Charting for DSMT

WEBINAR FOR DEAP QUALITY COORDINATORS
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Presenter

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Learning Objectives

1. Define DSMT and list the components required to be documented in a DSMT chart
2. Select targeted questions for each area of the initial assessment
3. Illustrate how to document an individualized education plan
4. Discuss the use of validated tools in DSMT documentation
Disclaimers

- The examples shown are by no means the only acceptable ways to meet the standards

- The validated tools listed on the slides may or may not be accessible, may have a cost, may be copyrighted; it’s up to the user to contact the author for permission if necessary.
What is DSMT?

- Medicare benefit called Diabetes Self-Management Training (DSME/T, DSMES)
- In order to bill for DSMT, must have accreditation showing meet standards and be a Medicare part B supplier
- There are only 2 billable codes: G0108 (individual) & G0109 (group) and are billed in 30 minute increments
- The billing NPI must match the name of the sponsor of the accredited program (name on accreditation certificate)
- Requires a referral order from a certified provider that is “managing the beneficiary’s diabetes”
  - Certified providers include MD/DO, NP, CNS,PA
  - referral is only good for one year
- Is NOT an incident-to service, so provider does not have to be present or sign your notes
Benefit has 2 parts

**Initial Benefit**
- Coverage is for 1 hour of individual and 9 hours of group
- Must be used within 12 consecutive months after the 1st G code billing
- Is a once-in-a-lifetime benefit
- May offer more of the 10 hours as individual if beneficiary has “special needs”
  - Hearing problems
  - Visual problems
  - Cognitive problems
  - Doesn’t speak the language
  - There is no group within 2 months of the referral
  - Beneficiary needs more individual instruction per provider on referral order
    - Older, needs to learn injections, etc
    - Order should specify the additional number of individual hours versus group out of the 9 hrs

**Follow up benefit**
- Coverage for 2 hours per calendar year, either group or individual, after initial benefit
What is DSMT continued

- Do **not** have to be a CDE to provide DSMT
- DSMT groups can be a mix of Medicare beneficiaries and non-Medicare beneficiaries
- Medicare defines a group as 2-20 people
- If a group is scheduled and only one person shows up, you ask the beneficiary if they agree to make that an individual visit, since there is a difference in copay, or they may have already used their 1 hour of individual coverage OR you could bill G0109 (you are down-coding)
Documentation follows the coding

• Always document according to the code you are billing for the visit
  – MNT documentation has different requirements than DSMT, but both are provided by an RD
  – MNT and DSMT cannot be provided on the same day, so can only code for one and documentation should follow coding
  – Therefore, may want to have a different note template for each
Reporting follows the coding and/or documentation

- Include all participants that you billed G0108 or G0109 for in your Annual Status Report
- If not billing, include all participants that you saw in your program and documented a DSMT visit for
- AADE encourages programs to provide other services for sustainability, such as the DPP and MNT, but for reporting purposes, we are looking for a report focusing solely on the outcomes of DSMT as defined
- Do not include participants who ONLY received MNT; if they receive BOTH MNT and DSMT, include them
So what does a DSMT chart look like?
Components of a DSMES/DSMT chart

1. Initial Assessment
2. Individualized Education Plan
3. Smart Goals and goal achievement
4. Education provided (curriculum content)
5. Ongoing support plan
6. Communication to the referring provider

**DSMES/DSMT chart note**
Initial Assessment

- For all participants who are new to your practice and/or newly diagnosed
- Even if participant is referred only for meter teaching or for insulin teaching or for CGM download, you still need to document pertinent assessment
  - Keep in mind that the assessment piece is what makes diabetes education unique and effective
- In subsequent years you would do follow up assessment on pertinent items
**Self-Audit Tool (on our website)**

