

The Mission of the North Carolina Diabetes Education Recognition Program is to provide quality comprehensive diabetes self management education to empower persons with diabetes.

2011 Continuous Quality Improvement Plan

The NC Diabetes Education Recognition Program (NC DERP) will meet all of the standards established by the American Diabetes Association in the *National Standards for Diabetes Self-Management Education, January 2011*.

One component of these standards is establishing a method to measure the effectiveness of the education processes and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the process and outcome data. Continuous Quality Improvement (CQI) is a formal process/plan that is a cyclic series of steps designed to enhance DSME processes leading to improved participant and DSME outcomes.

The N.C. Division of Public Health has adopted the PDSA (Plan, Do, Study, Act) methodology for quality improvement. PDSA steps include: 1. select the problem/process that will be addressed first and describe the improvement opportunity. 2. Describe the current process surrounding the improvement opportunity. 3. Describe all of the possible causes of the problem and agree on the root cause. 4. Develop an effective and workable solution and action plan including targets for improvement. 5. Implement the solution or process change. 6. Review and evaluate the result of the change. 7. Reflect and act on learnings.

The NC DERP has chosen to track patient foot exams, blood pressure and HgA1C as outcome measures to determine effectiveness of the program. Monitoring rates of patient self-foot exams will assess patient behavioral changes. The program's goal is to see that 75% of patients report they are checking their feet daily. Monitoring change in blood pressure and HgA1C will monitor patient clinical changes. The program's goal is that 75% of patients with a pre- and post- blood pressure will have a blood pressure of $\leq 130/80$; and patients with a pre- and post-A1c will have an A1c of 7% or less. Tracking foot exams and HgA1c began with data collection starting September 2007. The A1C goal was revised in October 2008. The blood pressure goal will be implemented June 1, 2010. Each site will submit a monthly data report for review by the Instructional Team.

All sites may be asked to complete a documentation chart audit to assure that ADA standards are being met. Audit sheets will be sent to the sites, and the sites will be asked to audit 10 charts, or 10%, whichever is greater. Sites will be given 30 days to complete the audit forms and return

them to the Instructional Team. The Instructional Team will review the audit forms for missing components, and will follow up individually with each site to discuss any necessary action.

In addition, during each site visit, the Instructional Team will conduct a random chart audit of 10% of charts (maximum of 10) to confirm that standards are being met. While chart audits are not a quality improvement method alone, the purpose of the audits is to identify and address any issues of documentation. Information gleaned from the audits may be incorporated into a quality improvement opportunity. The NC DERP currently uses the ADA Auditor Education Record Chart Review Form, 7th edition (see page 3).

Results of all performance improvement activities will be reported during the annual meeting of the Advisory Committee, and recommendations for action will be made. The results obtained will be used as part of the PDSA process to improve the diabetes self-management education program offered at the sites to ensure that all ADA Standards are met.

Plan Do Study Act
PDSA Method of Cyclic CQI

PLAN

1. Select the problem/process that will be addressed first and describe the improvement opportunity.
2. Describe the current process surrounding the improvement opportunity.
3. Describe all of the possible causes of the problem and agree on the root cause.
4. Develop an effective and workable solution and action plan including targets for improvement.

DO

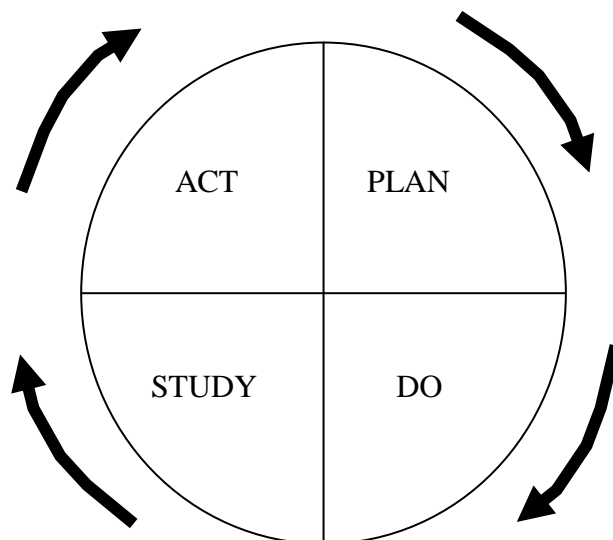
5. Implement the solution or process change.

STUDY

6. Review and evaluate the result of the change

ACT

7. Reflect and act on learnings.



Auditor Education Record Chart Review Form

Data Period or Current Operations

Use the following checklist to review at least one patient record of each program component (1:1 or group) to ensure that each element is included. A minimum of 5 charts from the data period and 5 current charts must be reviewed. If you have more than 6 patient records to review, initiate a second sheet.

Place a x in the box to indicate if an item is present and leave the space blank if the item is not present. The coordinator may point out to you the location of an item if it is not clearly evident.

Documentation in permanent record:	Patient record #1	Patient record #2	Patient record #3	Patient record #4	Patient record #5	Patient record #6
Program component (please write component in the space provided i.e. Individual, Group):						
1. Provider referral						
2. Participant assessment:						
▪ Clinical: Relevant medical history, diabetes history						
▪ Cognitive: Functional health literacy, Age, Self-management skills and diabetes related behaviors based on the 9 content areas:						
- Describing the diabetes disease process and treatment options						
- Incorporating nutritional management into lifestyle						
- Incorporating physical activity into lifestyle						
- Using medications safely (if applicable)						
- Monitoring blood glucose and other parameters; interpreting and using results						
- Preventing, detecting and treating acute complications .						
- Preventing, through risk reduction behaviors, detecting, and treating chronic complications						
- Developing personalized strategies to address psychosocial issues and concerns						
- Developing personalized strategies to promote health and behavior change (goal setting, behavior change strategies aimed at risk reduction e.g. preconception care, etc.)						
• Psychosocial and self care behaviors: (i.e., cultural influences, health beliefs, health behavior, lifestyle practices, support systems, barriers to learning, relevant socioeconomic factors, experience and behavior change potential)						
3. Education Plan based on assessment including:						
▪ Patient selected behavioral goal/objective (at least one)						
4. Summary of education intervention:						
▪ Date						
Content taught						
Name of instructor						
5. Evaluation of Learning, including						
▪ progress toward/or achievement of behavioral objectives and related outcomes						
6. Diabetes Self Management Support Plan (DSMS)						
7. Evidence of Communication with referring provider, including						
▪ DSMS plan an						
▪ Additional education needs if applicable						