Outpatient Diabetes Education & Support Services
ADVISORY MEETING REPORT
Planning for the coming year

Meeting: Virtual

COMPONENT	*ANALYSIS (REVIEW)*	*PLAN*
Stakeholders: MD	Endocrinologist & Physician liaison	Advisory Committee members represent all areas required.
RN, BSN (educator) RN, BSN, CDE (Quality Coordinator & committee chair)	Certified Diabetes Educators (CDE) in good standing	
RD, CDE(educator)	Program educators continue to complete their 15 hours of CEU credits in diabetes to meet AADE requirements.	
RN, CDE (educator)	Care Manager representative	
RN, BS (educator) RN, BSN MPH	Executive Director	JM-Coordinator of YMCA DPP program has referral form for patients that convert to DM during DPP and can be used for MNT referral for persons in DPP that have more questions regarding nutrition. will provide fliers for DPP to our participants that they can give to family members at risk to help prevent or delay diabetes in those persons. Welcome to JM.
RN, BSN	Inpatient nursing representative, inpatient diabetes coordinator Pharmacist Patient representative, Financial Counselor YMCA DPP	
RPh BA YMCA DPP YMCA MSW MS, CSCS	Representing YMCA fitness Social Worker Exercise Physiologist	Welcome to JP, we look forward to your input especially regarding mental health.
Policy Review	**Advisory committee policies reviewed:** **(attached)** • Outpatient Diabetes Self-Management program • Scope of Care • Curriculum Policy • CQI Policy • Behavior Change program goal **New policy:** • WHO-5	Policies accepted as written. Policies to be reviewed, changes made: Policy review date added. Verbiage Changes: • Patient to Participant • Diabetes Self-Management Education Training/Program to Diabetes Self-Management Education & Support Services Verbiage changes reflect forthcoming changes at AADE
Goal achievement of DSMES	1. Continue with database, which meets the data collection needs for AADE certification. 2. **Inpatient referrals:** to the Outpatient Diabetes Program: year 1 = 73 referrals year 2 = 16 referrals year 3 = 41 referrals year 4 = 36 referrals year 5 = 77 referrals	Will continue to work on ways to improve referrals from inpatient to outpatient diabetes education. Coordinator sits on Diabetes Excellence team and will continue to work with the Inpt Diabetes Coordinator and the Diabetes Excellence team to improve numbers.

	2016-2017 = 63 referrals 3. Continue to support the Diabetes Excellence team through participation in quarterly meetings and support of Inpatient Diabetes coordinator 4. Annual Diabetes program 43 people attended.	
Data Analysis: **1. Participant Access**	City Senior Center- as needed for non-Medicaid patients Number of patients attending at least once: Year 1 = 191 Year 2 =188 Year 3 = 192 Year 4 = 222 Number of participants that completed education: Year 1: 128 Year 2: 139 Year 3: 124 Year 4: 177 Increase of 43% (Last year the goal was to increase by 5%)	City site has two classes per year, spring and fall. Last year, changes were made to how we schedule class. We schedule class on the initial phone call and tell patients that we need to complete an assessment prior to class. Our class numbers have increased since this change. **Year 3:** 25 class participants **Year 4:** 91 class participants
2. Follow-Up Rates: (defined as assessment, education and 1-3 month follow up)	All participants are called per policy. Follow-up occurs approximately 1-3 months following education. Participants will be called in 1-3 months. If not reached, educator will call again at a different time of day. Data collection on goals will be either Met, Unmet, or Unable to reach. Two calls are made at varying times. Use AADE7 framework for follow-up Follow up rate: Year 1 Follow up rate= 58%. Year 2 Follow up rate = 60% Year 3 Follow up rate = 50% Year 4 Follow up rate = 60% Advisory meeting discussion: Are we satisfied with 50% follow-up rate? Yes. Dr. R stated that she felt that is a good rate and that a typical rate is 25-30%.	Last year we focused on data entry and put a process in place to make sure all patients are called according to the policy. We were able to get our number back up to 60%.
Mission Statement:	It is the mission of Medical Center's Diabetes Self-Management Education & Support Services to provide patient-centered, compassionate, timely, and comprehensive diabetes education, management, training, and support for all people with diabetes, to help improve the health of our communities	Revision: With our new CEO, we needed to have the mission statement signed. It was suggested in our audit, that we have more of the hospital mission statement language in our mission statement. This is the proposed change to our mission statement.
Organizational Structure:	Outpatient Diabetes Education Department reports to the Executive Director who reports to the CEO	
Population: **Target Population:**	Adults, 18 and older with type 2 -Community events and outreach -Barriers have been identified in the referral and assessment interview. -Gas cards were purchased for patients who state they have insufficient funds to travel to clinic.	Discussion: We are meeting the needs of our population, which are primarily adults with type 2 DM.

MDHHS and AADE will begin looking at Demographics to help with patient access. Our DSMES services are within 4% of the county demographics.