### Educational Record (Chart) Review Form

<table>
<thead>
<tr>
<th>Category</th>
<th>Item</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Order</td>
<td>Referral for DSME/T in chart (Medicare requirement)</td>
<td></td>
</tr>
<tr>
<td>Assessment of Health Status</td>
<td>Relevant medical and diabetes history</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physical limitations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current health service or resource utilization (hospitalizations, ER</td>
<td></td>
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<tr>
<td></td>
<td>visits related to diabetes)</td>
<td></td>
</tr>
<tr>
<td>Assessment of Psychosocial Adjustment</td>
<td>Emotional response to diabetes/diabetes distress</td>
<td></td>
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<tr>
<td></td>
<td>Social Support systems</td>
<td></td>
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<td></td>
<td>Readiness to learn</td>
<td></td>
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<tr>
<td></td>
<td>Financial Means</td>
<td></td>
</tr>
<tr>
<td>Assessment of Learning Level</td>
<td>Diabetes knowledge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Literacy and numeracy level</td>
<td></td>
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<tr>
<td>Assessment of Lifestyle Practices</td>
<td>Cultural influences</td>
<td></td>
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<tr>
<td></td>
<td>Health beliefs and attitudes</td>
<td></td>
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<td></td>
<td>Diabetes self-management skills and behaviors</td>
<td></td>
</tr>
<tr>
<td>Standard 7</td>
<td>Ongoing education planning and behavioral goal-setting with follow up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>based on collaboratively identified participant needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documented individualized follow-up on education and goals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Medicare participants, communication back to the referring</td>
<td></td>
</tr>
<tr>
<td></td>
<td>provider including the education provided, and the participant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>outcomes</td>
<td></td>
</tr>
<tr>
<td>Standard 8</td>
<td>Ongoing self-management support options specific to the community</td>
<td></td>
</tr>
<tr>
<td></td>
<td>where the DSMES services are delivered, with participant preferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>noted</td>
<td></td>
</tr>
<tr>
<td>Standard 9</td>
<td>At least one clinical outcome measure to evaluate the effectiveness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of the educational intervention</td>
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<td></td>
<td>Collaborative development of at least one SMART behavioral goal with</td>
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<tr>
<td></td>
<td>follow up and measurement achievement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Medicare participants, communication back to referring provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with education provided and participant outcomes</td>
<td></td>
</tr>
</tbody>
</table>
1. Assessment of Health Status (can be in other parts of the chart)

- Relevant Medical history Comorbidities, diabetes complications
  - Medications
  - History of GDM
  - Date of last eye exam, dental exam
  - Labs

- Physical limitations
  - Do you have any physical problems that prevent you from doing any activities?

- Relevant Diabetes history/Health Svc Utilization/Financial
  - Hospitalizations, ER, EMT for diabetes-related problems
  - Date of diagnosis, diabetes Type
  - Diabetes medication hx (including any intolerances or side effects), device history plus any issues affording diabetes medications/supplies
  - Previous diabetes education?
  - Significant family history (diabetes, thyroid, e.g.)
  - Hx hypoglycemia, DKA
  - How much has diabetes changed what you do every day?
  - What do you know about diabetes?
Validated tools to assess diabetes knowledge

The Diabetes Educator, Fitzgerald et.al.  
Volume 42, Number 2, April 2016, p178-187  
The Diabetes Knowledge Test 2 (DKT2)
2. Assessment of Psychosocial Adjustment

Sample Questions

- Social Support Systems
  - Where do you get support for helping manage your diabetes?

- Emotional response to diabetes/diabetes distress
  - How do you feel about your diabetes?
  - What is one thing about your diabetes that drives you crazy? (Bill Polonsky, Diabetes Behavioral Institute)

- Circle any words that describe how you currently feel about your diabetes
  - Burdened
  - Overwhelmed
  - Angry
  - Out of control
  - Hassled
  - Challenged
  - Ok
  - Not a problem
  - Alone

- Do you feel you are able to manage your diabetes?
- If no, what makes it difficult?
  - ☐ time
  - ☐ money
  - ☐ lack of support
  - ☐ living situation/family
  - ☐ not knowing what to do
  - ☐ job

Validated Tools

The Diabetes Distress Scale (DDS) (short form)
- A two-question initial screening tool to assess diabetes-specific distress (followed by the full 17-item scale when indicated) available in English and Spanish
  http://www.annfammed.org/content/suppl/2008/05/08/6.3.246.DC1/Fisher_Apps1-5_new.pdf

