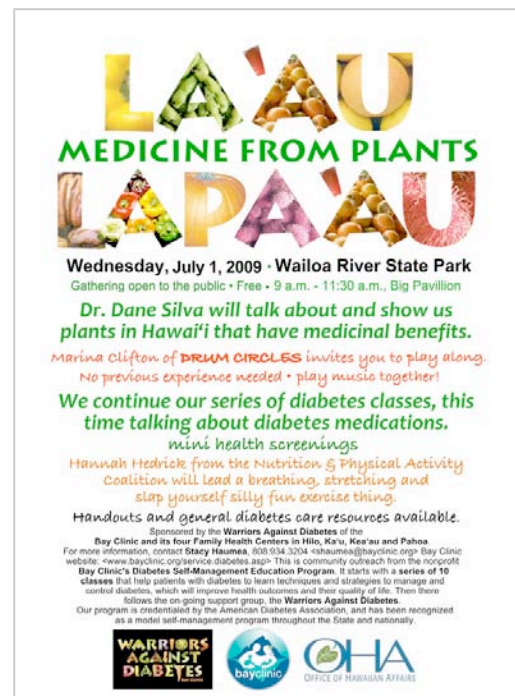
- **Prepare the flyers** The group uses a typestyle that was created by Warrior Tom Whitney especially for the program, so part of the design process flyer for an instantly attractive is to come up with an engaging headline of two to six words. Also included in the DVD is a file containing Tom Whitney’s Vegetable Alphabet, and the individual letters, so other diabetes groups can use the same type.

- **Notify the local newspaper** On the Internet the Calendar section for the local newspaper is accessed and a forty-word description and other details are typed in.

- **Send emails** to the list of diabetes people and organizations about the event. An email with the flyer is sent to all the local agencies and individuals who have diabetes and wanted to be included in the Bay Clinic list. To encourage participation, word of mouth is the biggest contributor to attendance at the event. A mailing list of people in the community interested in learning about diabetes events is being created.

- **Schedule the staff** The Park plan includes a lesson from the regular series of classes, so this speaker needs to be identified and scheduled by the program manager.

Included is **Monthly Meetings in the Park, Sample Flyer** on page 28 and a useable **Vegetable Alphabet starting on** on page 29. The individual letters of the Vegetable Alphabet are on the DVD and can be inserted in a layout as needed.



Weekly meetings of diabetes staff on Wednesday mornings.

Staff talks about how the flow of the classes is going; discusses procedures and improvements that might be made; what is needed; any budget issues; staff

vacations and how classes will be covered; etc. The regularity of the meetings helps because people don't fall off of thinking about diabetes.

There is no special preparation or agendas of forms except just before the meeting that occur on Tuesday mornings.

Grant Preparation

At the times it is necessary to prepare for grant proposals. In earlier years administrative staff did this more, but more recently diabetes staff has become more involved. The Clinic has a Development Director who takes the primary responsibility for writing the proposal, but now there are more things that the program manager is asked to write. Diabetes staff find out about funding opportunities from other agencies, friends and Department of Health emails. Monica Adams, the Bay Clinic Development Director, said she uses emails from the Hawaii Primary Care Association, the State Department of Health and the National Association of Community Health Centers and the Catalog of Federal Domestic Assistance to find out about grant possibilities.

Weekly Long-Term Support Groups

Stacy Haumea said she is always on the lookout for things to talk about with the group, but the subject matter is usually patient-driven. "What I really like about it is when we plan our outreach into the community; getting more people into knowing that it is ok to have diabetes, and there are ways to manage it. We want to get out there and do more."

Often she photocopies and passes out the group diabetes-friendly recipes, articles a participant has brought in, and notices about upcoming diabetes events in the community.

Class Procedures

1. Invitation to Attend Diabetes Classes

- ❖ Provider gives printed invitation to attend classes to the participant. It is also sent in the mail to people whose A1C tests show a level over 7. About 200 letters per month are sent. Page 31.

2. Class Schedule Page 32.



3. Individual Patient Folders

For each class and support group participant there is a folder that contains the following forms. Most of this information is also placed in

the electronic medical record. The following forms 3a through 3k are part of the Patient Folders

- 3a. Report to Physician and Clinical Information** The HMSA (Hawai'i Medical Service Association) form contains the initial basic information. Page 33.
- 3b. Participant Weekly Tracking Sheet** Diabetes program participants use this form to record weekly date, weight, blood pressure and fasting blood sugar or random blood sugar in their own folders. Page 35. This has been replaced by 3k Vital Signs & Goal Sheet.
- 3c. Diabetes Self-Management Education Course Referral Checklist** This was developed to enable staff to keep track of what patients were missing as part of their health screening. This sheet is often replaced when it is updated. Page 36.
- 3d. Diabetes Self-Management Group Visit Attendance Flow Sheet** This documents and dates each patient's attendance at classes. Page 37.
- 3e. Initial Intake Assessment** This is an American Diabetes Association required form used to track each patient's medical and diabetes history, literacy, activity, nutrition, medications monitoring, and complications, and current test status. Page 38.
- 3f. Diabetes Self-Management Pre- and Post-Test** This form is completed at the initial assessment and upon completion of the program. Page 42.
- 3g. Pre- and Post-Test Scoring Sheet** Page 46.
- 3h. Assumption of Risk / Release of Liability Form** Every effort is made to assure patient safety during the program, and here the Bay Clinic, Inc., is protecting itself against inadvertent injury or accidents that may occur during transportation and conduct of classes. If patients want to participate, they sign it. Page 47.
- 3i. Photo Release Form** This form gives permission by participants for Bay Clinic, Inc., to use of photographs of participants in publications about the program and related to publicity about the program. Page 48.

3j. Consent for Participation in a Group Medical Visit. “Group Medical Visit” is the technical term used to describe the diabetes classes and support group meetings. It indicates that patients will be in groups of from 10 to 20 other patients; that each person has the right to share only that information they feel like sharing; that each person will respect the privacy of others and not share their personal information outside the class; that each person may speak with a health provider alone if they wish; that they can withdraw at any time; that such withdrawal will not affect their ability to receive service at the Bay Clinic; and that payment for participation is the same as a regular doctor’s visit. Page 49.

3k. Vital Signs & Goal Sheet

This is for keeping track of improvement goals that are different for each person, depending on what they realistically think they can accomplish for themselves. Page 50.

4. Diabetes Self-Management Group Visit Attendance

This form is filled out by participants when they come in each day. This is then collected by staff with enough time left to enter the information into the electronic medical record system so the most recent readings are available in their electronic medical record if a participant sees the health provider at the end of the session. Page 51

5. Diabetes Curriculum Outline

This is derived from “Life with Diabetes.” Page 52.

6. Participant Satisfaction Survey Page 64.

7. Diabetes Collaborative Outcomes Audit Page 65.

8. Job Description, Program Coordinator Page 66.

9. Job Description, Nutritionist Page 67.

10. Provider Assessment Page 69.

Phase 1 Interventions and Documentation once a diagnosis of diabetes has been confirmed by the patient’s provider.

- ❖ Schedule of classes given to the participant by provider. It is this also sent in the mail to the patient with the invitation.

☛ **2. Class Schedule** Page 32.

- ❖ Verbal orientation to diabetes program given to participant by the provider. It is made clear to patients that they can jump into the class series at any time and just stay on until their ten-week series finishes.
- ❖ Initial intake assessment in the patient folder is completed by nursing staff with patient.
 - ☛ **3e. Initial Intake Assessment** Page 38.
- ❖ Pre-test of patient knowledge of diabetes completed. This form is part of the Individual Patient Folder.
 - ☛ **3f. Diabetes Self-Management Pre-Test** Page 42.

Phase 2 Interventions and Documentation This phase starts when a patient enrolls in classes. Because participants usually just start classes when they are ready, a separate appointment is made with each new participant to orient them and get appropriate forms filled out.

- ❖ Weekly Class Tracking Sheet. Participants fill out the form themselves. This is then collected with enough time left to enter the information into the electronic medical record system so the most recent readings are available if the participant sees the health provider at the end of the session.
 - ☛ **3b. Participant Weekly Tracking Sheet** Page 35.
- ❖ Diabetes flow sheet filled out for each person for each class.
 - ☛ **3d. Diabetes Self-Management Group Visit Attendance Flow Sheet** Page 37.
- ❖ Participants are taught self glucose testing, weight measurement and the Body Mass Index, blood pressure testing, and what other lab tests are important besides the HbA1c.
- ❖ Providers develop individual self-management goals and confidence intervals as they work with each participant. Confidence intervals are decided on when providers ask the participants to be very realistic about what they might really be able to do.
 - ☛ **3k. Vital Signs & Goal Sheet** is used for this.
- ❖ Providers of education services can use the electronic medical records system to enter reports for obtaining reimbursement. Nursing or clerical

staff gathers the Weekly Class Tracking form and enters this information in each person's chart and then when the provider is done with the class, the provider enters a summary of the information discussed with the participants, and this information can then be automatically entered in each person's chart.

- ❖ Providers in 2009 are able to fill out reports of their person-to-person visits with each patient on the electronic medical records system for obtaining reimbursement. Previously, the "3a. Report to Physician and Clinical Information" sheet had to be filled out to verify each patient consultation for payment.
- ❖ Providers regularly document clinical and behavioral outcomes in the electronic medical record.
- ❖ Providers determine when monthly and annual screenings are due for patients and order them.
- ❖ Providers participate in diabetes education in a manner consistent with ADA guidelines.
- ❖ Providers collaborate using a team approach to diabetes management. Included in the team at the Bay Clinic in 2009 are a Physician Assistant, a Registered Dietitian who is a Certified Diabetes Educator, an Advance Practice Registered Nurse, a Psychologist, a Licensed Practical Nurse, a Registered Nurse and a Behavioral Health specialist.
- ❖ Each team member takes responsibility to assure ongoing data reporting of clinical and behavioral outcome statistics for "continuous" quality monitoring plans.
- ❖ Post-Test Class 10 for each participant.
 - ☛ **3f. Diabetes Self-Management Post-Test** Page 42.
- ❖ Participant satisfaction survey given to each participant by nursing staff. This information is useful to improve the program.
 - ☛ **6. Participant Satisfaction Survey** Page 65.
- ❖ A male and female member of the Warriors are asked to visit the class to invite participants to attend the Warriors group meetings.

Phase 3 Interventions and Documentation

- ❖ Graduation pot luck party

- ❖ Graduation Certificate given to each participant.

- ❖ Graduates are invited to join the Warriors Against Diabetes. A letter is sent to each graduate inviting them to Warriors sessions.

- ❖ Pre- and post-clinical and behavioral data collection entered in the electronic medical record by Licensed Practical Nurse to document the effectiveness of the Diabetes Self-Management Education Classes.

- ❖ Providers assess additional needs/classes for each participant.

Forms

Annual Status Report for Recognized Diabetes Education Programs



ANNUAL STATUS REPORT FOR RECOGNIZED DIABETES EDUCATION PROGRAMS

SAMPLE - Do not return this form. 1st and 2nd ANNIVERSARY forms, completed with the contact information we have about your program, will be sent to you 1 and 2 years after you achieve Recognition. It will be sent during the month you were Recognized.

**Please review the following contact information.
Make any corrections directly on this form.**

Program ID # _____
Site: _____

Organization Name: _____
Program Name: _____

NOTE – If this site has been closed, please state when and why it was closed.

Address: _____

Coordinator: _____ Coordinator Title: _____

Important – if there has been a change in coordinator, attach a letter stating when the previous coordinator left the position and when the new person assumed the duties. If there was a break, list the person who served as coordinator in the interim.

Phone: _____ FAX: _____ email: _____
(Number to be listed on the web site) (Used for newsletter & special information)

Verify that all Standards have been met at all times. Answer Yes or No to all questions. If No is checked, attach a separate sheet to this document and explain why the Standard is not being met.

