

# **Sample<sup>1</sup> Policy and Procedure Manual**

## **Diabetes Self-Management Education Program**

### **Program Name**

PLEASE NOTE: The information contained in this manual is SAMPLE language only and does not represent nor portray any real AAA or program. Specific entries, such as mission statement, geographic area served, number of participants, etc., would need to change based on what applies to your location. You cannot simply adopt this manual as your own. You will need to read through this manual carefully and input/change information to reflect your situation. **Text in Blue is instructional information that should be deleted before submitting your procedure manual to the Georgia Department of Public Health for review. Text in Red is example information that should be used as a guide for developing your own procedures and should be replaced with your own information before it is submitted to GDPH.**

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## Introduction

The *Insert Program Name* is based on the ten (10) National Standards for Diabetes Self-Management Education and Support. The *Insert Program Name* Quality Coordinator and relevant stakeholders review the policies and procedures for the *Insert Program Name* at least annually.

The National Standards are reviewed every 5 years, when changes are made, the policies and procedures will be amended to reflect those changes.

Initial Implementation Date for the *Insert Program Name* Policy and Procedure Manual:

Date of Initial Approval	Quality Coordinator Signature
9/1/2017	

Policy Update Log (example entries):

Date Approved	Section/Paragraph Amended	Change
September 5, 2012	Section 3, Paragraph 1	Revised section relating to CHW supervision
ETC.	ETC.	ETC.

## The Ten 2017 DSMES National Standards (July 2017 standards, current version) and Policy Manual

[Here each of the standards are repeated, with the policies and procedures applicable to each standard. The procedures should be replaced with your location specific guidelines. Refer to the AADE Initial Application Document Check List to ensure you have included all the information needed for application approval.]

### *Standard 1 - Internal Structure*

The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization- large, small, or independently operated.

#### *Policies and Procedures Applicable to Standard 1:*

##### **Mission Statement:**

The **Insert Program Name** is committed to improving the quality of life and maintaining the dignity of older adults in our region. We achieve this mission by providing leadership and support, developing community partnerships, establishing comprehensive services, and disseminating accurate information.

##### **Program Goals:**

- To develop programs that meet the changing needs of the area's aging population
- To collaborate with other organizations to develop a comprehensive network of services for older adults in our community
- To secure adequate funding to serve the growing and diverse aging population
- To promote the well-being of older adults and empowering them through high-quality information and programs

##### **Diabetes education is part of Insert Program Name mission:**

As part of **Insert Program Name** core services and mission, we provide services funded in part through the Older Americans Act. These services include health promotion and disease prevention (Title IIID of the Older Americans Act). As a result of this focus on health, we expanded our core services to provide the Chronic Disease Self-Management Program (CDSMP) and the Diabetes Self-Management Program (DSMP). **Insert Program Name** targets older adults most in need; our Diabetes Self-Management classes focus on reaching older adults in minority groups who are most affected by diabetes and diabetes-related complications in our service area.



Below are the guidelines for the Stanford Program. You may leave the information in if you will be using the Stanford class design (1 intro week with individual assessment, 6 weeks of group classes, 1 closing week with a post-assessment and future planning). If you are using a different class design, please describe your basic class structure here (plan for staffing, number of classes and how far apart, how long will each class be, etc.), and ensure it meets AADE guidelines. Do not go into detail pertaining to the curriculum here, the curriculum information is included under Standard 6.

**Diabetes Self-Management Education Program Mission Statement:**

Our mission is to empower our clients with the diabetes self-care management skills necessary to improve their quality of life, using what they have learned through diabetes education and disease management strategies.

**Diabetes Education Process and Self-Management Support:**

The *Insert Program Name* is an eight-week intervention, which begins with each participant undergoing a detailed individual assessment conducted by the program's primary qualified instructor (PQI), a registered dietician. Based on the results of the individual assessment, the PQI develops a comprehensive education plan. A key component of the individual assessment and education plan is the establishment of individualized goals and self-management support strategies. This initial session is week 1 of the eight-week intervention.

After completion of week 1, the participant participates in the six (6) week Stanford Diabetes Self-Management Training program. Two trained Community Health Workers, under the supervision of the PQI, facilitate the group workshops from a highly-detailed manual. Participants, in the group education sessions make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their individualized self-management program.

The PQI directs the material covered during the group sessions. In addition, the group instruction occurs in a setting that allows for interaction between the participants and the trained group leaders. The PQI maintains responsibility for providing direct supervision of the educational process in the least obtrusive manner possible.

Physicians and other health professionals both at Self-Management Research Center and in the academic and healthcare community have reviewed all materials in the course. The instructional materials have been provided to our program's Advisory Council as part of our continual quality improvement review process. Workshops are conducted in a manner to encourage full participation by all members of the group. The group learning process increases participants' ability to learn self-management behaviors in an environment of mutual support enabling them to build on the success of their peers.

At the completion of the six-week group training sessions, each participant will complete a follow up assessment with the PQI to review their effectiveness in achieving the goals of their individualized education plan. This review provides the PQI with an opportunity to augment and modify the participant's disease self-management plan, if necessary. All follow up is communicated by PQI to both the participant and the referring primary care manager. This review constitutes the 8<sup>th</sup> week in the eight-week intervention.

Link to Self-Management Research Center:

<http://www.selfmanagementresource.com/programs/small-group/diabetes-self-management>

Link to more information about the Stanford program:

<http://www.selfmanagementresource.com/about/>

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*Standard 2 - Stakeholder Input*

The provider(s) of DSMES services will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.

*Policies and Procedures Applicable to Standard 2:*

The ***Insert Program Name*** program will seek stakeholder input to promote quality and enhance participant utilization in the program. Stakeholders will be from various interest groups (DSME participants, practitioners, community groups, outside health professionals, etc.) to ensure needs of the community are being met.