The WHO (Five) Well-Being Index
- Validated in many languages, is a reliable measure of emotional functioning and screen for depression and has been used extensively in research and clinical care including the DAWN2 study (Diabetes Attitudes, Wishes and Needs 2)
  https://www.psykiatri-regionh.dk/who-5/who-5-questionnaires/Pages/default.aspx
3. Readiness to Learn/Change

• Check all that apply:
  – □ I am thinking about changing
  – □ I have made changes in the past 6 months
  – □ I have made a healthy change for greater than 6 months
  – □ I do not plan to make any changes this year
  – □ I plan changes in the next 6 months
  – □ I plan to change this month

  **OR**

• How do you feel about making healthy changes in your life?

  **OR**

• Readiness to learn:
  – Eager
  – Receptive
  – Communication barriers
  – Sensory/cognitive impairment
  – Fatigue/pain/illness
  – Unreceptive

• Readiness to Change Ruler
  
  Not prepared to change

  Already changing
4. Assessment of Learning Level

Examples

Literacy
• “How confident are you filling out medical forms by yourself?”
  1-Extremely    2-Quite a bit    3-Somewhat
  4- A little    5-Not at all
  OR
  – There are literacy concerns for this participant Y  N

Numeracy
– Here is a nutrition label. Can you tell me how many servings are in this item?

Validated Tools

Three-item screen
• A tool to measure health literacy. It asks how often someone needs help reading hospital materials, how confident they are filling out forms, and how often they have difficulty understanding their medical condition https://afmc.org/wp-content/uploads/2017/01/Literacy-Tools-UAMS-CHL-DHS-2017.pdf

Newest Vital Sign

The DNT 5 (Diabetes Numeracy Test)
• Tests numeracy skills in people with diabetes. Can be written or orally administered. Estimated to take 5-10 minutes. https://www.mc.vanderbilt.edu/documents/CDTRfiles/DNT5.pdf
5. Assessment of Lifestyle Practices

- Cultural Influences
  - Is there any religious or other tradition or practice that affects how you manage your diabetes?
  - OR
  - Do you have any religious or cultural concerns or restrictions regarding healthcare?
  - OR
  - Does your culture influence your decisions about diabetes? (special foods, fasting, religious observances) If yes, how?
  - OR
  - Do you have any spiritual or cultural beliefs we should know about to help us plan your care?
6. Health beliefs and attitudes

Examples

• Check if you agree or disagree
  – I have some control over whether I get complications from high blood sugar
    □ Agree □ Disagree
  – Diabetes controls my life
    □ Agree □ Disagree
  OR
• How do you feel about your health?
  OR
• What do you see as your individual strengths to help you deal with your diabetes?
  OR
• What one thing has made the biggest difference in managing your diabetes?
  OR
• How do you rate your health?
  – Excellent - good - fair - poor
  OR
• Answer yes or no
  – I find it hard to believe I really have diabetes
    □ YES □ NO
  – I have difficulty managing my diabetes
    □ YES □ NO
  – I feel unhappy/depressed because I have diabetes
    □ YES □ NO
  – All things considered, I feel satisfied with my life
    □ YES □ NO
7. Diabetes Self-Management skills and behaviors

Examples

– Walk me through a typical day: when do you wake up, test your blood sugar, take your meds, eat your meals, snacks, beverages, work hours, exercise, go to bed
– Questions specific to taking insulin
  • Injection sites/rotation
  • Storage
  • Disposal
  • Dose and time
  • Technique
– AADE7 framework: Healthy Eating, Being Active, Taking Meds, Monitoring, Problem Solving, Reducing Risk, Healthy Coping
  • These are being revised this year
  • Can use AADE tools for this or use your own questions

Validated Tools

Self-Care Inventory (SCI-R)
• A survey that measures what people with diabetes do versus what they are advised to do in their diabetes treatment plan. For scoring, items are averaged and converted to a 0 to 100 point scale. A high score indicates high levels of self-care. To request permission to use the SCI, contact alagreca@miami.edu.

