Standard 7

An individual assessment and education plan will be developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record. Please see samples of an education plan below:

REFERRAL AND MANAGEMENT

1. Upon referral from their primary care provider or by self-referral, participants enter the program and receive consultation with an interdisciplinary team of professionals. If an individual is a self-referral and does not have a primary care physician, he or she will be referred to a family practice physician in our system. The completion of an outpatient referral form is requested from the physicians, and includes diagnosis, complications, laboratory tests, current diabetes medication management, and other conditions. Prior to entrance into the program, participants are asked to complete an initial history, which includes demographics, medical information, nutrition and lifestyle facts and a psychosocial assessment. An appointment is then arranged for participants and family members to come to the Diabetes Center where they meet with the nurse and dietitian in a group setting or individually. After each appointment, whether group or individual, the RN and the RD notify the physician of the visit through a progress note form. This form outlines education received, meal plans, activity/exercise plan, and participant's selected behavior change goals. An outcomes flow sheet and educational objectives sheet is also completed by the second visit by the RN/RD. If phone contact is made with the patient between appointments, a chart note is written on the progress note form, with a copy going to the physician. If oral medication/insulin adjustments are recommended, a letter and physician order form is also sent to the referring physician.

2. The basic education programs for Type 2 Diabetes, whether individually or in a group, consist of an initial consult and follow-up sessions at one month, three months and six months. After the completion of the program at 6 months, patients are scheduled for follow-up sessions as needed annually. Follow-up appointment reminders may be provided in the form of a written postcard encouraging patients to come in for annual follow-ups. Phone call follow-ups may also be utilized if patients are unable to come in. Data collection spreadsheets will be used to determine when the patient is due for an annual follow-up appointment. These visits are charged individually per a fee scale based on whether the instruction was done in a group of individually. Various instructional approaches are used throughout individual and/or group sessions. Lecture, discussion, demonstration, return demonstration and educational materials/handouts are utilized for all programs. DVD's and PowerPoint presentations are used in the group program. Checking the participant's A1C's, by measuring the frequency of pre- and post- program participants obtaining a dilated eye exam and foot screening. The appropriate forms for eye care and foot care are filled out and sent to the physician. If the patient has medical needs on follow-up that has not been taken care of with the patient's physician, this is addressed at this point. Any interventions are to be documented either in the patient's chart on the progress note with copies to the physician. The RD will also meet with the

patient at the scheduled session times and review their meal plans, and various other aspects of nutritional counseling. If the participant fails to keep a follow-up appointment, he or she will be contacted with a letter indicating the appointment was missed and that continual follow-up is important in the self-management of diabetes. The participant is encouraged to reschedule. If the participant fails to do this within four weeks, the diabetes educator will call the participant to discuss achievement of behavior change goals and answer any questions the participant might have or address any difficulties in coming back for follow-up visits. After two phone calls from the diabetes educator, the participant is then considered “lost to follow-up” and it should be noted in the patient’s record. A letter is also sent to the referring physician.