**Planned strategy for engaging stakeholders:**

- 1.) Identify social determinants related to our population and anticipated challenges in implementing the DSME program.
- 2.) Identify interest groups that may be able to help foster ideas related to improving the program and addressing the social determinants of program utilization.
- 3.) Reach out to the interest groups/stakeholders identified. Document our efforts, discussion key-points and any actions plans that are created.
- 4.) Create plan to reevaluate stakeholders and obtain continued input.

Below is an example of the document that will be used to plan stakeholder involvement and document discussions.

<b>Stakeholder</b>	<b>Discussion Summary</b>
List Stakeholders Here  Be sure to include: -Name -Position -Credentials -Planned Contribution (why are we contacting them and what insight do we think they can help us provide)	List contact attempts, methods of contact, discussion key points, next steps, etc.
ETC.	ETC.
ETC.	ETC.

Annual tasks to be performed by the Quality Coordinator in collaboration with relevant stakeholder input:

- Actively reviews the DSMES program
- Actively reviews the CQI data reports
- Makes recommendations to help improve and maintain the program
- Reviews the annual program plan and evaluation
- Reviews the Continuous Quality Improvement Plan
- Annually reviews the current policy and procedure manual
- Annually summarizes stakeholder input and communications in a report for AADE

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### *Standard 3 – Evaluation of Population Served*

The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services.

#### *Policies and Procedures Applicable to Standard 3:*

Below are links to websites where you can find population health data for your state, county or city. You can use this information along with your internal patient data to determine your target population.

<https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html>

<https://www.cdc.gov/diabetes/data/county.html>

<https://www.cdc.gov/diabetes/home/index.html>

<https://www.cdc.gov/healthliteracy/index.html>

<http://www.countyhealthrankings.org/>

### **Target Population**

**Geographic Region:** South East Metro, Anywhere USA

**Expected Volume:** 21-100 monthly

**Settings:** Older Adult Activity Centers in South East Metro area

**Setting Descriptors:** Wheelchair and Mobility accessible, handicap parking available at all locations, transportation provided to centers if needed

**Target Population's unique characteristic:** (consider characteristics such as literacy, transportation, uninsured rate, primary language, etc.) Older Adults (generally age 60+)

**Tailoring to target population:** You should now describe how you plan to tailor your program to the specific needs on the population you identified at need in your above assessment. This can include information on the space you will be using for classes, staffing, materials, times of classes, outside support, etc.

To meet the needs of this older adult population, the DSMES program will be particularly tailored to address challenges which include, but are not limited to: low vision, hearing loss, limited mobility. Educational material using large print will be utilized when necessary. Hearing assistance devices will be available. All site locations will accommodate walkers, wheelchairs and other devices designed to improve mobility.

Program instructors will have experience in working with older adults to have a heightened ability to recognize other needs of the population. While most the target population is English speaking, educational material will be available in the other languages prevalent in the geographic areas served (Spanish, Cambodian) and translation services will be made available

when necessary. Further, some segments of the target population have incomes at or below the federal poverty limits.

To address the challenge of meeting the needs of low-income elderly consumers, the program includes information on finding low-cost medication and services. Efforts to assist with transportation will be incorporated when possible. Any additional barriers and challenges discovered for members within the target population will be communicated to the participant's primary care provider. All resources expended in support of this DSME will be allocated to meet the needs of this target population.

At least annually, an assessment of the target population will be performed to address access to healthcare services, cultural influences, barriers to education, and appropriate allocation of resources. Resources allocated include funding for program intervention and assessment, physical space, transportation costs, etc.

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#### *Standard 4 - Quality Coordinator Overseeing DSMES Services*

A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement.

#### *Policies and Procedures Applicable to Standard 4:*

The **Insert Program Name** will maintain the services of a Quality Coordinator. The Quality Coordinator has the responsibility of providing oversight of the DSMES program, including planning, implementation, and evaluation of education services.

#### **Program Coordinator Job Description:**

<Insert the Quality Coordinator Job Description Here (Sample Below)>

TITLE: **DSMES Quality Coordinator**

REPORTS TO: **Program Director (manager, administrator, CEO, etc.)**

SUPERVISES: **DSMES program staff (primary qualified instructors, group leaders)**

POSITION OVERVIEW: **Provides oversight for planning, implementation and evaluation of the DSMES program and ensures the systematic and coordinated delivery of diabetes educational services.**

#### **DUTIES AND RESPONSIBILITIES:**

- Provides direction for the selection, and ongoing review, of the curriculum and educational materials to ensure they meet the needs of the population targeted.

- Directs marketing activities.
- Develops and directs the implementation of an annual program evaluation plan and performance improvement activities, including CQI projects.
- Ensures that DSMES program accreditation requirements are met and maintained.
- Oversees the diabetes educational process and ensures that services are provided in an individualized and fiscally feasible manner.
- Develops and maintains relationships and partnerships with community groups, payers and potential referral sources.
- Interfaces with the Volunteer Accreditation Advisory Group.
- Maintains 15 hours of continuing education annually as it relates to their profession.

**KNOWLEDGE, SKILLS AND ABILITIES:**

- Knowledge about chronic disease management and disease self-management educational processes
- Supervisory abilities
- Knowledge about program management
- Proficiency in various computer applications, including spreadsheets
- Marketing skills

**EXPERIENCE/EDUCATION:**

- Education and/or experience in program management
- Education in, and/or experience with, chronic diseases and disease self-management

*<Insert Quality Coordinator resume here>*

*<Insert copy of Quality Coordinator's license/certification here (if applicable)>*

*<Insert documentation of Quality Coordinator's pertinent training here (if applicable)>*

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### *Standard 5 - DSMES Team*

At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.