Summary of Diabetes Self-Care Activities (SDSCA)
• An 11-item or expanded 25-item measure of diabetes self-care behaviors

Diabetes Self-Efficacy Scale
• An eight-item self-report scale designed to assess confidence in performing diabetes self-care activities
Individualized Education Plan

• Based on assessment and participant’s self-identified needs

• Decision support (coaching)
Tell me about yourself.

What’s important to you?

What is it about XX (health condition) that drives you crazy?

Fill the tank (Relationship) with G.A.S. to keep the patient moving forward
Documenting an Individualized Education Plan

Examples

• Identify the top 3 issues that impact your ability to manage your diabetes
  
  OR

• Check the areas you would like help with
  – □ Eating healthier
  – □ Increasing my activity level
  – □ Monitoring my blood sugar
  – □ Increasing support from family/friends
  – □ Setting achievable weight loss goals
  – □ Increasing my understanding of diabetes
  – □ Improving my ability to manage stress and/or emotions that affect my diabetes
  – □ Increasing my ability to handle complications (such as vision problems, low energy, mobility issues, painful feet, bleeding gums)
  – □ Increasing my ability to use the medical system effectively (communicating with my provider)
  – □ Increasing my ability to give myself injections

• How do you rate your understanding of the following?

<table>
<thead>
<tr>
<th>Poor</th>
<th>Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

- Overall diabetes care
- Coping with stress
- Meds you are taking
- Eating for blood sugar control
- Role of activity in diabetes
- What makes blood sugar go up?
- Knowing what my test results mean

OR
Documenting an Individualized Education Plan cont’d

Examples

• Mark the topics you would like to learn about
  OR
• What do you hope to gain from this session?
  – □ improve blood sugar
  – □ improve eating habits
  – □ lose weight
  – □ feel better
  – □ learn how to start exercising safely

• Topics needed per assessment and participant’s request
  OR
• Check the topics you feel you need to learn more about so you can manage your diabetes
  OR
• For staff use: check any of the following educational needs
Another example

**Diabetes Clinic Individual Patient Education Plan**

Patient
Name: ______________________________
Date of Initial Visit: _______________

<table>
<thead>
<tr>
<th></th>
<th><strong>Introduction to Diabetes</strong></th>
<th>Knowledge Score</th>
<th>0 1 2 3 4</th>
<th>0 1 2 3 4</th>
<th>0 1 2 3 4</th>
<th>0 1 2 3 4</th>
<th>0 1 2 3 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Healthy Eating</strong></td>
<td>Knowledge Score</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td></td>
<td><strong>Being Active</strong></td>
<td>Knowledge Score</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
<tr>
<td></td>
<td><strong>Taking Medication</strong></td>
<td>Knowledge Score</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
<td>0 1 2 3 4</td>
</tr>
</tbody>
</table>

**Knowledge Score Scale**

0 = No Knowledge
4 = Extensive Knowledge
Another example

MY DIABETES EDUCATION PLAN

Patient Signature: ___________________________ Date: ___________________________

I want to learn how to start changing my behaviors in the key areas that I checked below when I’m ready (and not before) in order to get better control of my diabetes and reduce risk of complications.

☐ Healthy eating
  Menu planning, label reading, healthy cooking, portion control, dining out,
  holiday eating, carbohydrate, vitamins, minerals, fiber, sugar, sugar-
  free foods, omega 3 fats, dietary cholesterol, saturated fat, etc.

☐ Being active
  Easy ways to simple exercises into your everyday life, and why (great
  benefits).

☐ Reducing risks
  Risks of complications of uncontrolled diabetes: heart disease, problems
  with teeth, kidney disease, infections, nerve and vision problems, etc.

☐ Monitoring
  Monitoring of blood glucose, blood pressure, cholesterol, other health
  indicators.

☐ Taking medications
  How medication works, how to take it, precautions, side effects, how to
  prevent.

☐ Healthy coping
  Coping with diabetes, adapting to lifestyle changes at work, home, etc.

☐ Problem-solving
  Solving problems with high/low blood glucose, stress/anxiety, traveling, etc.