Standard	Yes	No
Standard #1: The Diabetes Self-Management Education (DSME) entity has documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.		
Standard #2: The DSME entity has determined its target population(s), assessed educational needs, and identified resources necessary to meet the self-management educational needs of the target population(s).		
Standard #3: An established system (committee, governing board, advisory body) involving professional staff and other stakeholders has participated in a planning and review process that includes data analysis and outcome measurements, and addresses community concerns at least once this year.		
Standard #4: The DSME entity has a designated coordinator with academic and/or experiential preparation in program management and the care of persons with chronic disease. The coordinator oversees the planning, implementation, and evaluation of the DSME entity.		
Standard #5: The DSME involves the interaction of the individual with diabetes with a multifaceted education instructional team which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, other health care professionals and paraprofessionals. DSME instructors are collectively qualified to teach the content areas. The instructional team must consist of at least an RN and RD.		
Standard #6: The DSME instructors have obtained regular continuing education credits (15 hours/year minimum) in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills or have maintained CDE certification.		
Standard #7: A written curriculum, with criteria for successful learning outcomes, is available. Assessed needs of the individual will determine which content areas are delivered.		
Standard #8: An individualized assessment, development of an educational plan, and periodic reassessment between participants and the instructor(s) directs the selection of appropriate educational materials and interventions.		
Standard #9: There is documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in a permanent confidential educational record. Documentation also provides evidence of collaboration among instructional staff, providers, and referral sources.		
Standard #10: The DSME entity utilizes a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.		

I have reviewed the above information and attest to its accuracy.

Coordinator _____

_____ Date

Return form to: American Diabetes Association, Education Recognition Program, Annual Report Response
1701 N. Beauregard Street, Alexandria, VA 22311

Bay Clinic, Inc. Diabetes Self-Management Education Program
Date: 1/29/07

**Diabetes Self-Management Education (DMSE)
ANNUAL PROGRAM REVIEW & PLAN**

MINUTES: Date 1/29/07

Chairperson: Cheryl Zorn

Attended: Cheryl, Maile, Charlotte, Stacy, Amy, Steve

Absent: Tony, Mike, Kim, Jason, Lisa, Eileen, Dinny, Mary Lou Loeak

Stake Holders: Becky Stubbs

Community Member: Diane Sampler

Items to be discussed:

- **DMSE goals**
- **DMSE Mission Statement**
- **Target Population analysis (IT staff)**
- **Staff, Advisory committee, Stakeholders, Support, resources**
- **CEU, CME requirements and verification**
- **Budget**
- **Equipment**
- **Curriculum review**
- **CQI Plan and Outcome measure reports**
- **Documentation**

DSME GOALS

Goals	Not met	Pending	Met
1. To improve the health outcomes of our diabetic patients as measured by an improved HbA1c			Met
2. To increase knowledge related to diabetes and risk reduction as measured by pre/post testing.		Pending	
3. To support and empower patients to manage their disease as measured by documented self-management goals and confidence intervals.			Met
4. A commitment to provide quality, effective diabetes education to our patients as measured by ongoing CQI			Met
5. To staff the DSME program with qualified, committed and effective instructional staff as measured by continued CEU attendance r/t diabetes.			Met

Additional objectives and goals of the DMSE program:

1. To improve patient adherence to medical regime through empowerment and education.
2. To monitor recommended diabetic annual and 3 monthly screenings:
 - o Annual screenings: Dilated eye exam, Micro albumin, Lipids and Creatinine lab work, Monofilament foot exams, dental exams, and influenza vaccinations
 - o 3 monthly screenings: HbA1c, FBS and PCP visits for DM review.
 - o Pneumovax :
3. To monitor and recommend use of ACE/ARBs, Statins, Aspirin for CVD prevention.
4. To alert PCP of any out of target Laboratory or diagnostic results.
5. To alert PCP of any concerning blood sugars, symptoms or blood pressure readings.

Mission statement of DSME:

The mission of the Bay Clinic DMSE program is to provide quality, comprehensive, effective, individualized and group Diabetes Self-Management education. Our goal is to empower our patients and families through education guidance and professional support to better manage their disease. We are committed to assisting our patients overcoming barriers to care, risk reduction and the achievement of their optimal health status.

Bay Clinic, Inc. Mission Statement

To promote and provide affordable healthcare and healing services to our community. Focusing on quality, access, prevention and collaboration.

Vision:

Community Health and Healing, We are One

Date: 1/29/07

Analysis of PROJECTED Target Population

	Measure	Data	Needs
Type of DM: (all sites or by clinic)	Type I, 250.01 total 0-18 yrs <19yrs Number or percent attending DSME program	_____ _____ _____ _____	Adding to DM screening template , Attending DMSE class Yes, No, tick box
Type of DM: (all sites or by clinic)	Type II, 250 total 0-18 yrs <19yrs Number or percent attending DSME program	_____ _____ _____ _____	Adding to DM screening template , Attending DMSE class Yes, No, tick box
Population Size of DM patients by clinic	Hilo Pahoa Kea au Kau	_____ _____ _____ _____	
Age (all sites or by clinic)	45-64yrs 19-44yrs <19yrs	_____ _____ _____	
Ethnicity	1. Asian/Chinese/Japanese/Korean/Pacific Islander 2. Black/African American 3. Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino 4. White/Caucasian	_____ _____ _____ _____	
Special Needs	1. Visually impaired 2. Hearing impaired 3. Low literacy 4. English as a second language	_____ _____ _____ _____	
Unique features of the program. (choose all that apply)	1. Interpreters 2. Low literacy education tools 3. physical clinic enhancements 4. transportation opportunities 5. allowance for cultural diversity 6. languages other than English		

Date: 1/29/07

Review of PARTICIPANT population data

	Measure	Data	Needs
Type of DM: (all sites or by clinic)	Type I, 250.01 0-18 yrs <19yrs	_____ _____ _____	
Type of DM: (all sites or by clinic)	Type II, 250 0-18 yrs <19yrs	_____ _____ _____	
Registry Size	Hilo Pahoa Kea au Kau	_____ _____ _____ _____	
Age (all sites or by clinic)	45-64yrs 19-44yrs <19yrs	_____ _____ _____	
Ethnicity	1. Asian/Chinese/Japanese/Korean/Pacific Islander 2. Black/African American 3. Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino 4. White/Caucasian	_____ _____ _____ _____	
Special Needs	1. Visually impaired 2. Hearing impaired 3. Low literacy 4. English as a second language	_____ _____ _____ _____	
Patient satisfaction survey	Are we meeting our participant's needs?	Plan to implement and analyze survey results annually.	Under development. To be given to each participant upon completion of the DMSE program.

Bay Clinic, Inc. Diabetes Self-Management Education Program

6

Date: 1/29/07

Resources of DSME:

Resource	Adequate	Upcoming needs	Plans to improve
Instructional personnel	Maile Cheryl Stacy Lisa Steve Charlotte Miles Nakatsu, guest Pharmacist Becky Stubbs CDE guest speaker	Need additional RN trained in DM education.	RN in Pahoia & Kea au to assist instructor with DMSE classes
Advisory committee members	Eileen, Kim, Jason Instructional Program Coordinator Medical director CEO Clerical Support staff, IT		Stakeholders invited Becky Stubbs CDE Diane Sampler
Stakeholder members			Becky Stubbs and Diane Sampler
Clerical	Amy 20hrs/week		
CDE credentialed		To be certified.	Maile To obtain RN license and then CDE by 2008. Stacy to obtain CDE by 2008
BCADM credentialed		To be certified	Cheryl & Charlotte, Steve to obtain BCADM by 2008
Handouts Language needs		In development and ordered.	Collect brochures and education materials in various needed languages.
Handouts			Smoking cessation handouts Ordered
Nursing Students			Stacy will action. Registered nurse precept student
Interpreter	Mary Lou Loeak	Hired. Hourly wage	Interpreter hired (date) Translation of handouts Marshallese

**Continuing Education Analysis for ALL
 Non-CDE/BCADM instructional staff**

(CEU hours needs to be diabetes specific, diabetes related, behavioral & lifestyle changes, psycho-social, educational, etc)

Online CEU's offered at www.diabetes.org/professionaleducation

Please provide copy of verification for file

Instructional staff members	CDE or BCADM Certified member	2006 CEU CME	2007 CEU CME	2008 CEU CME	Goal to meet CDE or BCADM requirement by
Charlotte Grimm APRN		14.75 +++			BCADM by 2008
Maile Estabillo LPN		21			RN boards and CDE by 2008
Stacy Haumea RD					CDE by 2008
Cheryl Zorn APRN		16	27		BCADM by 2008
Lisa Kaneshiro PsyD					
Steve Koshel PA					BCADA by 2008

Please give copy of certification to Maile to file.

• Budget

Aloha Grant \$130,000 +, Applied for 2007
Hawaii Dept of Health for diabetes education \$4,000
ADA recognition
HMSA & ALOHA Care contracts being negotiated(Plan March 1st, 2007)
Plan to be self sufficient by end of 2007 in Hilo
Bayer-

Budget largely staff costs
 KTA account \$500/monthly for class food
 1st 10 to complete program \$100 vouchers planned
 \$\$ to cover cost of class attendance to those with need
 Educational materials
 Equipment
 \$\$ to assist in cost of medications for those with need
 Taxi/transportation issues to be addressed

Equipment

Current Equipment in use	Bay Clinic equipment: Scale, glucometer, HbA1c, BP Cuff
Immediate needs	Electronic scale and HbA1c
Wish list	2 Lap top & projector DM Provider visit EMR template DMSE class EMR template. Nutrition EMR template Exercise EMR template Screening EMR template for tracking and statistics
Other	Equipment for DMSE use only: electronic scale, VS equipment imports to EMR, glucometers, test strips, new HbA1c.
Plan:	Add to grant cost of equipment for DMSE DM provider visit template being developed by Waianae and will be shared Staff needs to develop an EMR template to use for DMSE class documentation. RD to develop a nutrition assessment template for EMR DM cookbook, Diabetic Warrior Cookbook

RESOURCES

Resources	Up to date or adequate	Needs identified & plan to improve
Teaching materials/handouts (Visual, Audio, reading, learning tools)		Acquire handouts in Marshallese, ADA brochures ordered
<u>Physical space:</u> Lighting Ventilation Ambient noise Handicapped accessible Accommodates 10 participants.		New Building Hilo by Feb 2008 which includes a Kitchen for demonstrations, Educational facility for DM education program, women's health and other community needs by Feb 2008. Expansion of Bay Clinic DMSE that will be ADA accredited by July 2007.

Curriculum Review

(Curriculum needs to reflect identified target population needs)

Curriculum must meet educational requirements of the American Diabetes Association, Hawaii State Department of Health and the Hawaii Association of Diabetes Educators or meet the requirements of the National Certification Board for Diabetes Educators.

Class	Appropriate for population served?	Needs Curriculum updated	Needs updated handout	Update by:
1. Diabetes Process	To be determined through Population analysis	All curriculum according to ADA guidelines updated 1/2007		
2. Nutritional management				
3. Physical activity				
4. Medications				
5. Monitoring				
6. Prevent, detect and treat acute complications	Offered each session. Need determined per class.	Advanced Nutritional class added to current curriculum by Feb 2007		
7. Prevent, detect & treat chronic complications through risk management				
8. Goal setting & problem solving				
9. Psychological adjustment				
10/Option 1. Management during pregnancy & gestational DM				
10/ Option 2. Risk for CVD and DM.		HMSA contract potential to meet the educational needs of pregnant DM and those with gestational diabetes.		

Pre/post tests developed to determine effectiveness of education classes.