#### *Policies and Procedures Applicable to Standard 5:*

The ***Insert Program Name*** will have one or more instructors providing Diabetes Self-Management and Support (DSMS). At least one of the instructors will serve as the Primary Qualified Instructor (PQI). The Primary Qualified Instructor will be a licensed professional and hold a current license in one of the following professions – Registered Nurse, Registered Dietitian Nutritionist, Registered Pharmacist, or another health care professional holding a CDE or BD-ADM .

The ***Insert Program Name*** uses lay leaders/community health workers in the provision of diabetes self-management education. Lay leaders/community health workers aid with diabetes self-management education, under the supervision of the Primary Qualified Instructor or other affiliated licensed professional instructor for the program.

#### **Referral Mechanism:**

To ensure participants needs are met if they are outside of PQI/lay leader/community health worker instructor's scope of practice and expertise the following policy has been implemented.

1. The Primary Qualified Instructor will document initial nutrition counseling session using the intake form as described in Standard 7.
2. An appropriate referral will be made by the PQI if it is determined during the first session that the needs of the participant are beyond their professional knowledge or ability.
3. Before the start of the program, the PQI will identify licensed providers in the community that the patients can be referred to as needed based on the participant's needs
  - a. Exercise Physiologist-Anywhere Medical Center
  - b. Counselor-Anywhere Medical Center
  - c. Wound Care-Anywhere Medical Center Emergency Dept.
  - d. Cardiac Rehabilitation-location
  - e. Vision/Eye Associates- 123 Eye Associates
  - f. Podiatry- Better Feet Podiatry
4. If emergency assistance is needed, 911 will be called and the referring provider will be notified.
5. With the participant's permission, the individual's DSME record will be sent to the

referring provider's office. If the PQI determines the participant may need further counseling it will be included with the records that are sent to the referring provider. The PQI will also make the referring provider aware of any topics the patient had an interest in, but the instructor was not able to provide counseling on based on ability or it be outside their scope of work.

### **Job Description: Primary Qualified Instructors (PQI)**

<Insert the PQI and Group Leader Job Descriptions Here (Samples Below)>

**TITLE: Professional Diabetes Program Instructor/Primary Qualified Instructor (PQI)**

**REPORTS TO: DSMES Quality Coordinator**

**SUPERVISES: Non-professional instructional staff, Group Leaders**

#### **POSITION OVERVIEW:**

- Provides individualized diabetes self-management education/ training to individuals and groups according to the Scope of Practice, Standards of Practice, and Standards of Professional performance for Diabetes Educators (AADE, 2017).
- Provides direct supervision of the participating non-professional instructional staff and group leaders (i.e., community health workers) that assist in delivering the diabetes self-management education program to class participants. The primary qualified instructor is responsible for selecting community health workers, monitoring their performance, and assuring that they are properly trained. Direct supervision occurs during program instruction and entails: 1) oversight of the instructional material, 2) fidelity checks to ensure that approved material is being delivered as intended, 3) direct observation of community health worker-led instruction, and 4) constant physical availability to assist and answer questions that arise during community health worker led instruction periods.

#### **DUTIES AND RESPONSIBILITIES:**

80% (Instruction of program participants):

- Performs DSMES program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSMES program participants.
- Provides educational interventions that utilize primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods.
- Collaboratively develops an individualized follow-up plan with each program participant.
- Evaluates effectiveness of educational services provided by measuring attainment of learning objectives.
- Conducts a follow-up assessment upon completion of DSMES program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data, educational plan, educational services provided and evaluation results in each participant's educational records.

- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.
- Communicates relevant participant information to primary care provider 20% of the time
- Participates in the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSMES program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other professional instructional staff.
- Maintains 15 hours of continuing education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

**KNOWLEDGE, SKILLS AND ABILITIES:**

- In-depth knowledge about current diabetes treatment management.
- Ability to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).

**EXPERIENCE/EDUCATION:**

- A Registered Nurse, Registered Dietitian, or Registered Pharmacist who is or who is eligible to become a certified diabetes educator.
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.

*<Insert Primary Qualified Instructor's Resume here>*

*<Insert copy of Primary Qualified Instructor's license here>*

*<Insert documentation of Primary Qualified Instructor's relevant training here>*

**Job Description: Group Session Leader**

*<Insert Job description(s) of Lay Leaders/Community Health Workers here (Sample Below)>*

**TITLE: Group Leader/Community Health Worker**

**REPORTS TO: DSMES Quality Coordinator and Primary Qualified Instructor**

**SUPERVISES: Non-Supervisory Position**

#### POSITION OVERVIEW:

- Provides individualized diabetes self-management education/ training to individuals and groups per the Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators (AADE, 2017). Community Health Workers maintain a non- technical role in providing instruction to program participants.

#### DUTIES AND RESPONSIBILITIES:

80% (Instruction of program participants):

- Under the supervision of a licensed program instructor or PQI, collects DSMES program participant assessment data, using the AADE7 framework, in a collaborative and ongoing manner.
- Under the supervision of a licensed program instructor, collaboratively develops educational goals, learning objectives and a plan for educational content and teaching methods with DSMES program participants.
- Provides non-technical educational interventions that utilize primarily interactive, collaborative, skill based training methods and maximizes the use of interactive training methods.
- Collaboratively with the PQI, develops an individualized follow-up plan with each program participant.
- Collaboratively with the PQI, evaluates effectiveness of services provided by measuring the attainment of learning objectives.
- Collaboratively with the PQI, conducts a follow-up assessment upon completion of DSMES program services, using outcome measures from the AADE7 Continuum of Outcomes Framework.
- Documents assessment data of the PQI developed educational plan, educational services provided, and evaluation results in each participant's educational records.
- Utilizes a team approach to provide services and collaborates and communicates with team members when needed.
- Identifies when a program participant's needs are outside the scope of the instructor's practice and expertise, plus arranges for additional services to meet needs.