☐ Support after
  program
  Diabetes self-care support resources I can tap into, other than education
  program.

To achieve this, my education plan is to (check all those that apply):

☐ Schedule and attend 6 visits (5 group, 1 Individual) of the Education Program at

☐ Try to re-schedule a visit I missed as soon as possible by calling.

☐ Complete a diabetes assessment before the very first class and arrive 45 minutes early to do this.

☐ Ask these person(s) to also attend program at no extra charge to help me learn better/achieve
goals:
  __ spouse __ adult child __ parent __ friend __ caregiver __ neighbor __ co-worker

Also learn about:

☐ What diabetes is, my treatment options and what makes my blood glucose go up and down.

☐ The other diabetes benefits my healthcare insurance pays for, including follow-up education.

Individualized by education plan and my behavior and clinical/health goals (blood glucose, A1C, etc.)

☐ Have educators use these tools that help me learn best: __ Knowledge education __ Skill building
  __ Goal setting __ Behavior contracting __ Confidence building __ Handouts to take home
  __ Reducing obstacles to change __ Problem solving/Reducing __ Group discussion in class
SMART goals and achievement of goals

- **SMART means**: Specific, Measurable, Achievable, Relevant and Timebound
- The AADE7 self care behaviors are not SMART goals, they are self-care behaviors
  - Think of them as a framework or goal topics: Healthy Eating is NOT a smart goal, e.g.
  - A goal should be documented as a change in self-care behavior, not a recommendation or instruction

<table>
<thead>
<tr>
<th>General Instructions</th>
<th>Recommendation</th>
<th>SMART goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink plenty of fluids</td>
<td>Will use a pre-measured drink container to make sure I get at least XX ounces of water every day</td>
<td></td>
</tr>
<tr>
<td>Test more often to see the effects of your meals on your blood sugar</td>
<td>Will test pre and 2 hours post large meal at least one time per week.</td>
<td></td>
</tr>
<tr>
<td>Increase your insulin by 10 units daily.</td>
<td>Will rotate insulin injections to different areas of abdomen using clock method every day.</td>
<td></td>
</tr>
<tr>
<td>Make an appointment to see behavioral health.</td>
<td>Will listen to Meditation app every other day for at least 10 minutes</td>
<td></td>
</tr>
</tbody>
</table>
SMART goals and goal achievement

Examples

**My Diabetes Self-Management Plan**

1. One way I want to improve my health is (choose one of the topics in the circles above):

2. My goal is (the goal should be related to the topic you chose in number 1):

3. **When** will I do what I listed as my goal?

4. **Where** will I do what I listed as my goal?

5. **How often** will I do what I listed as my goal?

6. What might get in the way of following through on my plan to reach my goal?

7. What can I do about what I listed above that might get in the way of reaching my goal?

   **Example:** I want to improve my health by “Being Active”. My goal is to walk in the mornings before breakfast, at the park Monday through Thursday. Rain or snow might get in the way. On those days, I’ll go to the store to walk.

**Diabetes Self-Management Plan**

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>GOALS (what to aim for)</th>
<th>ACTION PLAN (how you will get there) Specific, measurable, achievable, relevant, timebound=SMART</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTHY EATING</td>
<td>( ) Follow eating schedule better</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Eat better foods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Overeat less often</td>
<td></td>
</tr>
<tr>
<td>BEING ACTIVE</td>
<td>( ) Exercise more often</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Exercise longer</td>
<td></td>
</tr>
<tr>
<td>MONITORING</td>
<td>( ) Check blood sugar more often</td>
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</tr>
<tr>
<td></td>
<td>( ) Miss fewer blood sugar checks</td>
<td></td>
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<tr>
<td></td>
<td>( ) Focused testing</td>
<td></td>
</tr>
<tr>
<td>TAKING MEDICATIONS</td>
<td>( ) Miss fewer medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Take medications on time more often</td>
<td></td>
</tr>
<tr>
<td>PROBLEM SOLVING</td>
<td>( ) Prevent and treat high blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Prevent and treat low blood sugar</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Manage diabetes when ill</td>
<td></td>
</tr>
<tr>
<td>REDUCING RISKS</td>
<td>( ) Stop smoking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Check feet daily</td>
<td></td>
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<tr>
<td></td>
<td>( ) Lose weight</td>
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<tr>
<td></td>
<td>( ) Get blood pressure under control</td>
<td></td>
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<tr>
<td></td>
<td>( ) Get preventative help</td>
<td></td>
</tr>
<tr>
<td>HEALTHY COPING</td>
<td>( ) Cope with diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( ) Get support from family/friends</td>
<td></td>
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<tr>
<td></td>
<td>( ) Get support from your medical team</td>
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</tbody>
</table>

