

## Additional Sites Application

### Application Information

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*Signature Statement signed by*

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone: \_\_\_\_\_

*Reporting Period*

Start Date: \_\_\_\_\_

End Date: \_\_\_\_\_

### Paper Audit Item(s) and Misc. Documentation *This lists the files you may need*

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- A formal description of CQI process and current project
- Documentation of annual program review and/or plan and advisory committee activities
- A copy of a de-identified patient chart showing complete education process
- A copy of a full section of Program's "Nutrition" curriculum
- A copy of a full section of Program's "Medication" curriculum
- A copy of a full section of Program's "Goals Setting and Behavior Change" curriculum
- Support Documentation

**Multi Site - Site Information** Complete this information once for each multi-site included in the application

*Site Name and Contact Information:*

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Add 1: \_\_\_\_\_

Add 2: \_\_\_\_\_

Spanish: \_\_\_\_\_

Single Discipline: \_\_\_\_\_

*How many years has the Site offered DSMES as an ADA Recognized program?*

Less than 1       1-2       3-5

6 or more

*Patients are seen in a year*

Total patients seen in last 12 months: \_\_\_\_\_

*What other services are provided in addition to DSMES?*

Medical/clinical (including lab)       Exercise facility

Foot screenings       Other nutrition counseling

*Total number of participants during reporting period*

Comprehensive and/or Initial: \_\_\_\_\_

Post Program Instruction: \_\_\_\_\_

Total: \_\_\_\_\_

*Average hours of DSMES received by participants during reporting period*

Comprehensive and/or Initial: \_\_\_\_\_

Post Program Instruction: \_\_\_\_\_

*Age of participants receiving DSMES during reporting period*

More than 65 years of age: \_\_\_\_\_

45-64 years of age: \_\_\_\_\_

19-44 years of age: \_\_\_\_\_

Less than 19 years of age: \_\_\_\_\_

Total: \_\_\_\_\_

*Diabetes type of participants receiving DSMES during reporting period*

Pre-diabetes 0-18 years old: _____	Pre-diabetes 19+ years old: _____
Type 1 0-18 years old: _____	Type 1 19+ years old: _____
Type 2 0-18 years old: _____	Type 2 19+ years old: _____
GDM: _____	Other: _____
<b>Total:</b> _____	

*Race/ethnicity of participants receiving DSMES during reporting period*

<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian/Chinese/Japanese/Korean/Pacific Islander
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino
<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Middle Eastern

*Special needs of participants receiving DSMES during reporting period*

Physically disabled       Visually impaired

Hearing impaired       Low literacy

English as a second language

Other: \_\_\_\_\_

*Unique features of the site*

<input type="checkbox"/> Print augmentation	<input type="checkbox"/> Interpreters
<input type="checkbox"/> Low literacy education tools	<input type="checkbox"/> Physical plant enhancements
<input type="checkbox"/> Transportation opportunities	<input type="checkbox"/> Allowances for cultural diversity
<input type="checkbox"/> Languages other than English	
<input type="checkbox"/> Other: _____	

**Multi Site - Site Information (Continued)** Complete this information once for each multi-site included in the application

**Site Service Area**

Urban
  Rural
  Suburban

**Site Setting**

Community based
  Pediatric  
 Home health
  RD practice  
 Outpatient hospital based
  Nurse Practitioner practice  
 Long term care facility
  Long-distance learning/telemedicine  
 Pharmacy
  Skilled Nursing Facility  
 Physician practice
  Patient Centered Medical Home  
 Worksite health
  Government or public health

*If Government or public health:*

Federally Qualified Health Clinic
  Veterans Administration  
 Indian Health Services
  Department of Health  
 Rural health clinic
  Other  
 Military

**Site DSMES method(s)**

1:1
  Group
  1:1 and Group

**Continuous Quality Improvement (CQI) Process at this Site**

There is documentation that the DSMES Provider(s) measure or plan to measure the effectiveness of the education (and support if applicable), and look for ways to improve any identified gaps in services or service quality using a systemic review of process and outcome data.

**Topics / Content**

Diabetes disease process and Treatment options  
 Incorporating nutritional management into lifestyle  
 Incorporating physical activity into lifestyle  
 Using medications safely  
 Monitoring blood glucose, interpreting and using results  
 Prevention, detection and treatment of acute complications  
 Prevention, detection and treatment of chronic complications  
 Developing strategies to address psychosocial issues  
 Developing strategies to promote health/change behavior

**Elements**

Evidence that the teaching approach is interactive, patient centered and incorporates problem solving  
 Methods of delivery  
 Methods of evaluation