20% of the time:

- Contributes to the development of training materials.
- Contributes to, and participates in, a continuous quality improvement process to measure DSMES program and to identify and address opportunities for improvement.
- Appraises his/her performance to identify areas of strength and areas for improvement and to develop a plan for improvement and growth.
- Participates in peer review process to evaluate performance of other non-professional instructional staff.
- Maintains 15 hours of continuing education annually specific to diabetes, diabetes related topics and behavior change and self-management education strategies.

**KNOWLEDGE, SKILLS AND ABILITIES:**

- In-depth knowledge about current diabetes treatment management.
- Able to lead and effectively manage groups.
- Ability to develop a collaborative, therapeutic alliance with individuals.
- Basic computer skills (use of Internet and e-mail).
- **Completion of Stanford CDSMP Training (4 days).**

**EXPERIENCE/EDUCATION:**

- **Experience working with community based groups and providing outreach to seniors.**
- Minimum of 6 months experience (preferably more) providing diabetes education and/or 15 contact hours within past year in diabetes and diabetes clinical and educational subjects.
- Experience making oral presentations on health topics in community settings.

*<Insert resume of any instructors that will participate as a group session leader/lay leader>*

*<Insert any training for group session leaders/lay leaders>*

*<Insert Documentation for all instructors that shows at least 15 CE credits in the last year related to diabetes, behavior change, chronic disease care or program management>*

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### *Standard 6 - Curriculum*

A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.

### *Policies and Procedures Applicable to Standard 6:*

<Insert a copy of your program curriculum here. This is a sample. If you are using the Stanford curriculum, the below description will likely be similar to your own program. Review the curriculum below and edit as needed based on how you envision your own program utilizing the Stanford curriculum and provide evidence of adaptation to best serve your target population. If you are using a curriculum developed by your clinic/location, ensure the information written below includes all essential element content areas, adopts the principals of AADE7 behaviors, and maximizes use of interactive training methods. >

### **DSMES Curriculum:**

The Eight (8) week DSMES curriculum set forth below is designed to provide each participant with an individual assessment and education plan that has been developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies.

#### **Week 1: Individual Assessment with Registered Dietitian or Registered Nurse (PQI):**

Each new participant will undergo a 1:1 in person assessment with either a Registered Dietitian, or Registered Nurse with training specific to diabetes. The assessment will include information about the individual's relevant medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, self- management skills and behaviors, readiness to learn, health literacy level, physical limitations, family support, and financial status.

The current assessment/intake tool is attached and subject to modification as part of our ongoing quality improvement efforts.

During this assessment, educational goal(s) and learning objectives, and the plan for educational content and method/s will be developed collaboratively between the participant and instructor(s). This plan will include, where appropriate, ongoing assessment with the Registered Dietitian, or Registered Nurse and/or referral to the Stanford Diabetes Self-Management Program (DSMP).

During the initial assessment, any additional participant needs that are identified by the participant, in collaboration with the PQI, will be addressed outside of the Stanford Class individually, but will be an integral part of the entire DSMES process. This plan will also include a personalized follow-up plan for ongoing self-management support, which will be developed collaboratively by the participant and instructor (s). The patient's outcomes and goals and the plan for ongoing self-management support will be communicated and documented. These outcomes and goals may be distinct and in addition to the goal or "action plan" participants develop in the Stanford DSMP program as discussed below. The follow-up plan for

ongoing self-management support will focus on long-term self- management that occurs after the Stanford DSMP class ends. PQI reviews his/her contact information (telephone and email) with an invitation for participant to contact PQI with any follow up questions or concerns.

In an effort to provide an ongoing evaluation of the consumer's attainment of educational goals, the PQI will continue discussions with the participant during the eight- week intervention no fewer than twice in an effort to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The assessment and any follow-up documentation will be provided by the PQI to the PCP and the PQI will be available to discuss the assessment and plan with the PCP.

PQI and group leaders will further engage in regular communication with one another during the six week Stanford intervention to ensure that the participant's plan is appropriate and to address any challenges, questions, lack of information, or other support the participant may need from either the PQI, primary care provider or another professional. The PQI will document regularly all communication with group leaders.

**Weeks 2, 3, 4, 5, 6 and/or 7:** The PQI will continue discussions with the participant during the eight-week intervention no fewer than twice during Weeks 2-7.

The Stanford DSMP class is the base curriculum for our DSMES service. During this six (6) week workshop, participants will be provided with an array of tools to improve their ability to self-manage their conditions. The Stanford DSMP class is the primary intervention, to fulfill the participant's need for improved diabetes self-management, but will not be the only intervention and will be coupled with the individualized education plan developed collaboratively based on the initial assessment. The Stanford DSMP class is provided by group leaders, under the supervision of the PQI and includes discussion of all relevant AADE diabetes education benchmarks, including but not limited to the following:

- overview of diabetes,
- blood glucose monitoring, nutrition,
- preventing high and low blood sugar,
- preventing or delaying complications from diabetes,
- physical activity,
- dealing with stress,
- muscle relaxation,
- reading nutrition labels,
- depression management,
- communication with health care providers,
- medication usage,
- foot care,
- working with the health care system, and
- planning for the future.

The program also requires participants to continue to set individualized weekly goals or

"action plans" and to provide follow-up for each action plan achieved. For action plans not achieved, participant engages in problem solving activities with the group to brainstorm potential solutions.

During weeks 2-7, the PQI remains available to both the Group Leaders and the participant to measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention. The primary goal is an improvement in the participant's self-management behaviors. Outcomes will be compared to quality indicators to assess the effectiveness of the participant's care plan and the education intervention.