Continued Quality Improvement Plan

Behavioral and Clinical Outcome data of DMSA participants:

To develop, implement, evaluate, maintain, improve and enhance the quality of the DMSE program.

Outcome measured	Meeting program goals	Continue	Needs review	Add new parameters to audit	Change in program
<u>Behavioral outcomes</u> Self management goal and CI. (Documented) Increased knowledge of DM (Pre/post testing)	As of 11/06, 100% of patients attending DMSE with doc goal and CI	<u>Yes</u>	<u>2008</u>	<u>No</u>	
<u>Clinical outcome</u> Improved HbA1c (Pre/post results)	Improvements are seen	<u>Yes</u>	<u>2008</u>	<u>No</u>	
CQI program		<u>Yes</u>	<u>2008</u>		Formal CQI plan in place
Audit Review	Continue to improve our electronic statistic capability				
Health Disparities Outcome results Electronic audit accuracy		On hold until accuracy verified	System needs review		Question accuracy of statistical program vs. accuracy of data input.

EMR system of generating statistics and reports needs to be improved to ease the input of data & the statistical analysis of collected data.

Analysis of Community concerns.

DMSE involvement in the Community

1. **Class timing to meet the needs of working community members.**
2. **Developing nontraditional hours for class program**
3. **Targeting work places in an outreach capacity Improved health in the workplace through (State, County offices, Educational system staff, Grocery stores, Hawaii electric.)**
4. **Bay clinic currently involved in Take it off Hawaii, Active for Life Program**
5. **Transportation Options: taxi coupons, community center outreach sites, neighborhood centers, Van driver & van cost added to grant.**
6. **One day weekly a class designated to exercise.**
7. **Insulin pump training, certification**

OUTCOMES AUDIT: 5/07
THOSE WHO ATTENDED AT LEAST ONE DMSE CLASS

OUTCOME	ACTUAL NUMBER AUDITED	%	BAY CLINIC GOALS
NUMBER OF DM WHO ATTENDED AT LEAST ONE DMSE CLASS	115		
CURRENT SMOKERS	17	15%	0%
HBA1C LESS THAN 7%	22	20%	70%
AVERAGE HBA1C			<7%
MEDIAN HBA1C			<7%
2 OR MORE HBA1C/YR	29	26%	24%
DOC SELF MANAGEMENT GOALS	60	53%	70%
BP >130/80	64	56%	75%
BMI <40 (IS THIS REALLY NUMBER OF PATIENTS WITH A BMI LESS THAN 40???)	77	67%	90%
ON STATIN	33	29%	80%
ON ACE OR ARB	33	29%	80%
ON ASA	37	33%	80%
ANNUAL MICROALBUMIN	35	31%	90%
ANNUAL MONOFILAMENT	33	29%	90%
ANNUAL RETINAL EYE EXAM	30	26%	90%
ANNUAL LIPIDS	51	45%	90%
PNEUMOVAX	30	26%	90%
INFLUENZA	38	33%	90%

**OUTCOMES AUDIT:
RANDOM AUDIT OF ALL DIABETIC PATINETS AT HILO BAY**

OUTCOME	ACTUAL NUMBER AUDITED	%	BAY CLINIC GOALS
NUMBER OF DIABETIC PAPER CHART AUDITED	105		
TOTAL NUMBER OF DM AT HILO BAY CLINIC			
CURRENT SMOKERS	31	30%	0%
HBA1C LESS THAN 7%	25	24%	70%
AVERAGE HBA1C	8.4%		<7%
MEDIAN HBA1C			<7%
2 OR MORE HBA1C/YR	37	36%	90%
DOC SELF MANAGEMENT GOALS	9	09%	70%
BP >130/80	48	46%	75%
BMI <40 (IS THIS REALLY NUMBER OF PATIENTS WITH A BMI LESS THAN 40???)	63	60%	90%
ON STATIN	44	42%	80%
ON ACE OR ARB	38	37%	80%
ON ASA	38	37%	80%
ANNUAL MICROALBUMIN	58	56%	90%
ANNUAL MONOFILAMENT	21	20%	90%
ANNUAL RETINAL EYE EXAM	32	31%	90%
ANNUAL LIPIDS	67	64%	90%
PNEUMOVAX	43	41%	90%
INFLUENZA	49	47%	90%

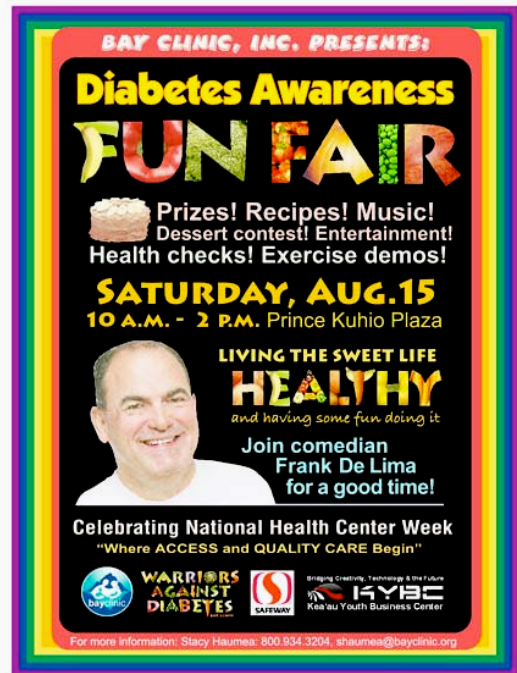
Annual Diabetes Fun Fair

– Living the Sweet Life Healthy and having fun doing it!

The Prince Kuhio event sponsored by the Bay Clinic, Inc., coincides with the annual National Health Center Week that is promoted by the National Association of Community Health Centers in Washington, D.C. This event happens the second week of August. At the mall, the event is scheduled from 10 a.m. - 2 p.m. as this time block allows for families that are out early in the morning and those who may get out later in the morning.

The first event was held in 2008 at the largest shopping mall in the Hilo area and was very successful. There were about 20 health providers who participated and about 250 people observed the event and interacted with people in the booths. In 2009 attendance was less, about 200 people attending. The

decrease in attendance was possibly due to local recession and another event that was happening in town on the same date. Advertising for the event was similar for both years which included the event being advertised in the Calendar Section of the local newspaper, in local radio interviews and by flyers put on bulletin boards around town. The event theme “Living the Sweet Life Healthy – and having fun doing it!”, was coined by Sue Ann Regules,



*The University of Hawaii Diabetes Education and Detection Program attracted much activity at their booth where they offered free A1C tests. The booth was staffed by students in the University's **Pharmacy** program.*

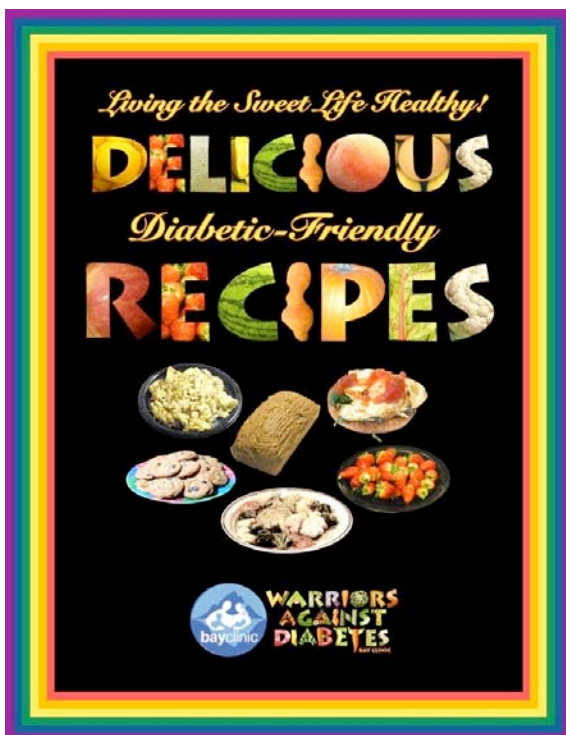
a former member of the Warriors who has passed on. The idea came about from group discussions, how everyone needs to have a good life and enjoy living life, and that one can do both with a chronic disease from support given and received. The information and support has helped many of our members and the

members felt it is important to share with the community.

During both years' events there was good diabetes information shared at the microphone balanced between health providers and entertainment headlined by perhaps the most popular comedian in Hawaii, Frank De Lima, also a diabetic. Exercise demonstrations were also scheduled. Speakers were given 15 to 20 minute slots to provide diabetes care information and prevention to those attending.

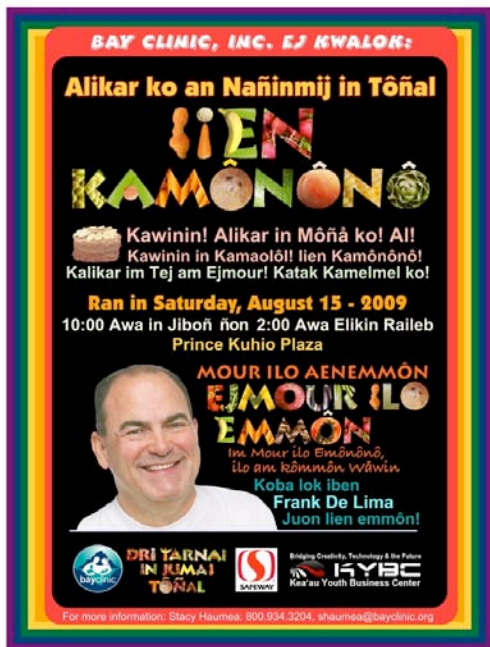
Agencies that have a diabetes focus were invited to sponsor their own tables. These agencies have included American Cancer Society, the Women Infants and Children program, Ke Anuenue Diabetes Education and Counseling Center, Hilo Medical Center, Hui Malama Ola Na Oiwī, University of Hawaii Diabetes Education and Detection Program, Keaau Youth Business Center Middle College Program, Aloha Care Chronic Disease Education Services, Keaau Bay Clinic Dental Program, Hawaii Kidney Foundation, Kick the Nic Smoking Cessation Program, American Lung Association, Curves, Novo Nordisk Diabetes Sales, Clinical Laboratories of Hawaii, LLP, Roche Diabetes Care, Saladmaster and Portion Plenty Plate. During the period of advertising the event, the Clinic usually receives additional requests that are accommodated if the vendor has a wellness focus that benefits people with diabetes.

This first year each table cost \$50 that the Bay Clinic absorbed. The second year it was decided to have each of the approximately 20 groups that participated pay the \$50 for their table. The Bay Clinic paid the overall fee to hold the event, and paid Frank De Lima's fee plus air transportation for him. De Lima discounted his fee because the Bay Clinic is a 501(C)(3) nonprofit organization and because of the educational nature of the event.



Each participating group was asked to provide two diabetes-friendly recipes available printed on three-hole punched paper. At the information booth, cookbook covers were provided with rings and people were invited to visit every table to pick up pages for the cookbook. This idea of Stacy Haumea's was to promote more people to visit the tables.

The mall fee of \$1,000 for the event included set up and removal of the tables and chairs and audience seating by mall staff. The fee also includes the use of a center stage and sound system with three microphones. The mall also agreed to post banners and posters from the organization



Here members of the Bay Clinic’s Marshallese Diabetes Support Group are singing a Marshallese song during the Fun Fair sponsored by the Bay Clinic at Prince Kuhio Plaza on August 15, 2009.

inside and outside the mall for 2 weeks before and after the event at no additional charge. Because the mall is an indoor location, there was protection from the weather in rainy Hilo.

The event was planned by the Bay Clinic’s Warriors Against Diabetes support group. The Warriors are regularly involved in public outreach and diabetes advocacy activities that include an event held on the first Wednesday of each month at Wailoa River State Park. The Warriors also have culturally based affiliations. The largest affiliations are Marshallese and Chuukese.