Demographics	White	Black	Hispanic	Am. Indian	Asian
County	92%	2.3%	3.0%	0.2%	0.5%
Clinic DSMES	89%	5%	2.8%	0	1.7

Advisory group agrees that 4% is acceptable at this time.

Adequacy of Resources:	**Appointments:** Monday-Friday 8:00-4:30 pm Flexible appointment times are available **Classes are offered:** 12:00pm - 4:30pm (afternoon classes) See new class and Support Group schedules. Schedules, with referral forms and Diabetes department brochure, will be placed in all physician mailboxes. **Personnel**: **FTE for department:** Coordinator-.35, RN - .4, RD -.6 **Budget**: Adequate **Equipment**: None purchased this year. **Physical space**: Office and classroom space adequate. Need larger classroom for classes that have more than 5 participants. Reserve the 1st Floor Conference Room for larger groups.	Discussion: We can schedule patients at their convenience during the week. Educators flex their time when necessary.
Curriculum Review:	Curriculum reviewed by RN and RD and include the following additions: • WHO-5 • Integrated activity- Q1 hour stand or seated activity into class time. • Basic Meal Planning Guidelines Handout-expanded each section slightly • Tips for Dining Out • Eating on the run • Patients asked to bring in a food label from home to make the label reading experience more personal. • Added Basaglar and removed Tanzeum from the medication handout.	WHO-5 survey identifies patients sense of wellbeing. This survey is used to foster a discussion of depression in diabetes, and stress reduction during class. Results are sent to each patient's PCP along with a copy of the survey and scoring grid.
Previous Outcome Measure and Behavior Change **Last year**	Increase physical activity from baseline: Year 1: 45% Year 2: 45% Year 3: 40% Year 4: 69% goal achieved. Increase number of patients that complete education: Year 1: 128 Year 2: 139 Year 3: 124 Year 4: 177 Increase of 43% (Last year the goal was to increase by 5%)	**Goals achieved. Will continue to monitor on random basis.** . Goals monitored in last year showed great improvement. Quarterly monitoring, staff meeting education, and brainstorming helped to improve our process.

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<tr>
<td>CQI for the coming year: Program Outcome Measure: Confidence level
Goal:
To measure the effectiveness of our services, participants confidence level will show at least a 1% increase, on average, from first encounter at the 1:1 to the end of the class series, as measured by a question on the pre/posttest.</td>
<td>Measure Pre/Post DSMES Confidence level:

<table>
<tr><th>Quarter</th><th>Pre</th><th>Post</th></tr>
<tr><td>Q1:</td><td></td><td></td></tr>
<tr><td>Q2:</td><td></td><td></td></tr>
<tr><td>Q3:</td><td></td><td></td></tr>
<tr><td>Q4:</td><td></td><td></td></tr>
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Data will be collected quarterly, and the percentage recorded.
Data will be reported to Advisory group if not showing increase.
Will measure increase by at least a 1% increase from pre-score to post-score.

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<td>CQI
Behavior Change Goals and Participant-based Outcome Measures:
Monitoring
Goal: The aggregate monitoring goal will be measured quarterly and show an increase of at least 2% over the year.</td>
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<table>
<tr><th>Quarter</th><th>% achieved</th></tr>
<tr><td>Q1:</td><td></td></tr>
<tr><td>Q2:</td><td></td></tr>
<tr><td>Q3:</td><td></td></tr>
<tr><td>Q4:</td><td></td></tr>
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<td>Plan:

Questions regarding monitoring added to assessment.
Discussion about remembering to test and take medications added to class
Enhanced goal setting section in class
Reminder give-a-way, like a cling for bathroom mirror, is being researched

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<td>Other comments</td>
<td colspan="2">Dr. SR, MD-Endocrinologist Add Soliqua and Xultophy to medication handout. Add Dr. G B-Endocrinologist to committee. Consider use of PAID. Typo-Tanzeum-corrected. Consider holding classes at North Campus as additional Endocrinologists are added. (See reply)
TO-The ADA is emphasizing the role psychosocial issues impact self-care in diabetes. I am very excited and confident that by utilizing the WHO survey which measures emotional well-being we can identify and set goals to help patients improve outcomes. (See reply)
KW- CQI Process might include input from class evaluations and how that information was used. Since prevention is a goal-how are we addressing pre-diabetes & obesity (high BMI) in our program? We do see patients who are not yet diagnosed, should they be in our scope? Also- 48 hours (call to schedule) should be restated to say “attempt to contact patient will be within 3 business days to accommodate weekends. (see reply)
RM- I am pleased with increased attendance based on new way of scheduling.
TW- One suggestion I have, with the holidays coming would be a mailing or special holiday food demonstration online. Showing what are healthier choices during the holiday (maybe connected to website). (See reply)
JC- Thank-you for your comments. The 150 minutes of light aerobic activity or 75 minutes of moderate aerobic activity recommendations are what we discuss in class. We do also recommend participants start where they are, with their doctor’s approval, and increase their activity level from there. We will use the statistic that this activity level can decrease disease risk by 20-50%. Can you provide me with the reference for this stat? Thank-you.</td>
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