Both individualized and aggregate outcomes data will be collected and will include, at a minimum, the following: attainment of participant-defined behavior change goal(s) (intermediate outcomes) and at least one post-intermediate or long term health outcome measure. In a collaborative manner, the participant and PQI will define the individualized goals. These individual participant outcome measures are used to guide the intervention and improve care for that participant. The aggregate population outcome measures (program outcome measures) are used to guide programmatic services and CQI activities for the DSME and the population it serves.

During this time, the success of the Stanford DSMP intervention in meeting the participant's defined goals is measured by the participant's ability to set weekly measurable goals and report back on attainment of these weekly goals in a group setting, with peer involvement. Documentation of the attainment of this goal will be class attendance and participation in the weekly goal setting process with the peer group.

Other goals outside of improved self-management behaviors will be addressed as part of the individualized plan and will occur outside of the Stanford DSMP, but remain part of the entire DSMES program and will be directed by the PQI in collaboration with the participant. Methods of attaining these other goals are decided by the participant in collaboration with the PQI. Documentation of class participation, weekly goal setting, and individualized assessment will be maintained in the participant's chart.

**Week 8:** At the end of the Stanford DSMP intervention, the participant will develop a follow-up plan in a collaborative manner with the PQI. There will be a multi-disciplinary approach to completing this process. The multi-disciplinary team works with the participant to develop realistic, individualized goals and an ongoing evaluation plan.

The multi-disciplinary team consists of, at a minimum, the following:

- the PQI,
- the group leaders delivering the diabetes self-management classes, and
- the participant's primary care provider.

Long-term evaluation can include things such as improved HgbA1C values, improved fasting glucose values, improved lipid levels, increased frequency of physical activity, and improved dietary intake. These long-term goals and follow-up will be documented in the participant's

record. Resources to support the attainment of these goals will be identified in a collaborative manner. The goals for ongoing self- management, support resources, and ongoing evaluation plan will be communicated to the referring provider. The communication with the referring provider will be documented in the participant's record.

### Summary Table

<b>Workshop Overview – Activity</b>	<b>Session 1</b>	<b>Session 2</b>	<b>Session 3</b>	<b>Session 4</b>	<b>Session 5</b>	<b>Session 6</b>
Overview of self-management and diabetes - <b>Reducing Risk</b>	✓					
Making an action plan - <b>Reducing Risk</b>	✓	✓	✓	✓	✓	✓
Monitoring - <b>Monitoring</b>	✓	✓	✓	✓	✓	✓
Nutrition/Healthy Eating - <b>Healthy Eating</b>	✓	✓	✓	✓		
Feedback/problem-solving - <b>Problem Solving</b>		✓	✓	✓	✓	✓
Preventing low blood sugar - <b>Reducing Risk</b>		✓				
Preventing complications - <b>Reducing Risk</b>			✓			
Fitness/exercise - <b>Being Active</b>			✓	✓		
Stress management - <b>Healthy coping</b>			✓			
Relaxation techniques - <b>Healthy coping</b>			✓	✓		
Difficult emotions - <b>Healthy coping</b>				✓		
Monitoring blood sugar - <b>Monitoring</b>					✓	
Depression - <b>Healthy coping</b>					✓	
Positive thinking - <b>Healthy coping</b>					✓	
Communication - <b>Healthy coping</b>					✓	
Medication - <b>Taking medication</b>					✓	
Working with healthcare professional - <b>Reducing Risk</b>						✓
Working with healthcare system - <b>Reducing Risk</b>						✓
Sick days - <b>Healthy coping</b>						✓
Skin and foot care - <b>Monitoring</b>						✓
Future plans - <b>Reducing Risk</b>						✓

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### *Standard 7 - Individualization*

The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES member(s) will develop an individualized DSMES plan.

#### *Policies and Procedures Applicable to Standard 7:*

The Professionally Qualified Instructor (PQI) is responsible for the overall delivery of course content. Each participant will have an initial assessment done by the PQI. At this time a customized education plan will be developed. The education plan will identify areas of need that are particular to the condition of the participant.

After the initial assessment (week 1), the participant will begin attending the group sessions. The group sessions provide general diabetes information about diabetes that is publicly available and the delivery of this information in the group setting is overseen by the professional instructor and is delivered by the community health workers. The PQI is always available to the Lay Leader/CHWs and provides additional individualized instruction based on the education plan that was developed at the time of the initial assessment.

Each participant has subsequent individual educational sessions with the PQI during the delivery of the course content. The frequency of the individual educational sessions is based on the clinical needs of the participant. The individual educational sessions provide an opportunity for the PQI to provide detailed clinical content that applies the general diabetes educational material to the specific clinical needs of the participant.

Most of the participants that complete the course will have a minimum of three (3) meetings with the PQI on an individual basis. These individualized educational sessions have an objective to deliver individualized instruction to the participant in a one-on-one setting with the PQI. However, the number of individualized sessions is dependent upon the clinical and educational needs of the participant and is at the discretion of the PQI that is leading the course.

The Lay Leader/CHWs role is to deliver the general diabetes information content, under the supervision of the professional instructor. The general information is then reviewed with the participant in a manner that addresses their specific clinical presentation and educational needs as determined by the professional instructor and the education plan that is completed by the professional instructor.

The PQI and Lay Leader/CHWs work in a collaborative manner to address the educational needs of the participant by presenting each person with general diabetes educational content with individualized education sessions that are delivered by the professional instructor on a one-on-one basis. The PQI oversees the entire educational process, monitors the delivery of the general diabetes information, and provides individualized instruction based on the needs of the participant and documents the delivery of the educational content in the education plan.

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. If the participant has medical needs on follow-up that has not been taken care of with his/her physician, this is addressed at this point. Any interventions are to be documented in the participant's chart in the progress notes with copies to the physician.