**How confident am I that I can reach this goal? (circle one)**

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>A little</td>
<td>Somewhat</td>
<td>Very sure</td>
<td>Totally</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

If less than 8, what can I do to increase my confidence?________________________
SMART goals cont’d

Self-Management SMART Goals
Specific  Measurable  Attainable  Realistic  Timely

Name: __________________________  Date: ____________

The healthy change I want to make is (remember to be specific)
Here is what I can do:
________________________________________________________________________
________________________________________________________________________
How much:
________________________________________________________________________
________________________________________________________________________
When:
________________________________________________________________________
________________________________________________________________________
How often:
________________________________________________________________________
________________________________________________________________________
The things that could make it difficult to achieve my goal include:
________________________________________________________________________
________________________________________________________________________
My plan for overcoming these difficulties includes:
________________________________________________________________________
________________________________________________________________________
Support and resources I will need to achieve my goal include:
________________________________________________________________________
________________________________________________________________________
On a scale of 1-10 how sure are you that you can achieve this goal?
Not sure  Very Sure
1  2  3  4  5  6  7  8  9  10

Follow up date: ___________ With _______________________
(health team member)

How often did [patient name here] achieve goal?
__________ % of time

Goal #
I want to improve my health by (please check one):
☐ Eating a healthy diet (e.g. make better food choices, reduce portion sizes, follow meal plan)
☐ Being physically active (e.g. exercise longer, exercise more often)
☐ Monitoring my blood sugar
☐ Taking my medication
☐ Problem-solving (e.g. prevent/plan how to deal with problem situations)
☐ Coping with stress (e.g. schedule pleasant/relaxing activities)
☐ Reducing Risks (e.g. stop smoking, perform daily self-care activities, get eye exam, see dentist)

My Specific goal: (e.g. walk for 20 minutes, 3 times a week)

My Plan:
When will I do it? (e.g. Mondays, Wednesdays and Fridays)
________________________________________________________________________
Who can I turn to for help or support? (e.g. I will ask my friend if she wants to walk with me)
________________________________________________________________________

Obstacles and alternatives:
What might get in the way of my plan? (e.g. Rain, bad weather)
________________________________________________________________________
What can I do about it? (e.g. I will exercise inside instead of walking outside)
________________________________________________________________________

Reward:
What will I give myself as a reward when I meet my goal? (e.g. go to the movies)
________________________________________________________________________
Education provided (both group and individual)

**EMR example**

**Paper Example**
Ongoing support plan

When? Any time, most commonly during last visit

Example

- Include things like:
  - Magazines
  - ADA, JDRF
  - Peer support online communities
  - Apps
  - Websites
  - Smoking cessation programs
  - Walking trails
  - Mall walking groups
  - Senior center fitness classes
  - Diabetes support groups
  - Behavioral health resources
  - Pharmaceutical financial assistance programs
  - Electronic newsletters
  - Weight management groups, programs
  - Food assistance programs
  - Specialists for oral health, foot health, eye health, kidney health, etc
Communication to the referring provider

• Required if Medicare beneficiary, but also good way to market your program and outcomes
  – Should include the education provided and participant outcomes achieved (both behavioral and clinical)

• If communicate via EMR, make sure stated in your Standard 9 policy
Communication with referring provider

Examples

Sample letter to referring provider

Date of Service: Diabetes Self-Management Education and Support (DSMES) Service
Patient Name: Date of Birth:
Referring Provider: Dear Dr. X,