**Education records from this site**

Referral from a provider managing patient's diabetes if insurance requires one  
 A comprehensive assessment of the participant's diabetes knowledge, self-management skills, diabetes- and health-related behaviors, behavior change potential, and other relevant information including medical history  
 An education plan which includes patient-selected behavioral objectives based on the assessed needs of the participant  
 Educational interventions which include the date of intervention, content taught and the name(s) of the Instructional Staff, or Resource Person  
 Evaluation of progress towards/or achievement of learning and behavioral objectives and related outcomes  
 Communication with other members of the Health Care Team, including plan for diabetes self-management support (DSMS)

Outcome	Target %	Actual %
<b>Behavioral Outcome(s)</b>		
<input type="checkbox"/> Nutritional Management/Healthy Eating	_____	_____
<input type="checkbox"/> Physical Activity/Being Active	_____	_____
<input type="checkbox"/> Taking medications	_____	_____
<input type="checkbox"/> Monitoring	_____	_____
<input type="checkbox"/> Preventing, detecting, treating acute complications/Problem Solving	_____	_____
<input type="checkbox"/> Preventing, detecting, treating chronic complication/Reducing Risks	_____	_____
<input type="checkbox"/> Psychosocial Adjustment/healthy Coping	_____	_____
<input type="checkbox"/> Other: _____	_____	_____
<b>Other Participant Outcomes</b>		
<input type="checkbox"/> A1c	_____	_____
<input type="checkbox"/> Eye Exam	_____	_____
<input type="checkbox"/> Foot Exam	_____	_____
<input type="checkbox"/> BP	_____	_____
<input type="checkbox"/> Lipids	_____	_____
<input type="checkbox"/> Quality of Life	_____	_____
<input type="checkbox"/> Weight Change	_____	_____
<input type="checkbox"/> Patient Experience	_____	_____
<input type="checkbox"/> Other: _____	_____	_____

**Multi Site - Team Member Information** Complete this information once for each staff member included in the application

**Note about Resource Staff and Temporary Staff:** Resource staff and temporary staff are not required to obtain 15 hours of CEUs annually and should not be added to the application. Resource staff are professionals that teach less than 10% of the entire program. Instructors that fill in for permanent staff and are with the program less than 4 months are considered temporary instructors and are not required to be on the application.

**Instructional Staff Members at this Site**

<i>Instructional Staff Member</i>			
Name: _____			
No. of hours per month in DSMES during reporting period: _____			
<b>Certifications</b>			
<input type="checkbox"/>	CDE	ID #: _____	Exp: _____
<input type="checkbox"/>	BC-ADM	ID #: _____	Exp: _____
<input type="checkbox"/>	Other cert:	_____	_____
<b>Credentials</b>			
<input type="checkbox"/>	RN	Lic. #: _____	Exp: _____
<input type="checkbox"/>	RD	CDR #: _____	Exp: _____
<input type="checkbox"/>	Pharm	Lic. # _____	Exp: _____
<input type="checkbox"/>	Exercise Physiologist	Prof. Reg. #: _____	Exp: _____
<input type="checkbox"/>	Physician	Prof. Reg. #: _____	Exp: _____
<input type="checkbox"/>	Physician's Assistant	Prof. Reg. #: _____	Exp: _____
<input type="checkbox"/>	Podiatrist	Prof. Reg. #: _____	Exp: _____
<input type="checkbox"/>	Social Worker	Prof. Reg. #: _____	Exp: _____
<input type="checkbox"/>	Other	Prof. Reg. #: _____	Exp: _____
<b>If this staff member is not a CDE or BC-ADM</b>			
<input type="checkbox"/>	There is documentation to support that this Staff member has received 15 contact hours in any one or a combination of diabetes specific topics, diabetes related topics, psychosocial topics, or educational topics within the 12 months prior to the date this application is being entered online.		

**Paraprofessionals at this Site**

Examples are LPN, Dietary Tech, Community Health Worker, MA, Lab Technician, Yoga Instructor or a Personal Trainer.

<i>Paraprofessional Staff Member</i>	
Name: _____	
Credentials: _____	
Title: _____	
<b>Diploma or Certification</b>	
Certificate, Diploma, or Training: _____	
<input type="checkbox"/>	Proof of training
Description: _____	
Expiration date: _____	
<input type="checkbox"/>	Does not expire

**Expansion Site - Site Information** *Complete this information once for each expansion site included in the application*

*Site Name and Contact Information:*

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Add 1: \_\_\_\_\_

Add 2: \_\_\_\_\_

*Service Area*

What is the service area around this site considered:

Urban                       Rural                       Suburban

*Expansion Site Information*

There is evidence to show that each of the following items is the SAME at the expansion site as it is at the site from which you are expanding:

Curriculum

At least one instructor who is RN, RD or pharmacist

Instructors who have the academic credentials to sit for the CDE exam

Instructors are CDE, BC-ADM or have CEU's in the past 12 months

Continuous Quality Improvement Process and Current Project

Policies and Procedures

Educational Chart Forms