**DSMES Participant Intake Form**

**Section 1: PARTICIPANT INFORMATION:**

Name \_\_\_\_\_

Address: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell/other phone: \_\_\_\_\_

Best time to call: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Male Female

Participant's primary language: \_\_\_\_\_

Race/ethnicity: \_\_\_\_\_ Latino/Latina

Workshop Site Assigned: \_\_\_\_\_

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

Class Zero Intake Site: \_\_\_\_\_

**Section 2: BILLING INFORMATION:**

Medicare number: \_\_\_\_\_

Supplement/Advantage plan: \_\_\_\_\_

Prior diabetic education: Yes\_\_\_ No\_\_\_

If yes, what was the class? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_ (within a year)

Is Medication Nutrition Therapy recommended by your physician? Yes\_\_\_ No\_\_\_

Referring Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Referral Source: \_\_\_\_\_

**Section 3: MEDICAL INFORMATION:**

Type of Diabetes\_\_\_\_\_ Age\_\_\_\_ Ht\_\_\_\_\_ Wt\_\_\_\_\_ BMI\_\_\_\_

Most Recent Fasting Blood Glucose (date/result): \_\_\_\_\_

Most Recent HgbA1c, if available (date/result):\_\_\_\_\_

Most Recent LDL-C, if available (date/result): \_\_\_\_\_

1. Are you taking oral medications to treat your diabetes? Yes No

Have you ever taken oral medication to treat your diabetes? Yes No

Name(s) of medication and dosage(s): \_\_\_\_\_  
\_\_\_\_\_

2. Are you currently taking insulin to control your diabetes? Yes No

Have you ever taken insulin to control your diabetes? Yes No

Name(s) of medication and dosage(s): \_\_\_\_\_  
\_\_\_\_\_

3 Have you taken any steroids such as prednisone which impacted your diabetes? Yes No

How did it impact your diabetes?\_\_\_\_\_

4. How often do you measure your blood sugar level?

Never          Rarely          1-3 times per month          1 – 3 times per week;

4 – 6 times per week          1-2 times per day          3+ times per day

If you keep a log of your blood sugar level what is your usually range? \_\_\_\_\_

5. How often are you physically active (e.g., walking, exercise?)

Never          Rarely,          1–3 times per month          Once a week

Two or more times per week Daily

Please share examples of the types of physically activity

\_\_\_\_\_

6. Do you follow a specific meal plan? Yes\_\_\_ No\_\_\_

If yes, what is your meal plan?

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7. Are you use tobacco? Yes\_\_\_ No\_\_\_

If yes, what type? Cigarettes\_\_\_\_\_ Chew\_\_\_\_\_ Snuff\_\_\_ Pipe\_\_\_\_\_ Cigar\_\_\_\_\_

If you stopped smoking, when was your last use?\_\_\_\_\_

8. Do you have pain from your diabetes or any other condition? Yes\_\_\_No\_\_\_ If yes, describe how this affects you\_\_\_\_\_

9. Have you been in the emergency room or hospitalized for a condition related to your diabetes in the last 12 months? Yes\_\_\_ No\_\_\_

Details:

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8. Have you had your eyes checked by a specialist in the last 12 months?

Yes No Results: \_\_\_\_\_

9. Have you had a foot examination in the last 12 months?

Yes No Results: \_\_\_\_\_

10. Do you have high blood pressure?

Yes No Name(s) of medication and dosage(s):

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11. Do you have pain from your diabetes or any other condition?

If yes, please briefly describe how this affects you: \_\_\_\_\_

**Section 4 - SOCIAL FACTORS**

**Family Environment and Support:**

1. Do you live alone? Yes     If no how many people live with you \_\_\_\_\_
2. Are there relatives or others caring helping you on a regular basis?
3. Do you prepare your own meals? Yes If no, who prepares them for you?  
\_\_\_\_\_
4. Do you have support from family or others to deal with your diabetes? Yes No
5. Other psychosocial factors impacting diabetes management  
\_\_\_\_\_

**Cultural Factors:**

1. Is there anything specific to your culture that you think influences your ability to manage your diabetes?  
\_\_\_\_\_  
\_\_\_\_\_
2. Do your cultural beliefs influence your ability to manage your diabetes?  
\_\_\_\_\_  
\_\_\_\_\_
3. Are there certain types of foods important to your culture?  
\_\_\_\_\_  
\_\_\_\_\_
4. Does having diabetes or having a serious illness create culture stress?  
\_\_\_\_\_  
\_\_\_\_\_
5. Are there any religious or cultural factors that affect how you eat?  
\_\_\_\_\_  
\_\_\_\_\_

6. Emotional symptoms associated with diabetes (stress, anxiety, depression): How do you feel about having diabetes?

Okay	Anxious	Angry
Afraid	Sad	Depressed
Overwhelmed	"Unsure of what to do, alone"	

Additional Comments

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Other cultural factors that impact the management of diabetes

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### Section 5 -- Individual Educational Plan:

**Paraphrase:** The XYZ workshop meets for 6 weeks, covering a range of topics. Participants learn in the workshop to work on their own goals related to managing their diabetes. Now, we're going to create an individual educational plan for you so that you can get the most out of the workshop.

1. Would you like help with any of the following things (Check as many as applicable)?

- Eating healthier meals/following a healthier meal pattern
- Increase my level of physical activity/exercise
- Increase my monitoring of blood sugar
- Increase the support from family or friends
- Set an achievable weight lose goals
- Increase my understanding of diabetes
- Improve my ability to manage stress and/or emotions that effect my diabetes

- \_\_\_ Improve my ability to manage my depression
- \_\_\_ Increase my ability to work with complications from diabetes (such as medical issues like neuropathy, vision problems, low energy, mobility problems)
- \_\_\_ Increase my ability to use the medical system effectively (for example: better communication with doctors)
- \_\_\_ Increase my ability to give myself injections at appropriate/regular time

2. Identify the top three problems or issues which impact your ability to managing your Diabetes: (for example, blood sugar fluctuations; poor diet; depression; or other factors)

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3. Identify barriers to managing your diabetes successfully: (physical barriers; language; literacy; appropriateness for self-management)

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**INDIVIDUAL PROBLEMS/NEEDS/GOALS:**

4. Participant's readiness for change (Pre-contemplative; contemplative; preparation; action; maintenance; relapse)

Participant's initial goals:

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**ACCOMMODATION FOR PARTICIPANT'S INDIVIDUAL EDUCATIONAL NEEDS:**

Visual/Learning/Mobility/other disability that needs an accommodation:

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Summary of Plan

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Instructor's Signature\_(RN, RD, PharmD, RPh)\_\_\_\_\_

Date\_\_\_\_\_

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### *Standard 8 - Ongoing Support*

The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will maintain their self-management needs.