A flyer was created using the Marshallese language, translated by Dr. Keola Downing, a Marshallese interpreter contracted by Bay Clinic since 2006 and added to staff in 2009. Contracted interpreters also include Chuukese and Kosraean and the need for more interpreters is growing. Members of the Marshallese diabetes support group provided singing entertainment at one point and hosted a weaving craft table.

Members of the Warriors Against Diabetes staff the information booth at the Fun Fair. From left to right, Jim Foxworthy, Melonie Leopoldo, Rose Camero, and Helen and Alan Galiza-Somalpong.



Monthly Meetings in the Park, *sample flyer*



Wednesday, Feb. 4, 2009

from 9 a.m. - 12 p.m., Big Pavillion

Wailoa River State Park.

Gathering open to the public.

- *Healthy Pot Luck*; * mini health screenings; Charlotte Grimm will talk about "Steps to Take for Chronic Disease Prevention;" *All hands on deck cooking demonstration making healthy ziplock omlettes.*

Hannah Hedrick from the Nutrition & Physical Activity Coalition will lead a breathing, stretching and tai-chi demonstration; Sylvia and Gracel from Novo Nordisk will share how "Medicine and Insulin is Your Friend." Handouts and general diabetes care resources available.

Celebration of Life for fellow warrior Sue Anne Regules.

* *Low salt, low sugar, NO white rice, white potatoes, white sugar, or white flour*

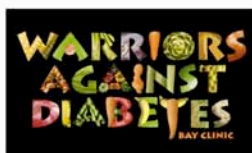
Sponsored by the **Warriors Against Diabetes** of the

Bay Clinic and its four Family Health Centers in Hilo, Ka'u, Kea'au and Pahoa.

For more information, contact **Stacy Haumea**, 808.934.3204, <shaumea@bayclinic.org> Bay Clinic website: <www.bayclinic.org/service.diabetes.asp> This is community outreach from the nonprofit

Bay Clinic's Diabetes Self-Management Education Program. It starts with a **series of 10 classes** that help patients with diabetes to learn techniques and strategies to manage and control diabetes, which will improve health outcomes and their quality of life. Then there follows the on-going support group, the **Warriors Against Diabetes.**

Our program is credentialed by the American Diabetes Association, and has been recognized



The Kea'au Youth Business Center is providing sound and video documentation of this community event.

Each headline we make with the veggie type is attractive. It is important to keep type on flyers in a large size for the important information.

We learned a lesson about having public pot lucks – that we were violating health regulations! We still have the pot lucks but do not advertise it. Because the Bay Clinic is still getting the word out about its diabetes program we thought it would be a good idea to have a complete description of the program. The type style for the script is Bradley Hand ITC; for the dates is Arial,

and for the headlines is Hawn Litho black. We have converted the type to paths so we have an individual graphic for each letter and then pasted photographs of vegetables inside the individual letters.

Vegetable Alphabet

This section may seem odd in this medical document, but it is not, because it is a staff time saver, thus an agency money-saver. It can enable staff to fairly easily make up attractive, professional-looking, attention-getting flyers for events as the Bay Clinic does for its monthly park events open to the public. It demonstrates the creativity that can occur with involving patients in the program. We thought it could be useful for other diabetes programs as well.

The main task now is not coming up with an attractive design, but writing a short, attention-getting phrase to describe the main activity in up to six words.

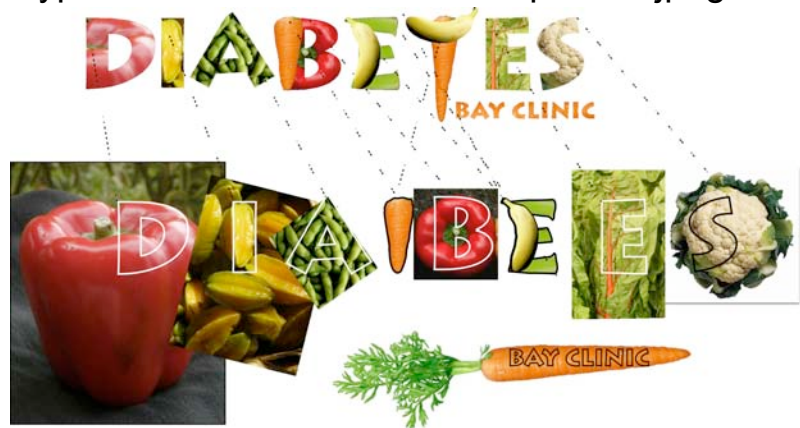
This is a diabetes-appropriate type style that was designed by diabetes patient Tom Whitney, a former graphic designer who participated in the Bay Clinic's classes and the Warriors Against Diabetes group. Tom designed the logo for the Warriors group as he started learning to love vegetables, which was a stretch for him.

Briefly, the way to make such letters is to use a type with thick letters and to use a program like Freehand or Illustrator to convert the type to paths, which creates an outline of the letters. The type style used here is named Hawn Litho Black. Then take many photographs of the desired subjects, in this case vegetables, and bring them into the computer and then do a "paste inside" command. Adobe Illustrator and the Freehand programs allow this. There are other programs that will do this as well.

The most attractive arrangement of the letters is to get a good balance of many colors, almost like an attractive salad.

The graphic below shows the process of fitting the photographs into the letters. Any group is welcome to use this type. On the DVD there are separate .jpeg files for each letter on the next

page coded the same way they are on the page in small type. Thus the letters can be called up from the DVD into Microsoft Word or some other program to create a graphic. Another type often used in its flyers by the Bay Clinic is one that looks hand printed type, called Bradley Hand ITC. A similar script is Comic Sans MS.



Within the Vegetable Alphabet folder in the "11. Vegetable Alphabet & Graphics folder" is the "Vegetable Alphabet Folder" and in there is a page that tells "Accessing letters . . ." letters from the file.



Forms

1. Invitation to Attend Diabetes Classes

Bay Clinic invites you to attend Diabetes Self Management Education Group Classes

It is estimated that 72,000 to 100,000 people currently have diabetes in Hawaii! Diabetes can lead to blindness, heart disease, kidney disease and amputations. If diabetes is well managed many of these serious complications can be prevented.

Please join your health care team at these ten short group education sessions. Together we can help you prevent serious diabetic complications and improve your level of well-being. After each class you will have the opportunity to discuss specific concerns & needs with a Family Nurse Practitioner or a Physicians Assistant.

Where: Hilo Bay Clinic, Inc. Conference room.

Check in at the front desk, pay your regular co-pay and a receptionist will direct you to our meeting place.

When: Thursday mornings 9am to 12pm

Wednesday mornings 9am to 12pm (with Marshallese interpreter)

Please check with Maile for weekly class schedule

Healthy snacks are provided after each class session.

Learn about:

- Diabetes disease Process
- Nutritional management
- Physical activity and diabetes
- Diabetic medications
- Blood sugar monitoring
- Personal health habits and foot care
- Preventing serious complications
- Goal setting and problem solving
- Psychological adjustment to diabetes
- Cardiovascular & diabetes risk prevention

Feel free to bring a family member

**If you are interested in attending,
Make an appointment for an intake interview
With Maile, our diabetic nurse.
934-3246**

Please bring with you all the medications you are currently taking

2. Class Schedule



Bay Clinic, Inc. Diabetes Self-Management Education Class Schedule



Hilo Family Health Center

1178 Kinoole Street Bldg B Hilo,

Tuesday 9:00 am – Advanced class support group
(Graduates of Thursday new patients class)

Wednesday 9:00 am – Marshallese

Thursday 9:00 am – New patients (10 or 11 week course)

Ka`u Family Health Center

95-5583 Mamalahoa Highway, Na`alehu

3rd or 4th Friday of each month 9:00 am - 11:00 am

Kea`au Family Health Center

16-192 Pilimua Street Kea`au

Wednesday – 2:00 pm - 3:00 pm

Pahoa Family Health Center

15-2866 Pahoa Village Road, Bldg C, Ste. A, Pahoa

Thursday – 9:00 am

For more information, contact

Stacy Haumea, Director of Diabetes Education

Tel 808.934.3204 Email: shaumea@bayclinic.org

Website: www.bayclinic.org/service.diabetes.asp

3. Individual Patient Folders

a. Report to Physician and Clinical Information



Ver 1.7 **Report to Physician and Clinical Information**
 (Please print clearly.)

First Name M.I. Last Name

Member No Birthdate (MM/DD/YYYY) Phone Number

Physician First Name Last Name

Facility Name

Initial Education Initial Education Date (MM/DD/YYYY) Re-Assessment Re-Assessment Date (MM/DD/YYYY)

Standards of Care	
HT: [] [] in.	Diagnosis Date (MM/YYYY) [] [] / [] [] <input type="checkbox"/> Don't know
WT: [] [] lbs.	Medication: (May check more than one.) <input type="checkbox"/> Insulin Injection <input type="checkbox"/> Oral Medication <input type="checkbox"/> Other
BP: [] [] / [] [] mm/Hg	
HbA1c (May check more than one. Fill in value if known.) <input type="checkbox"/> Self-Reported [] [] . [] [] % <input type="checkbox"/> MD Reported [] [] . [] [] % <input type="checkbox"/> Lab Reported [] [] . [] [] % <input type="checkbox"/> Don't know	Patient's Understanding of HbA1c: (May check more than one.) <input type="checkbox"/> Pt. knows their value <input type="checkbox"/> Pt. doesn't know their value <input type="checkbox"/> Pt. can explain importance of HbA1c
LDL-C (May check more than one. Fill in value if known.) <input type="checkbox"/> Self-Reported [] [] mg/dl <input type="checkbox"/> MD Reported [] [] mg/dl <input type="checkbox"/> Lab Reported [] [] mg/dl <input type="checkbox"/> Don't know	Patient's Understanding of LDL-C: (May check more than one.) <input type="checkbox"/> Pt. knows their value <input type="checkbox"/> Pt. doesn't know their value <input type="checkbox"/> Pt. can explain importance of LDL-C
Eye Exam: Within one year: <input type="checkbox"/> YES <input type="checkbox"/> NO	Last Eye Exam Date (MM/YYYY) [] [] / [] [] [] []

Self-Monitoring Blood Glucose (May check more than one.)
 Information Obtained from: Log Book Verbally Reported Meter Download
 Frequency: [] [] x day [] [] x week Currently not testing

Most recent blood glucose reading was at:
 Fasting/Before meals: [] [] mg/dl 2 hrs. after start of meals: [] [] mg/dl Bedtime: [] [] mg/dl

Activity Level (May check more than one.)

<input type="checkbox"/> Aerobic/Cardio Exercise Frequency: [] [] x week Duration: [] [] min/session	<input type="checkbox"/> Resistance/Weight Training Frequency: [] [] x week Duration: [] [] min/session	<input type="checkbox"/> Recreational Athletics Frequency: [] [] x week Duration: [] [] min/session	<input type="checkbox"/> Other type of activity Frequency: [] [] x week Duration: [] [] min/session	<input type="checkbox"/> None or inconsistent
--	---	---	---	---

Nutrition Meal Plan (select only one)
 Pt reports following plan 80-100% Pt reports not following plan
 Pt reports following plan 50-79% Pt does not have a meal plan at this time
 Pt reports following plan less than 50%

Hx of Patient Diabetic Education
 Has Patient ever attended diabetes class? Yes No
 If yes, where was class offered? _____
 If yes, date class was taken: (MM/YR) _____
 If yes, what topics were covered? _____

Education Content Areas (Check all that apply.)