Thank you for your referral of [Patient Name]. He completed all 3 sessions of DSMES and was provided the following education:

<table>
<thead>
<tr>
<th>Day</th>
<th>Day 1</th>
<th>Day 2</th>
<th>Day 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>What is diabetes?</td>
<td>Meal planning, continued</td>
<td>Exercise and benefits</td>
</tr>
<tr>
<td>2</td>
<td>Types of diabetes</td>
<td>Oral agents</td>
<td>Chronic complications</td>
</tr>
<tr>
<td></td>
<td>Hyperglycemia, s/s causes, treatment</td>
<td>Insulin overview</td>
<td>Foot care</td>
</tr>
<tr>
<td>3</td>
<td>Hypoglycemia, s/s causes, treatment</td>
<td>Stress management</td>
<td>Effects of smoking</td>
</tr>
<tr>
<td>4</td>
<td>Target blood glucose and HbA1c</td>
<td>Sick day care</td>
<td>Personal diabetes ID</td>
</tr>
<tr>
<td>5</td>
<td>Nutrition and Meal Planning</td>
<td>Community resources</td>
<td>Blood glucose monitoring</td>
</tr>
<tr>
<td></td>
<td>Balancing meals, medications and exercise for glucose control</td>
<td>Immunizations</td>
<td></td>
</tr>
</tbody>
</table>

Other Outcomes RT achieved:
- Pre-education knowledge test score = 55%
- Post-education knowledge test score = 84%
- Comprehension assessment: good to excellent
- Readiness for change: good to excellent

Below: Blood glucose = 90 mg/dl, BP = 142/68

Concerns and Recommendations:

1. RT was attentive and asked numerous questions during the sessions. He is receptive to learning more about diabetes and how to better manage it. He was accompanied by his wife at all sessions.
2. RT has a blood glucose meter and continues to check once daily, as you prescribed. I provided a new lancing device and he returned demonstrated successfully. He was instructed to contact you for readings trending > 150 mg/dl.
3. He continues on Metformin 1000mg BID and has not had any side effects or missed doses.
4. RT may benefit from a visit with a registered dietitian for Medical Nutrition Therapy.
5. He has been very excited by his 18lb weight loss since diagnosis and his reduction in A1c.
6. I provided my phone number if he has any questions related to anything we discussed. As a reminder, Medicare covers up to 2 hours of DSMES every calendar year as needed with a new referral.

Thank you for allowing me to participate in the education of your patient. I look forward to continuing to work with you and your patients in the future.

Sincerely,

Diabetes Educator

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Sample Letter to Referring Provider

Date: RE: Patient name: [JL]

Patient name: [JL] has completed Diabetes Self-Management Education and Support Services offered by D Health Center. Here are JL’s results:

<table>
<thead>
<tr>
<th>Clinical Outcomes</th>
<th>Baseline</th>
<th>After Participation in DSMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight/BMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lipids</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavioral Outcomes</th>
<th>Baseline</th>
<th>After Participation in DSMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Eating</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being Active</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Coping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking Medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing Risks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem Solving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

JL was instructed on diabetes care and skills according to the Standards of Care established by the American Diabetes Association and the Diabetes Education Curriculum: A Guide to Successful Self-Management by the American Association of Diabetes Educators. Topics covered included:

- Basic pathophysiology of Type 1, 2 diabetes
- Use of blood glucose meter and target blood glucose levels
- Meal planning with a focus on carbohydrate counting
- Exercise and travel guidelines
- Pharmacological agents (orals, injectables, insulin)
- Sick day management, hypoglycemia
- Detection and prevention of chronic complications

JL was instructed to contact you regarding her ongoing diabetes care.

Thank you very much for your referral to our program. Feel free to contact us if you have any questions or concerns. Medicare provides coverage for up to 2 hours as needed each calendar year with a new referral. We would be happy to continue to work with JL if needed.

Diabetes Educator: __________________________
Charting Tips

• Keep in mind that an auditor has a checklist of items they are looking for in the chart, so make it easy for them to find it!

• If a standard calls for documentation of X, make X a heading in your chart template; don’t bury it in narrative
Thank You!