#### *Policies and Procedures Applicable to Standard 8:*

Below are the standard procedures for providing and developing ongoing support of the participants in the DSMES program. Procedures may vary slightly from location to location, however be sure if you edit this section to include who will be assessing the participant's health status, what quality control checks are being completed, how the participant creates their own goals and that all information about care gets sent back to the referring physician. Include procedures on what the coordinator will do if the participant does not present for a class (how will they be contacted, how many times, at what point are they considered "lost to follow-up", etc.)

With your initial application, you must provide a de-identified patient chart that documents the ongoing support efforts.

#### **Policy: Follow up Plan**

A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and multidisciplinary team led by the PQI. The participant's outcomes and goals, and the plan for on-going self-management support will be communicated to the referring provider. The completed follow-up plan will be documented in the participant education record and will be communicated with the referring healthcare provider and/or primary care physician.

At each follow-up visit, the participant meets with a 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 participant's blood glucose meters along with assessment of the participant's ability to perform their own blood glucose testing with their blood glucose meter.

At this time behavior change goals are evaluated and, if needed, new goals are developed. The participant is given a copy of his behavior change goals. The RD or other diabetes educator also evaluates the participant's continuity of care to make sure all areas are being addressed appropriately. Outcomes are also measured by tracking the following clinical measures: Participant's HGB Alc testing results, Frequency of pre-and post-program participants obtaining an annual dilated eye exam, and Frequency of participants that obtain required foot screening.

The appropriate forms for eye care and foot care are filled out and sent to the referring physician. If the participant has medical needs on follow-up that have not been taken care of with the participant's referring physician, this is addressed at this point. Any interventions are to be documented in the participant's chart with a progress note with copies submitted to the

referring physician.

The PQI will also meet with the participant 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 that the appointment was missed. The letter will highlight the importance of adhering to the recommended follow-up schedule as this is an integral part of the diabetes self-management learning process. The participant is encouraged to reschedule any missed appointments. If the participant fails to comply with the follow-up schedule 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 documenting all care provided and attempts made to adhere to assist the participant with maintaining the follow-up schedule.

See the follow-up plan form sample on the next page:

**DSMES Follow-Up Plan**

**Name:**

**Date:**

**Recommendations:**  Dentist  Foot Doctor  Eye Doctor  Quit Smoking  Dietitian  
 Flu Vaccination  Pneumonia Vaccination  Diabetes ID  Support Group  Social Worker  A1c  
 Cholesterol  HDL  LDL  Triglycerides  Microalbuminuria

**Behavior Change Goal:** Specific behavior to be changed

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How will you change the behavior?

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How will the behavior change improve your health or quality of life?

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Clinician Signature/Date

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**Follow Up Assessment**

How successful are you with your behavior change goal?  Never  Sometimes  Usually  Always

If unsuccessful, what were some of the issues? \_\_\_\_\_

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Did you follow through with recommendations? (see above)  Yes  No

If not, why? \_\_\_\_\_

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How is your current health?  Poor  Fair  Good  Excellent

How frequently do you check your blood sugar?

What does it range?

Do you like the blood sugars you're seeing?

How often do you follow your meal plan?  N/A  Rarely or never  Occasionally  Often

Always

How often do you do a self foot exam?

How often are you physically active?

How well do you feel you are able to do the following?

Oral medication/Insulin use:  N/A  Poor  Fair  Good  Excellent Blood Sugar meter use:

N/A  Poor  Fair  Good  Excellent Foot Exam:  N/A  Poor  Fair  Good  Excellent

How sure are you that you can manage diabetes?

Not sure  Somewhat sure  Very sure

Date(s) of any hospital stays for diabetes since class: \_\_\_\_\_

\_\_\_\_\_

What is one example of how you used what you learned about diabetes in your class?

What has changed in your diabetes care since the classes?

Additional interventions provided/follow-up needed see education record:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Clinician Signature/Date \_\_\_\_\_

**FOR INSTRUCTIONAL STAFF ONLY**

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### *Standard 9 - Participant Progress*

The provider(s) of DSMES services will monitor and communicate whether participants are achieving their personal diabetes self-management goals and other outcome(s) to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

#### *Policies and Procedures Applicable to Standard 9:*

The plan below is based on the Stanford curriculum, if you are using the Stanford curriculum you can keep the plan below if it fits your needs and vision for progress evaluation. Add any additional information pertaining to your individual plan for participant progress (Do you plan to use the AADE data collection system? Do you plan to do additional assessments? Who will complete the assessments?) If you are using a different curriculum or your own curriculum, use below as a guide for developing your own participant progress evaluation plan.

#### **Performance Measurement Plan/QI Plan**

The Diabetes Self-Management Training (DSMES) program will measure attainment of participant-defined goals and outcomes to evaluate the effectiveness of educational interventions. The performance measurement plan will begin at the initial assessment between the participant and PQI. The plan may be increased and/or modified during the 8-week intervention based on collaborative input from participant, PQI, and the multidisciplinary team.