Ver 1.7



5489600

The following education services were provided:

	Select one:	Pre Test	Post Test
<input type="checkbox"/> Diabetes Overview	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Medication Overview	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Monitoring Blood Glucoses: SMBG	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Nutrition Management	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Advanced Nutrition Therapy/Counseling	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Reducing Risk of Diabetes Complications: Acute	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Reducing Risk of Diabetes Complications: Chronic	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Goal Setting/Problem Solving	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Psychosocial Adjustment	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Preconception Care	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Physical Activity/Exercise	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%
<input type="checkbox"/> Other	<input type="checkbox"/> Individual <input type="checkbox"/> Class	%	%

Behavior Change Goals set by patient **Date Set** **% Goal Met** **Date & Evaluated**

<input type="checkbox"/> Food Plan <input type="checkbox"/> Stress <input type="checkbox"/> Physical Activity <input type="checkbox"/> Medication <input type="checkbox"/> Support <input type="checkbox"/> Blood Sugar Testing <input type="checkbox"/> Other			
Patient's Goals Is to:			Other Labs HDL _____ Trig _____ MicroA _____ BMI _____

Other Comments:

Recommendations/Plan:

Diabetes Educator First Name	Last Name

	_____	_____
Diab Educ HMSA Provider No.	Diabetes Educator Signature	Date

Diabetes Educator First Name	Last Name

	_____	_____
Diab Educ HMSA Provider No.	Diabetes Educator Signature	Date

Diabetes Educator First Name	Last Name

	_____	_____
Diab Educ HMSA Provider No.	Diabetes Educator Signature	Date

3b. Participant Weekly Tracking Sheet

Name _____

<i>Date</i>	<i>Weight</i>	<i>Blood Pressure</i>	<i>FBS/RBS</i>

This form was originally used and kept in each participant’s record, but has been replaced by Form 3k on page 50. That new “Vital Signs & Goal Sheet” places a weekly emphasis on goal setting and follow-up that had been missing.

3c. Diabetes Self-Management Education Course Referral Checklist

Name: _____ DOB: _____ Phone
Number: _____ Insurance Co: _____ Insurance ID
No: _____
Referring Provider (PCP) Name: _____
Date Referred: _____

Referral To: Last Appointment Date Appointment Date

Ophthalmologist _____ _____
Dentist _____ _____

Labs: Last Lab Date Current Lab Order Date

HgbA1C _____ _____
Cholesterol Panel _____ _____
Creatinine/BUN _____ _____
MicroAlbumin _____ _____

Immunizations/Vaccine Date Last Vaccinated Vaccination Date

Influenza _____ _____
Pneumovax _____ _____
Tetanus/other: _____ _____ _____

**Treatment
Needed:** _____

Results

Date: _____
HgbA1c: _____ **Cholesterol:** _____
Goals : **Less than 7%** **Less than 200 mg/dL**

3d. Diabetes Self-Management Group Visit Attendance Flow Sheet

Diabetes Self-Management Group Visit Attendance Flow Sheet

Name: _____ DOB: _____ Onset: _____

<u>Class # and /or Course Taken</u>	<u>Date Completed</u>	<u>Instructor</u>	<u>Hours</u>
Initial Assessment Form	_____	_____	_____
Pre-test (Date & Result %)	_____	_____	_____
Invitation or Invite Back Letter	_____	_____	_____
Post-test (Date & Result %)	_____	_____	_____
1. Diabetes Disease Process	_____	_____	_____
2. Nutritional Management	_____	_____	_____
3. Physical Activity	_____	_____	_____
4. Medication	_____	_____	_____
5. Monitoring	_____	_____	_____
6. Prevent, Detect, & TX Acute Comp	_____	_____	_____
7. Prevent, Detect, & TX Chronic Comp	_____	_____	_____
8. Goal Setting & Problem Solving	_____	_____	_____
9. Psychological Adjustment	_____	_____	_____
10. Perception Care w/Preg & Gest. Manag or Other	_____	_____	_____
Incentive Gift Card	_____	_____	_____
Satisfaction Survey	_____	_____	_____

*****Congratulations! You have completed the Diabetes Self Management Education Course*****

Do you have any additional educational needs? Yes No

Are you interested in attending a diabetes support group? Yes No

<u>Advanced Classes:</u>	<u>Date Completed</u>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

3e. Initial Intake Assessment

Diabetes Self-Management Education Program (DMSE)

1:1 Initial Assessment

Demographics & Social:

Name: _____ Date of Birth: _____

Marital status: **Single** **Married** **Divorced** **Widow** **Significant other**

Primary Care Provider: _____

Language Preference? Spoken _____ Reading _____ Intrepreter **Yes** **No**

1. Is there anyone at home who will help you with your diabetes care? **Yes** **No**
2. Last grade of school completed: _____
3. Can you read English? _____
4. Can you hear and see okay? _____
5. How will you get to the diabetes class? _____
6. Occupation _____
7. Do you have any cultural needs or preferences we should be aware of? **Yes** **No**

Diabetes History:

1. When were you told you had diabetes? _____
2. What type of diabetes do you have? **Type 1** **Type 2** **Don't know** **During pregnancy**
3. List family members with diabetes. _____
4. What does having diabetes mean to you? _____

5. How would you rate your understanding of diabetes? **Good** **Fair** **Poor**
6. Has diabetes caused a problem in any of the following areas?
 - Family and social activities
 - Work or school
 - Money
 - Sports or exercise
 - Sexual relations
 - Other _____

7. Check the areas of diabetes would you like to learn more about?

- What is diabetes?
- Diet and diabetes
- Physical activity
- Medication
- Blood sugar monitoring
- Stress & goal setting
- Pregnancy and diabetes
- Diabetes complications
- Smoking
- Weight management
- Reducing risk
- Other _____

Activity:

1. How do you exercise and how often per week? _____

Don't exercise 1- 2 per week 3-4 per week 5-6 per week Everyday

2. How long do you exercise? **0 5-10min 10-15min 15-25min 30min or more**

3. List any problems you have with exercise _____

Cardiovascular Risk Assessment: Check any of the following conditions you have?

- Smoking history (305.1)
- High blood pressure (401.1)
- High cholesterol (272.4)
- Over weight (278)
- Lack of physical activity
- Heart disease
- Family history of heart disease (V17.3)
- Family History of Diabetes (V18.0)

Nutrition:

1. Are you happy with your weight? **Yes No** Weight goal _____

2. Have you ever received nutrition counseling? **Yes No**

3. How many meals/snacks do you eat per day? **1-2 2-3 3-4 4-5**

4. How many times per week do you eat at fast food chains? **0 1 2 3 4 5**

5. How is your food typically prepared? **Fried Baked Broiled Grilled Boiled**

Medication:

1. Do you take insulin for your diabetes? **Yes No**
2. If you take insulin, what injection sites do you use? _____
3. What pills do you take for diabetes? _____
4. How often do you forget to take your medications? **Daily Weekly Never**
5. Do you understand your diabetes medication? **Yes No Sort of**

Monitoring:

1. Do you have a glucometer for testing your blood sugar at home? **Yes No**
2. Do you test your blood sugar at home? **Yes No**
3. How often do you test? _____
4. What time of day are you testing? _____
5. Have you ever had a low blood sugar reaction? **Yes No**
What did you do? _____

Complications:

1. Check any of the following diabetes related complications you have/had?
 - o **Eye problems** (retinopathy, **250.52**)
 - o **Heart problems** (Stroke, heart attack, stent, bypass, angina, **429.2**)
 - o **Kidney problems** (nephropathy, **250.42**)
 - o **Intestinal problems** (gastroparesis, **236.3**)
 - o **Numbness or pain in your feet, toes, legs** (neuropathy, **250.62**)
 - o **Sexual problems** (impotence, decreased desire)
 - o **Depression**
 - o **Hospitalized for diabetes complications** (ketoacidosis)
 - o **Year hospitalized** _____

Other pertinent History:

1. When was your last visit with your Health Care provider? _____
2. Do you check your feet? Yes No How Often? _____
3. When was your last dental exam? _____
4. Do you drink alcohol? Yes No Amount and type _____
5. Is there much stress in your life? Explain _____
6. Are you pregnant or planning to become pregnant? Yes No

Educational Needs (assessed by your Diabetes Educator)

- Diabetes disease process
- Nutritional management
- Physical activity
- Medications use, purpose, administration, side effects
- Glucose monitoring
- Acute complications and personal health
- Chronic complications
- Goal setting & coping
- Cardiovascular and Diabetes Risk Reduction

CURRENT STATUS:

	FBS	RBS	HbA1c	Micro Alb	Crea	Total Chol	LDL	HDL	Trig	Eye exam
Result										
Date										

	Dental	MF Foot	Influ	Pneu	ACE	ARB	Statin	ASA
Result								
Date								

Special Needs: _____

Comments _____

3f. Diabetes Self-Management Pre- and Post-Test

Diabetes Self-Management Pre & Post Test

To be completed at initial assessment meeting and upon completion of DMSE program

Diabetes Disease

1. Type 2 diabetes occurs in adults only
 - True
 - False
2. Risk factors for diabetes include;
 - Being overweight and not being active
 - Family history of diabetes
 - Having diabetes when pregnant (gestational Diabetes)
 - All of the above
3. Diabetes is a chronic condition that affects the way your body metabolizes (breaks down) sugar (glucose) your body's main source of fuel.
 - True
 - False
4. Diabetes can be better managed through what lifestyle changes?
 - Eating a healthy diet
 - Staying active
 - Taking your medications as prescribed
 - All of the above

Nutritional management

5. How can you best manage your diet for better diabetes control?
 - Limit sugars
 - Watch your portions
 - Eat a balanced diet
 - Limit animal fats and tropical fats
 - Increase whole grains and vegetables
 - All of the above
6. Why should you keep a blood sugar log and a food diary?
 - To become aware of what you eat
 - To understand how certain foods effect your blood sugar
 - To help your primary care provider in managing your medications
 - All of the above
7. What effect does alcohol have on your cholesterol and blood sugar?
 - None
 - Increased triglycerides and increase blood sugar
 - Lower LDL (bad cholesterol) and lowers blood sugar

Physical Activity

8. Exercise improves your
 - Blood sugar
 - Blood pressure
 - Cholesterol
 - Weight
 - All of the above
9. Twenty minutes of exercise will
 - Increase blood sugar
 - Decrease blood sugar
 - Have no effect
10. Best kind of exercise activity is
 - Something you enjoy
 - Vigorous
 - Works all your muscles
 - Raises your heart rate

Medications

11. Diabetes pills _____
 1. Are taken to lower blood sugar
 2. Is a type of insulin
 3. Are effective only when the pancreas still produces some insulin
 4. 1 and 3
12. A good reminder for taking your medications is to;
 - Take them at the same time everyday
 - Put pill bottles by your toothbrush
 - Put your medications in daily pill boxes
 - All of the above
13. Who is the most important person in the management of your diabetes?
 - Your pharmacist
 - Your primary care provider
 - Your wife, husband, family or friends
 - Yourself

Blood sugar monitoring

14. What are some of the symptoms of hypoglycemia? (Low blood sugar)
 - Confusion, weakness and change in vision
 - Sweating and hunger
 - Nausea and drowsiness
 - All of the above

15. If feel your blood sugar is low, you should;
- Take a glucose tablet
 - Check your blood sugar
 - Eat a snack or meal that includes protein and complex carbohydrate
 - All of the above

Complications

16. What can you do to reduce your risk for diabetes complications?
- Blood sugar control, Stay active and quit smoking
 - Reduce fats in your diet
 - Manage weight and eat a healthy diet
 - All of the above
17. Risk factors for heart disease include:
- Diabetes and obesity
 - Smoking and high blood pressure
 - High cholesterol and lack of activity
 - All of the above
18. You should see this specialist every year to check for diabetic retinopathy.
- Ophthalmologist
 - Optometrist
 - Podiatrist
 - Cardiologist
19. Diabetes can lead to complications such as nerve, kidney, eye, blood vessel and heart damage.
- True
 - False

