Standard 8

A personalized follow-up plan for on-going self-management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals, and the plan for on-going self-management support will be communicated to the referring provider. Below are a couple of samples on how to comply with Standard 8.

Example 1
Letters are generated biweekly and faxed or mailed to the respective provider. Correspondence is intended to establish open communication between the provider and then education center. It is our intent to keep the provider informed of the patient's progress or lack thereof throughout the program. We also want to make them aware of education needs and possible compliance concerns. Letters are also generated to inform providers of a patients' willingness, or lack thereof, to attend initial or follow up appointments. Pre and post assessments of all individuals involved in group education sessions are conducted. The assessment plans are reviewed at regular intervals and as a component of documentation with group encounter notes. Evaluation is an ongoing process. During individual and/or group sessions, our clinicians remain astute to participants who are demonstrating difficulty grasping certain concepts. This is documented and addressed. It is first determined through care planning conferences which method and how best to make the problem known to the patient (sometimes patients deny learning difficulties). Then a phone follow up call is made to the patient to discuss any perceived challenges and involve them in the care process. This may warrant additional individual counseling or it may be resolved by answering a question over the phone that the patient was unwilling to ask in a group session.

We recognize that individuals with diabetes have diverse and often demanding sets of circumstances. We also recognize that people with diabetes have the innate human need to gather collectively and socialize and that despite the assistance of loved one, many of the psychological barriers to self-management are unmet. As such, we strongly recommend the use of support groups when available. In an effort to care for our patients beyond the walls of the center, we have considered beginning a support group at one of the area churches. We have discussed this and are hoping to begin the implementation phase of the support group within the next 3 months.

Example 2

FOLLOW-UP AND DIABETES MANAGEMENT DURING CLASSES

At each follow-up visit, the participant meets with a nurse or other diabetes educator who assesses the participant's current health status, knowledge, skills, attitudes and self-care behaviors. The blood glucose results are reviewed, quality control checks are done on the meters along with assessment of the patient's skills at testing their blood glucose. At this time behavior change goals are evaluated and, if needed, new goals are developed. The patient is given a copy of his behavior change goals. The nurse or other diabetes educator also evaluates the patient's continuity of care to make sure all areas are being addressed

appropriately. Outcomes are also measured by tracking 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 nterventions 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.