#### **Patient-defined Goals and Patient Outcomes**

##### 1. Data Collection

- Individualized data provided in initial assessment with PQI
- Participant-defined behavior change will be measured based on the AADE7 self-care behavior framework spreadsheet. This self-care framework is based upon the belief that behavior change can be most effectively achieved using the following 7 behaviors as a framework: healthy eating, being active, monitoring, taking medication, problem solving, reducing risks and healthy coping. The Stanford DSMP compliments the AADE7 framework with participant-created weekly action plans.
- Community Health Workers will be provided a SMART goal sheet for each participant to monitor the weekly focus of action plans. The multidisciplinary team will review progress to identify opportunities for participant motivation and program documentation. Participants will be asked to provide progress in the following health outcomes areas: weight, hemoglobin A1C, and medication compliance and monitoring during the follow-up session conducted on week 8 of the intervention. Data will be indicated on the participant's SMART goal sheet as part of their overall educational record.

Long-term outcomes measures will be tracked through the AADE electronic data collection tool. The resulting data will provide the Quality Coordinator with a data set to perform CQI. The results of this program data analysis will be reported AADE upon reaccreditation and will be shared with stakeholders as needed to foster ideas for improvement.

Results will be evaluated and program changes will be made based on the analysis of:

- Aggregate data
- Participant-defined behavior change, measured using a database, based on the AADE7 self-care behavior framework.
- Long-term health outcomes

## 2. Frequency of Measurement

a. Individual self-care behavior change data and selected health outcomes will be documented in the database at three points during the eight-week intervention. Those times are:

- Prior to beginning the **Stanford** program
- Midway through the workshop during session three (3)
- Week 8 will be a follow-up session by the PQI. Major changes in health outcomes occurring outside of this timeline will also be noted.

b. Individual self-care behavior change data will guide the education/training process. PQI and instructors will work with the participant if data analysis suggests self-care improvements are not made by a participant.

### **Diabetes Self-Management Support:**

Each participant will receive diabetes self-management support materials. In addition, a diabetes self-management support plan will be developed and reviewed with the participant and the referring provider. The Diabetes Self-Management Support (DSMS) Plan will be documented on the program DSMS Plan form.

See the following page for a sample DSMS Plan form.

**Diabetes Self-Management Support (DSMS) Plan**

Name:

Date:

**Congratulations on completing the DSME program! This is your Diabetes Self-Management Support Plan. You are being asked to select activities that will give you access to educational or motivational support in managing your diabetes.**

**Recommendations:**

Subscribe to a diabetes magazine

Diabetes Forecast ([www.diabetes.org](http://www.diabetes.org))

Diabetes Self-Management ([www.diabetesselfmanagement.com](http://www.diabetesselfmanagement.com))

Diabetes Health ([www.diabeteshealth.com](http://www.diabeteshealth.com))

Access diabetes informational websites

[www.diabeteseducator.org](http://www.diabeteseducator.org) (American Association of Diabetes Educators)

[www.diabetes.org](http://www.diabetes.org) (American Diabetes Association)

[www.dlife.com](http://www.dlife.com) (Diabetes Life)

[www.americanheart.org](http://www.americanheart.org) (American Heart Association)

[www.eatright.org](http://www.eatright.org) (American Dietetic Association)

[www.ndep.nih.gov](http://www.ndep.nih.gov) (National Diabetes Education Program)

Visit with a Registered Dietitian

Join a Fitness center, Gym or YMCA

Contact your health insurance company to ask about their diabetes management programs

Join a weight loss program

Attend a healthy cooking class

Other \_\_\_\_\_

**Written Support Materials Given**

Diabetes Brochures (List title, author, and date given)

\_\_\_\_\_  
\_\_\_\_\_

*Living a Healthy Life with Chronic Conditions*

Clinician Signature/Date \_\_\_\_\_

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### *Standard 10 - Quality Improvement*

The DSMES services quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.

#### *Policies and Procedures Applicable to Standard 10*

#### **Quality Improvement Process:**

The Quality Coordinator will identify areas for improvement by answering the following three questions (based on Institute for Healthcare Improvement process guidelines): What are we trying to accomplish? How will we know if a change is an improvement? What changes can we make that will result in an improvement?

The Quality Coordinator will complete a plan for implementing and evaluating the changes by utilizing the Plan Do Study Act method of quality improvement. This method will help the Coordinator to answer the IHI questions above.

The Quality Coordinator will document the quality improvement process and will present the written results to relevant stakeholders, program staff, and others as needed. The Quality Coordinator will be prepared to share the initial quality improvement plan, results and further plans with the AADE upon reaccreditation.

A Sample CQI plan following the Plan Do Study Act method is below. Our own plan and evaluation will be based on the problems we observe in the first few weeks of our DSME program implementation.

#### **Identified Problem:**

A significant portion of the participants are not completing the curriculum and are dropping out of the program.

#### *Plan:*

Improve the percentage of participants who are completing the entire Stanford curriculum.

#### *Do:*

Each patient enrolled in the classes will be entered in the AADE7 software program.

At the end of each class, a report will be compiled of the number of participants who have attended based on initial enrollment.

An additional question has been added to the intake form asking for potential barriers to continued participation. This question is also asked by the PQI at the mid-point evaluation to determine if there are any new barriers to participation. The answer from both the initial intake and mid-point evaluation are entered in a spreadsheet and reviewed by the QC, PQI and lay leaders.

*Study:*

Monitor the percentage of participants who are completing milestones in the program (completing 2 classes, completing the mid-point evaluation, completing 5 classes, completing the entire program).

Analyze the percentages and the answers to potential barriers to determine a plan to aid in program compliance and attendance.

*Act:*

Implement the plan to address barriers to participation. Review the milestone percentages. Report results to relevant stakeholders. Repeat cycle to either continue to improve on participation, or if results have been successful move onto another identified problem.