Goal setting & Psychological adjustment

20. How does stress affect you?
- Physically
 - Psychologically
 - Behaviorally
 - All of the above
21. What are some obstacles to making lifestyle changes?
- Setting unrealistic goals
 - Lack of commitment
 - Setting a goal that is too hard
 - All of the above
22. Which of the following are symptoms of “fight or flight”?
- Heart racing and sweating
 - Muscle tension and upset stomach
 - All of the above

23. My goal HbA1c is

- 7% or lower
- 8%
- 9%
- Don't know

Personal Habits and Diabetes screenings

- 1) I should have a blood test to check my kidneys every _____, but every 3 months if abnormal.
 - Year
 - Month
 - 3 Months
 - Doctors Visit

- 2) I should check my feet for sores, cuts, redness every
 - Year
 - 3 Months
 - Month
 - Day

- 3) I need to have my cholesterol (lipids) checked every _____, but every 3 months if abnormal.
 - Year
 - Month
 - Doctors Visit

- 4) My HbA1c should be checked every
 - Year
 - 3 Months
 - Month
 - Doctors Visit

- 5) I should see an ophthalmologist (diabetes eye specialists) every
 - Year
 - 3 Months
 - Month
 - Doctors Visit

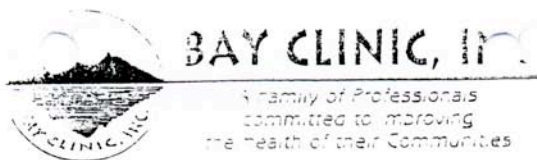
- 6) I should have a dental exam every
 - Year
 - 3 Months
 - Month
 - Doctors Visit

3g. Pre- and Post-Test Scoring Sheet

Pre/Post test scoring

Number correct	Number wrong	Percent score
29	0	100%
28	1	96%
27	2	93%
26	3	89%
25	4	86%
24	5	82%
23	6	79%
22	7	75%
21	8	72%
20	9	68%
19	10	65%
18	11	62%
17	12	58%
16	13	55%
15	14	51%
14	15	48%
13	16	44%
12	17	41%
11	18	37%
10	19	34%
9	20	31%
8	21	27%
7	22	24%
6	23	20%
5	24	17%
4	25	13%
3	26	10%
2	27	06%
1	28	03%
0	29	0%

3h. Assumption of Risk / Release of Liability Form



Assumption of Risk/ Release of Liability Form

I understand and agree that the _____ which I am in involves certain risks and that regardless of the precautions taken by the organization, some bodily injuries may occur. Specific risks/hazards involved in the activity include, but are not limited to the following:

Knowing this information, in consideration of my participation in the organization's activity, I **expressly** and **knowingly** release the organization, its representatives, officers, advisors and agents; the Bay Clinic, Inc, its officers, and employees, from any and all claims and causes of action for property damage, personal injury or death sustained by me arising out of any travel or activity conducted by or under the auspices of the organization caused by **risks associated by this activity and/or the negligence of the sponsoring group.**

In addition, I understand and agree the organization cannot be expected to control all of the risks articulated in this form, but may need to respond to accidents and potential emergency situations. Therefore, I hereby give my consent for any medical treatment that may be required during my participation with the understanding that the cost of any such treatment will be my responsibility. I **voluntarily** and **knowingly** agree to **protect, hold harmless, and indemnify** the organization, its representatives, officers, advisors and agents; the **Bay Clinic, Inc,** its officers, and employees, against all claims, demands, or causes of action for property damage, personal injury, or death, including defense costs and attorney's fees arising out of my participation in the organization's activity.

I have read the agreement and have willingly signed for the consideration expressed and with a full understanding of its purpose. Participant represents that he/she is eighteen (18) years of age or older and is otherwise competent to execute this agreement, or that his/her legal guardian is also signing.

Date: _____

Print Name _____ DOB: _____

Signature _____

Local Address _____

10/24/06hd

Serving You With Aloha!

HILO BAY CLINIC
311 Kalanianaʻole Avenue • Hilo, Hawai'i 96720-4740
Tel: (800) 969-1427 • Fax: (800) 961-4795

3i. Photo Release Form



Family Health Centers

Hilo • Pāhoa • Kea'au • Ka'ū

Administrative Offices

224 Haili Street Hilo, Hawai'i 96720

www.bayclinic.org

PR/Marketing Department: 808-961-4080

Photo / Video / Voice Recording Consent and Release

I hereby consent to and authorize use and reproduction of the photographs and/or video and or voice recording taken of me (or the said minor _____). I understand that all video, photographs, voice recordings and images may be reproduced without compensation to me or minor named above. I agree to indemnify and hold harmless Bay Clinic, Inc from any and all liability arising from the use of this video and/or voice recording and/or photographic image. I hereby authorize the reproduction, copyright, sales, exhibition, internet postings, broadcast and/or distribution of said videotape, photograph, voice recording or image by the produce of his/her agent without limitation.

I hereby release and discharge Bay Clinic, Inc. from any and all claims and demands arising out of or in connection with the use of the photographs, images, and text, including any and all claims for libel.

Address: _____

City / State: _____ Zip: _____

Phone: _____

Name (Printed): _____

Signature (Parent or guardian if under 18): _____

Date: _____

3j. Consent for Participation in a Group Medical Visit

BAY CLINIC, INC.
311 Kalanianaʻole Ave.
Hilo, HI 96720
969-1427

CONSENT FOR PARTICIPATION IN A GROUP MEDICAL VISIT

I, _____ hereby consent to participating in a Group Medical Visit on
____/____/____ at _____ (am)(pm).

The staff has explained to me the activities that occur during the Group Medical Visit and provided me with pertinent handouts.

I understand that :

- _____ I will be in a group with my Doctor and 10 – 20 other patients with similar problems.
- _____ It is my right to discuss only personal information that I wish to share with the group.
- _____ It is my responsibility to respect the privacy of others in the group and that I will not share their personal information with anybody else.
- _____ I may speak to my Doctor alone if I have additional personal problems to discuss.
- _____ I can withdraw from the Group Visit at any time for any reason.
- _____ Not participating will not affect my relationship with my Doctor or my ability to receive service in the center.
- _____ Payment for participation is the same as for a regular Doctor’s visit.
- _____ This consent is a supplement to the general consent for services.

My signature confirms that I clearly understand the activities that occur in a Group Medical Visit and that I am willing to participate.

Patient’s Signature: _____

Doctor’s Signature: _____

3k. Vital Signs & Goal Sheet

Name _____

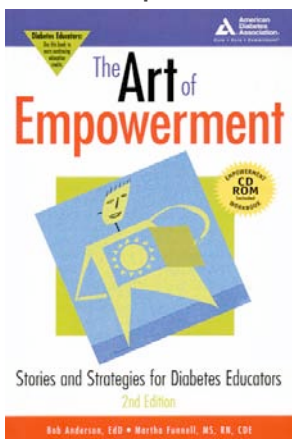
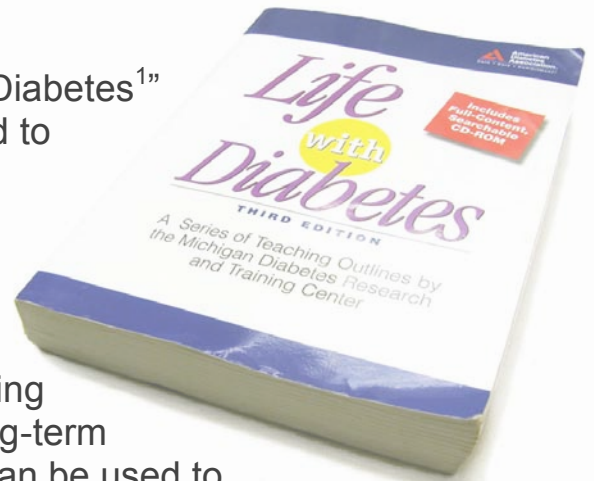
Date	Weight	BP	FBS/RBS	Topic #
A health goal of mine is to: _____ I'll achieve this goal by: _____ I feel I can meet this goal _____ times a day _____ times a week Follow-up date: _____ I met this goal 100% 75% 50% 25% 0% of the time				
Date	Weight	BP	FBS/RBS	Topic #
A health goal of mine is to: _____ I'll achieve this goal by: _____ I feel I can meet this goal _____ times a day _____ times a week Follow-up date: _____ I met this goal 100% 75% 50% 25% 0% of the time				
Date	Weight	BP	FBS/RBS	Topic #
A health goal of mine is to: _____ I'll achieve this goal by: _____ I feel I can meet this goal _____ times a day _____ times a week Follow-up date: _____ I met this goal 100% 75% 50% 25% 0% of the time				
Date	Weight	BP	FBS/RBS	Topic #
A health goal of mine is to: _____ I'll achieve this goal by: _____ I feel I can meet this goal _____ times a day _____ times a week Follow-up date: _____ I met this goal 100% 75% 50% 25% 0% of the time				

5. Diabetes Curriculum Outline

The hefty 581-page large paperback “Life with Diabetes¹” includes the content areas that must be covered to meet the National Standards for Diabetes Self-Management Education required for becoming an American Diabetes Association certified program.

This book offers important insight into all areas of diabetes – from eating and meal planning to regulating blood glucose, monitoring, and long-term complications. It is a complete curriculum that can be used to deliver quality diabetes care self-management education.

An important aspect of the teaching approach is place the program participant at the center of the activity and answer questions that participants are interested in, even though this might not seem so productive, at first. The focus is meant to be less on delivering a set amount of educational information (and stopping there) and mostly on motivating participants to change their behaviors. This requires a re-thinking on the part of all the medical staff in how they approach this assignment. The patient is now supposed to be part of the team dealing with his or her disease and is really the expert on how they themselves are going to deal with it. It is sort of like that old saying that you can lead a horse to water but you cannot make him drink. So the idea here is to provide the conditions where people will feel empowered to make the changes themselves with help from the medical providers.



Another book that provides a fundamental understanding of this approach is “The Art of Empowerment²,” by Bob Anderson, EdD and Martha Funnell, MS, RN, CDE.

The book is written for diabetes educators and the authors recommend that people study it and discuss it with some trusted colleagues. The book is filled with stories that illustrate the new approach they developed after twenty years in the diabetes field trying to understand why the traditional approaches were not working. They say in the introduction that “the assumption underlying the traditional approach to diabetes care and education – that the health care professional is in charge – does not work for diabetes. The patient is in control.”

¹ Funnell MM, Arnold, M, Barr P, Lasichak A. Life With Diabetes: A Series of Teaching Outlines by the Michigan Diabetes Research and Training Center, Third Edition, (05/01/04) McGraw-Hill Item Number: MCGRA040205

² Anderson R, Funnell MM. The Art of Empowerment, Stories and Strategies for Diabetes Educators, 2nd Edition, © 2000, 2005, American diabetes Association

Diabetes Collaborative Curriculum

Class Title	Diabetes Disease Process, Class # 1
Purpose:	To provide information to patients definition of diabetes, pathophysiology and treatment regimes.
Goal of class:	Increase patient and family knowledge related to the diabetes disease process and treatment regimes.
Objectives:	<ul style="list-style-type: none"> • To describe diabetes as Chronic metabolic disorder • To differentiate Type I, II, impaired glucose intolerance and gestational disorder • Metabolic Syndrome X • Risk factors associated with diabetes • Discuss Function of the pancreas and liver in diabetes control • Define hyperglycemia and hypoglycemia signs, symptoms and action • Importance of self-management & goal setting • Coping with the diagnosis and coping with changes in lifestyle. • Role of Meals, Medications and Activity to attain blood sugar goal.
Content:	Definition, pathophysiology, and treatment regimes of diabetes
Method of Presentation:	Question/discussion format with Diabetes Nurse Educator
Materials needed:	Handouts: Pancreas, normal and abnormal glucose metabolism, natural history of Type II diabetes, hyperglycemia and hypoglycemia symptoms and plan
Content outline:	<ol style="list-style-type: none"> 1. Definition of diabetes 2. Describe Type I, II, impaired glucose tolerance, gestational 3. Syndrome X & DM risk 4. Pancreas and liver function 5. What are the symptoms of low/high blood sugar? What should you do? 6. Coping with the diagnosis and lifestyle changes 7. Goals in fasting and random blood sugars 8. Self-management behaviors
Pre/Post test:	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

We need the Word document that has Class 2 curriculum to insert it here.

Diabetes Collaborative Curriculum

Class Title	The Basics of Eating, Class # 2
Purpose:	To provide information to patients emphasizing the critical role of macronutrient intake in diabetes management.
Goal of class:	Increase patient knowledge related to how food groups impact blood glucose and the reasons for meal planning.
Objectives:	<ul style="list-style-type: none"> • Identify three macronutrients and their impact on blood glucose • State the most important personal reason they might use a meal plan • State how the timing of food can help them reach their blood glucose goals • State how monitoring the amount of food eaten can help them reach their blood glucose or weight goals • Demonstrate how to measure liquid and dry ingredients • Describe how to keep a food diary • Identify one action they could take during the coming week to space the timing or modify the amount or type of food eaten. • Label reading • Food groups and Food guide Pyramid
Content:	Nutritional Management
Method of Presentation:	Question/discussion format with Diabetes Nutritionist
Materials needed:	Handouts: Healthy eating with Diabetes, Portion control, Tips on Fiber, Food Pyramid, Portion Sizes, Reasons for Meal Planning, Food Diary Example, Food Diary (blank) Various food props
Content outline:	<ol style="list-style-type: none"> 1. Definition of diabetes 2. Role of diet 3. Reasons for meal planning 4. Timing 5. Portion size 6. Weighing and measuring food 7. Assessing how you eat now 8. Getting started
Pre/Post test:	Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.

Source: Life with Diabetes-3rd edition. American Diabetes Association.

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Physical Activity and Exercise, Class 3
Purpose:	To provide information about the effects of physical activity on blood glucose and necessary dietary adjustments for changes in activity.
Goal of class:	Increase knowledge of beneficial effects of activity on DM management.
Objectives:	<ul style="list-style-type: none"> • Benefits of exercise • Effects of exercise on blood sugar • Target heart rate determination & pulse taking • Anaerobic vs. aerobic exercise • Signs and symptoms of hypoglycemia during or after exercise • Adjustments in food intake or insulin doses to balance with activity • Develop a personal exercise plan & goal
Content:	Physical activity
Method of Presentation:	Question/discussion format with diabetes educator. Short demonstration of warm up & chair and/or theraband exercise
Materials needed:	Pedometers when available, sample activity snacks, handout on hypoglycemia s/s and tx. Target heart rate scale
Content outline:	<ol style="list-style-type: none"> 9. Benefits of exercise 10. Effects of exercise on blood glucose 11. Balancing food/insulin with activity 12. Carbohydrate adjustments 13. Signs of intolerance 14. Duration, consistency and target heart rate 15. Examples of anaerobic examples of aerobic exercise 16. Creating a personalized exercise plan 17. Warm up and chair & theraband activity demonstration
Pre/Post test:	Short pre test given prior at initial intake appointment and post test given upon completion of DMSE program. Answers discussed in class. Pre/post testing will allow documentation of occurred learning.

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Medications, Class # 4
Purpose:	To provide information about the purpose, action, use and side effects of oral diabetes medication. To provide information about insulin, how it works, and how it is administered.
Goal of class:	Improve patient's knowledge of diabetes oral and injectable medication use, purpose, side effects and administration.
Objectives:	<ul style="list-style-type: none"> • To define the purpose, action and side effects of oral diabetes medication. • To know the name, dose and timing of DM medications • Techniques for remembering to take medications. • To define insulin, source, strength, length of action. • Insulin storage, measurement, administration and site rotation • Treating hypoglycemia • Define normal blood glucose values in pre and post prandial states
Content:	Medications
Method of Presentation:	Question/discussion format with a Diabetes Educator, Nurse or Pharmacist.
Materials needed:	Injection sites and site rotation. Insulin action times. Giving an injection. Diabetes Pills. Treatment of low blood glucose.
Content outline:	<ol style="list-style-type: none"> 1. Types of oral diabetes medications; Sulfonylureas, Biguanides, Alpha-glucosidase inhibitors, Thiazolidinediones, Meglitinidies and combinations. 2. Mode of action, dosing, timing, duration of action, benefits, side effects, precautions. 3. Remembering to take medications, missed dosage, care and storage. 4. Initiating insulin therapy. 5. Types of insulin; short acting, intermediate acting, long acting. 6. Source, strength, storage, mixing insulin 7. Equipment needed for insulin therapy, techniques of administration. 8. Injection sites and rotation 9. Hypoglycemia treatment 10. Pre and postprandial goals
Pre/Post test:	Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program. Pre/post testing will allow documentation of occurred learning.

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Monitoring your diabetes and managing blood glucose, Class # 5
Purpose:	To provide information about the purpose of regular blood glucose testing and urine testing for ketones. How to record results. Identify and define the factors that influence blood glucose levels. Recognizing and treating hypoglycemia and hyperglycemia.
Goal of class:	To improve patient & family knowledge of blood sugar monitoring and self management of blood glucose.
Objectives:	<ul style="list-style-type: none"> • Blood test vs. finger prick blood glucose values • HbA1c • When to test blood glucose and urine ketones • Blood glucose log book and diet/activity diary • Factors that effect blood glucose • Blood glucose goals; fasting and postprandial • Hypoglycemia and hyperglycemia causes and treatment of. • Sick day management
Content:	Blood glucose monitoring and acute complications
Method of Presentation:	Question/ discussion format with a Diabetes Nurse Educator.
Materials needed:	Handouts: Blood glucose log books, Dietary diaries, HbA1c, Target glucose levels (fasting, pre and post prandial), Sick day guidelines, Hypo/Hyperglycemia s/s.
Content outline:	<ol style="list-style-type: none"> 1. Home glucose monitoring vs. blood testing and 3 monthly HbA1c. 2. Glucometers and supplies 3. When to check blood glucose 4. Blood glucose goals/targets (fasting, pre and post prandial) 5. Tips for testing, recording results 6. Factors that affect blood glucose (meals, medication, activity) 7. S/S hypo/hyperglycemia and treatment 8. When to test for ketones 9. Sick day management
Pre/Post test:	Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program. Pre/post testing will allow documentation of occurred learning.

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Prevent, Detect & Treat Acute Complications & Personal Health Habits Class # 6
Purpose:	To provide information about lifestyle habits that are important for people with DM.
Goal of class:	Increase knowledge of foot care, dental care, skin care and wound care & infections.
Objectives:	<ul style="list-style-type: none"> • Why are personal health habits particularly important for people with diabetes? • Recognize the early signs of infection • Preventive foot care, daily foot care • Preventive dental care, daily dental care • Smoking & alcohol's detrimental effect on Diabetes, heart, lipids, weight, BP, etc. • Nail care • Care of minor cuts and bruises • Ways to improve circulation (sugar control, exercise, smoking cessation) • Risk & symptoms of urogenital infections • Frequency of health monitoring
Content:	Reducing risk& improving health
Method of Presentation:	Question/discussion format with Diabetes Nurse Educator
Materials needed:	Foot care handout, smoking cessation handout
Content outline:	<ol style="list-style-type: none"> 1. Health habits (sleep, nutrition, activity, foot, dental, skin care. 2. Smoking risks & benefits of quitting. cessation techniques 3. Effects of alcohol 4. Risk, symptoms and care of infections 5. Why importance of dental care 6. Importance of foot care, prevention, monitoring, treatment 7. Prevention, symptoms & risks associated with decreased circulation 8. Urogenital infections: yeast, UTI, balanitis 9. Health maintenance monitoring
Pre/Post test:	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Long Term Complications, Class # 7
Purpose:	To provide patients/families information about the chronic complications that occur with diabetes
Goal of class:	For patients to gain a better understanding of the complications that can occur in diabetics, symptoms associated with those complications and ways to monitor and prevent such complications.
Learning Objectives:	<ul style="list-style-type: none"> • Increase knowledge of potential DM complications, symptoms and prevention • Describe major consequences of small vessel disease to eye & kidney • Describe symptoms that may occur with retinopathy & nephropathy • Value of annual ophthalmologic and renal function examinations • Describe major consequences of large vessel disease (heart, legs, feet & toes) • Describe symptoms and ways to prevent large vessel disease. • Risk factors for heart disease & ways to reduce risk
Content:	Chronic complications
Method of Presentation:	Question/discussion format with Diabetes Nurse educator
Materials needed:	Handouts: Circulatory & Nervous system, Cardiovascular disease book, Retinopathy book, foot care book, ADA handouts r/t chronic disease in DM, resources for support groups.
Content outline:	<ol style="list-style-type: none"> 1. Occurrence of long-term complications 2. Systems affected 3. Circulatory system 4. Diabetic retinopathy 5. Diabetic cataracts 6. Diabetic nephropathy 7. Cardio Vascular Disease 8. Risk factors for heart disease 9. Prevention, detection and treatment of heart disease 10. Feet, legs and hands 11. Autonomic neuropathy 12. What you can do (methods of self-management & prevention)
Pre/Post test	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Goal setting and Problem solving, Class # 8
Purpose:	To present a problem solving approach to diabetes self-care and general health habits. To guide patients in goal setting.
Goal of class:	For patients and family to set and sustain goals for diabetes self management
Objectives:	<ul style="list-style-type: none"> • Strategies for making changes • Choices for behavior change • Setting behavior change goals • Making a plan • Making a commitment
Content:	Goal setting and problem solving
Method of Presentation:	Question/discussion format with diabetes educator.
Materials needed:	None
Content outline:	<ol style="list-style-type: none"> 1. Health habits 2. Strategies for lifestyle behavior changes 3. Creating new healthy habits 4. Choices 5. Making a plan 6. Setting behavior change goals 7. Problem solving
Pre/Post test:	Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program. Pre/post testing will allow documentation of occurred learning.

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Stress and Coping, Class # 9
Purpose:	To provide information about stress and how it affects glucose levels. To help patients and families recognize stressful situations and develop methods for coping.
Goal of class:	For patients and families to gain an understanding of the effect of and coping with stress, problem solving and setting goals.
Objectives:	<ul style="list-style-type: none"> • Define stress • Body's response to stress • Effects on blood glucose • Identify personal stressful situations • The coping response. • Identifying positive & healthy coping techniques.
Content:	Psychological adjustment
Method of Presentation:	Question/discussion format with diabetes educator.
Materials needed:	Stress handout
Content outline:	<ol style="list-style-type: none"> 1. definition of stress 2. evaluating stressful situations 3. Body's response to stress, "fight or flight" 4. effect on blood glucose 5. coping 6. tips for managing stressful situations 7. deep breathing exercise demonstration 8. visual imagery demonstration
Pre/Post test:	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Pregnancy and Diabetes, Class # 10 Option 1
Purpose:	To provide information about preconception care for women with existing diabetes, care of diabetes during pregnancy, gestational diabetes and the effect of diabetes on pregnancy and its outcomes.
Goal of class:	To improve knowledge of effect of diabetes on pregnancy and effect of pregnancy on diabetes.
Objectives:	<ul style="list-style-type: none"> • Preconception counseling, blood glucose control, risks of pregnancy when diabetic, tests for complications. • Define gestational diabetes, meal plan during pregnancy, effect on birth weight, treatment fro hypoglycemia, emergency situations, specialized tests, baby special care. • Pre-existing diabetes and pregnancy; blood glucose control, value of intensification of diabetes control, treatment of hypoglycemia during pregnancy, emergency situations, specialized testing and baby special care needs.
Content:	Pregnancy; preconception care, gestational diabetes, pre-existing diabetes and pregnancy.
Method of Presentation:	Question/discussion format with diabetes educator.
Materials needed:	Insulin needs in pregnancy. Where weight goes during pregnancy. Treatment of low blood glucose in pregnancy.
Content outline:	<ol style="list-style-type: none"> 1. Preconception counseling; overview, effect of pregnancy on diabetes and diabetes on pregnancy, caring for your diabetes in pregnancy, health considerations, planning to become pregnant 2. Gestational diabetes; why does it occur?, risks, special testing, blood glucose management, insulin injections, monitoring. 3. Pre-existing diabetes and pregnancy; changes during pregnancy, risks in pregnancy, special tests, managing diabetes in pregnancy, meals, exercise, insulin and treatment of hyper/hypoglycemia, team care approach, labor and delivery, care of your baby
Pre/Post test:	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

Diabetes Collaborative Curriculum

Class Title	Risk for Cardiovascular disease and Diabetes, Class # 10 Option 2
Purpose:	To provide information related to risk factors associated with acquiring diabetes and cardiovascular disease.
Goal of class:	For patients and families to increase their knowledge of risks factors associated with acquiring diabetes and/or CVD.
Objectives:	<ul style="list-style-type: none"> • To list the risks associated with acquiring diabetes • To list the risk factors associated with acquiring CVD • To discuss the risk factors we can change • To discuss the risk factors we can not change • To develop lifestyle change goals
Content:	Risk for diabetes and risk factors associated with CVD
Method of Presentation:	Question/discussion format with diabetes educator.
Materials needed:	Atherosclerosis, lipid handout, Effects of Diabetes on vascular system, BP control, BMI chart
Content outline:	<ol style="list-style-type: none"> 1. Who is at risk for developing diabetes? 2. Who is at risk for developing CVD? 3. Lifestyle behaviors you can change; Lipids, weight, smoking, exercise, diet, blood pressure, stress, blood glucose 4. Metabolic syndrome, syndrome X 5. Lipids goals, Blood pressure goals, blood glucose goals 6. Smoking cessation, stress 7. Activity, weight, diet 8. Risk factors you can not change; Family history, gender, age, ethnicity 9. Developing goals for lifestyle change, to reduce you risk for Diabetes and/or CVD.
Pre/Post test:	<p>Short pre test given when enrolled in DMSE, the same test given after completion of DMSE program.</p> <p>Pre/post testing will allow documentation of occurred learning.</p>

Source: Life with Diabetes, 3rd Edition, American Diabetes Association

6. Participant Satisfaction Survey

Date / /

Sex: O M O F

Age:

Based on your experience in the diabetes education classes:

Rate the diabetes education program according to the following scale.

What	Agree	Some	NO	Not Sure	Does Not Apply
1. The Diabetes education classes helped me get a better understanding of diabetes Self-Management through diet, exercise and medications.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. The classes were taught in a way I could understand.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Handouts I received in the diabetes classes were helpful, easy to read and understand.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The nutrition education classes helped me to make healthy changes in the way I eat.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. The Diabetes education classes are given in a way that respects me and my cultural beliefs and knowledge.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. An interpreter in my own language would have made the Diabetes education classes easier to understand. What language? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I know my target goal for HbA1c.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I understand the importance of exercise in controlling diabetes and I am going to start a my own exercise program.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I understand how to improve my cholesterol and triglycerides.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I know what the serious complications of diabetes are and how to avoid them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I am able to monitor my blood sugar and change my diet at home to get better diabetes control.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I understand all my diabetes medications and I take them as prescribed by my health care provider.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How can we improve?: _____

Mahalo, for helping us improve our program to better suit our needs.

7. Diabetes Collaborative Outcomes Audit

Diabetes Collaborative Outcomes Audit Self Management Group

Outcome	Actual #	% of total Self Management group	Bay Clinic Goals
Number patients enrolled in DM self-management classes			70%
Currently smoking			0%
HbA1c <7%			70%
Average HbA1c			<7%
Patients with 2 or more HbA1c per year			90%
Documented self management goals			70%
BP <130/80			75%
BMI < 40			90%
On Statin			80%
On ACE or ARB			80%
On ASA			80%
Annual micro albumin			90%
Annual monofilament			90%
Annual Retinal eye exam			90%
Annual lipids			90%
Pneumovax			90%
Influenza			90%

Total number of diabetics enrolled in Self management group classes

Audit 10% of that total (If we have 300 total, audits 30)

Total divided by # actual = % of total.

Frequency: Audit once every 3 months for now

Problems? Suggestions?

8. Job Description, Program Coordinator

Bay Clinic, Inc

Job title: Diabetes Self-Management Education (DMSE) Program Coordinator

Reports to: Medical Director & CEO

Job Purpose:

To oversee, develop, coordinate and manage the Diabetes Self-Management Education Program.

Duties and Responsibilities:

Duties include but are not limited to;

- Responsible for assisting in the development of the DSME program
- Managing the DMSE program
- Supervising diabetes educators
- Acting member of the Advisory Committee for DSME program
- Organizes the periodic and annual program review meetings
- Acquire and maintain ADA program recognition (CDE or BCADM)
- Assisting in coordination, consistency and integration of the DSME program
- Assist in the development and implementation of DSME program policies
- Leading or participating in CQI activities aimed at evaluating and improving the DMSE program
- Assisting in marketing and promoting the DMSE program
- To work towards the development of the DMSE program in all affiliated Bay Clinic sites.

Qualification:

(RN, RD or APRN with the following qualifications and/or experience)

Bachelors Degree in Nursing Science RN

Masters degree in Nursing Science RN MS, preferred

Valid State of Hawaii RN

Valid State of Hawaii APRN license preferred

Registered Dietitian with valid license in the State of Hawaii

Working towards or certified as a CDE

BC-ADE certification preferred

Experience in Program Development & Program Management

Experience in Chronic Disease Management

I have received a copy of my job description on _____

Signature_____

9. Job Description, Nutritionist

BAY CLINIC INC.

JOB DESCRIPTION

NUTRITIONIST

DIABETES MANAGEMENT PROGRAM – DIABETIC WARRIORS

This program is grant funded .5 FTE until 12.31.2006

Report to: 1. DM Program Coordinator 2. Medical Director, 3. Chief Executive Officer

Major Responsibilities: Demonstrates a high level of professional competence and experience in the treatment and education of adults with metabolic syndrome, Type 1 or Type 2 diabetes in the area of Medical Nutrition Therapy. Direct involvement in the assessment, planning, implementation and evaluation of the patient centered diabetes education services in the 'Diabetic Warriors' group education classes. The Nutritionist is responsible for assessing and coordinating the nutritional care and educational needs of patients, their families and care partners in a variety of settings. Other responsibilities include collaborating with other clinicians and educators in helping patients to optimize their diabetes management.

Specific duties:

- Effectively and efficiently assesses, counsels, develops care plans and monitors diabetic clients.
- Maintains credentials as a Registered Dietitian and member of the American and Hawaii Dietetic Association.
- Maintains credentials as a Certified Diabetes Educator or Advanced Diabetes Management Practitioner.
- Monitors the content of the Journal of the American Dietetic Association and key National nutrition and diabetes policies; shares this information with staff as appropriate.
- Assists in training other staff in health, nutrition and medical areas as needed.
- Provides Bay Clinic Inc. and Diabetes Management Program outreach to the community and health providers as needed.
- Work in collaboration with other colleagues and as a member of the multidisciplinary team to provide specialist advice for people with diabetes.
- Demonstrate responsibility for professional growth by ensuring personal and professional development.
- Follows Bay Clinic Inc. policies and procedures and recommends changes to policies to expedite quality services cost effectively as needed.
- Attends meetings as appropriate or as directed by supervisor.
- Other duties as assigned.

Minimum qualifications:

- B.A. in Nutrition or Dietetics, Master's degree preferred.
- 1 ½ years experience in diabetes or 3 years of education/counseling with chronic diseases.

- Registered with the Commission on Dietetic Registration in good standing.
- Member of the Hawaii Dietetic Association and the American Dietetic Association.
- Certified Diabetes Educator or Advanced Diabetes Management Practitioner or must sit for the exam within six months of eligibility.
- Ability to communicate effectively orally and in writing and lead assigned activities.
- Works effectively with multi-ethnic families and socio-economically diverse staff and clients.
- Competent with computers, office machines, and office procedures. Able to type 35 wpm.
- Physically able to perform efficiently the duties of this position, including lifting 25 pounds.
- Able to multi-task, notable able to concurrently work with clients kindly, quickly and accurately, answer phones and type well.
- Able to work calmly and effectively under stressful situations, as a team player.
- Able to follow ethical guidelines and assure confidentiality of client information.
- Must be a critical thinker, assume leadership independently and support the Diabetes Management and Bay Clinic Inc. Team.
- 15 hours/year of continuing education in areas of DM management, behavioral interventions, or teaching, learning and/or counseling skills.

Desirable qualifications:

- Three or more years working as a Nutritionist in a clinical/community settings.
- Masters Degree in Foods and Nutrition, Public Health Nutrition, Health Education, Social Work.
- Advanced training in diabetes management and nutrition education.
- Able to speak a second language commonly spoken in the community.
- Experience working in a diabetes management program and with individual and group sessions.
- Familiar with Bay Clinic Inc.
- Familiar with the Hawaiian Islands and the Island of Hawaii.
- Personal experience with diabetes.
- Strong leadership and management skills.

Salary Level:

\$25.00-37.00 hourly based upon passage of probational period; expected to progress if funds sufficient.

10. Provider Assessment

Name _____ DOB _____ Date _____

Subjective:

Hx Hypoglycemia				
Home BS ranges	High		Low	
Activity level	Sedentary	Light	Moderate	Vigorous
Duration/Frequency/Tolerance:				
Fat intake	Ultra low	Low	Medium	High
Fruits/day	<2	2-3	3-4	>4
Vegetables/day	<2	2-3	3-4	>4
Med adherence?	No	Sometimes	Yes	Intolerant
Weight: changes/complaints/goal?				
Other:				

Assessment:

250.01	DM Type I well controlled			
250.00	DM Type II well controlled			
250.03	DM Type I hyperglycemia			
250.02	DM Type II hyperglycemia			
401.1	HTN Dx	Well controlled	Uncontrolled	
	Blood pressure	Well controlled	Uncontrolled	
272.4	Hyperlipidemia	Well controlled	Uncontrolled	
272.1	Hypertriglyceridemia	Well controlled	Uncontrolled	
277.7	Metabolic syndrome	Nephropathy 250.42		
278	Obesity	Neuropathy 250.62		
	Weight well managed	Retinopathy 250.52		
305.1	Smoker	Current	Former	Never
316.	Maladaptive behavior affecting medical condition			
Healthy lifestyle apparent				
Knowledge deficit related to diabetes self management				
Medication adherence		Medication non-adherence		
Medical regime adherence		Non-adherence to medical regime		
Labs/Screening past due		Labs/Screenings up to date		

Plan:

Notes:

Review Target HbA1c	
Review target BP	
Review Target Lipids	
Review med use/purpose/side effects	
Weight management/goal discussed	
Diet changes discussed	
Smoking cessation counseling, referral	
Encourage/review activity	
Schedule dilated eye exam	

Schedule podiatrist appt	
Recommend dental appt	
Schedule monofilament foot exam	
Schedule PCP appt for DM review	
Labs ordered	
New Rx or refills	
Provider signature	

Orders/Comments: _____

Provider Assessment