

Diabetes Education Program Review Application - *Second Edition (Revised 11/2001)*

This application is your request to the Indian Health Service (IHS) National Diabetes Program to review your diabetes education program. Any Indian health facility (IHS, Tribal or Urban) is eligible to apply. Your diabetes education program can request a review by completing this application.

As you prepare for *IHS Diabetes Education Program Recognition*, please check the IHS National Diabetes Program web site at: www.ihs.gov/medicalprograms/diabetes for any application updates.

You can send the completed application and supporting documents in one of the following ways:

1. Electronic submissions: send completed application and supporting documents in PDF or MS Word format to: diabetesprogram@mail.ihs.gov

or
2. Hard copy submissions: send four (4) copies of completed application and supporting documents to:
Diabetes Education Review Coordinator
IHS National Diabetes Program
5300 Homestead Road
Albuquerque, NM 87110

You will receive notification of your program review outcome within twelve (12) weeks of receipt of the complete application at the IHS National Diabetes Program.

If you have questions about how to complete your application please contact:

IHS National Diabetes Program
505 248-4182
diabetesprogram@mail.ihs.gov

Note: Programs applying for *IHS Integrated Diabetes Program Recognition* will need to email diabetesprogram@mail.ihs.gov and request further instructions and application materials.

Each applicant must attach the following documentation:

Administrative

- Resolutions or support letters** from Tribal and Program Administration documenting support for diabetes education programming and diabetes team approach to education and care

Note: Separate letters for Tribal Administration and Program Administration are required. If multiple tribes are served, a single letter from the Tribal Health Board (or similiar entity) is acceptable documentation of Tribal support.

- Organizational Chart**

Note: The organizational chart submitted with the application should document the placement and relationships of the diabetes education program in the facility (including coordinator position).

- Program description and annual plan** (past year)
- Minutes of one team meeting** (past year)

Note: Team meeting minutes submitted with your application should reflect communication between team members about critical diabetes education issues.

- Minutes of one advisory body meeting** which reflects program review and planning (past year)

Note: Advisory committee minutes submitted with the application should reflect committee composition (i.e community representation, professional representation etc.) and communication between members about critical diabetes education issues.

Profiles (forms available within application)

- Education Program Profile
- Diabetes Coordinator Profile
- Instructor Profiles

Educational Materials

- Program brochure or other marketing materials
- Curriculum (if not on list of IHS approved curriculums)
- Education Documentation Forms

Program Evaluation

- Performance Improvement Report or similar evaluation for one behavioral outcome tracked in past year
- Diabetes Care and Outcomes Audit or similar report on one or more clinical outcomes tracked in past year

Date of Application: _____

Is this your first application? Yes -or- Reapplication? Yes

Application type (check one): Educational Integrated (educational, clinical and public health)

Date diabetes education program began services (month and year): _____

Name of Diabetes Education Program: _____
(This is the name that will appear on your Recognition Certificate.)

Sponsoring Organization/Facility: _____

Tribal Affiliation(s): _____

Address: _____ City: _____ State: _____ Zip: _____

The following questions apply to diabetes program services in your community:

Diabetes Coordinator

The coordinator is the contact person for this application.
(Attach coordinator profile.)

Name: _____ Credentials: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax: _____ Email: _____

Diabetes Team

List diabetes team members active in the past year:

Name and Professional Discipline:

Dates served:

List dates of diabetes team meetings in past year (attach minutes of one team meeting, reflecting discussion of diabetes education items):

Using the following codes, please note which team member is responsible for the following diabetes team functions. More than one team member may be listed for each function.

**C = Coordinator N = RN Instructor R = RD Instructor MD = Physician RPh = Pharmacist
 NP = Nurse Practitioner PA = Physician Assistant O = Other NA = Not Applicable**

<i>Diabetes Team Function</i>	<i>Responsible Team Member</i>	<i>Diabetes Team Function</i>	<i>Responsible Team Member</i>
Updates/maintains Diabetes Registry		Liaison between team & departments, programs, communities	
Updates/maintains Program Manual (policies)		Reviews/approves education documentation methods	
Reviews/approves program policy changes		Reviews/approves annual program plan (goals & objectives)	
Updates/maintains curriculum		Reviews/approves annual CQI/evaluation plan (progress toward goals & objectives)	
Reviews & approves education materials, teaching methods, and curriculum content		Collects/compiles data for program review	
Field tests new education materials (when appropriate)		Completes annual IHS Diabetes Care Audit	
Coordinates diabetes education team efforts		Conducts community needs assessments	
Chairs team meetings/prepares agendas		Conducts education code reviews	
Maintains team meeting minutes		Conducts consumer satisfaction survey	
Administers program budget		Coordinates advisory systems for education program	
Assesses/recommends program resources		Other, please indicate:	

Diabetes Instructors

List diabetes education instructors who taught during the past year (attach instructor profile for all instructors teaching 10% or more of content):

Name and Professional Discipline:

Dates served:

Community Diabetes Program Needs Assessment Method(s)

What methods have you used in the past year to assess diabetes program needs for your community?
(check all that apply)

- Diabetes Registry: How often is your registry updated? monthly quarterly annually
- Community forum Community focus groups
- Diabetes Advisory Body(s) feedback Patient Satisfaction Survey
- Diabetes Care and Outcomes Audit Other community information (please describe)
- Other utilization analysis (please describe) Other consumer feedback (please describe)

Diabetes Program Advisory Body

What advisory body system do you use? (check all that apply)

- Tribal Health Board/Committee Diabetes Advisory Council
- Tribal Council Other (please give title)
- Clinic Governing Body

Does the advisory body annually review program data, goal achievement, mission, organizational structure, target population, resources, quality improvement and plan services with the team based on this review?
Yes___ No___

List dates of advisory body(s) meetings during past year:
(Attach minutes that reflect diabetes program review and program planning within advisory system.)

Diabetes Education Program (Attach program description and annual plan from within past year.)

Where do you provide diabetes education services? (check all that apply)

- | | |
|--|---|
| Clinic or hospital setting: | Community-based setting: |
| <input type="checkbox"/> Freestanding Clinic | <input type="checkbox"/> Community Education Center |
| <input type="checkbox"/> Hospital Outpatient | <input type="checkbox"/> Elder Center |
| <input type="checkbox"/> Hospital Inpatient | <input type="checkbox"/> Community Wellness Center |
| <input type="checkbox"/> Other (describe) | <input type="checkbox"/> Other (describe) |

Target Population: (check all that apply)

- New diagnosis Elder
- Youth Gestational
- Adult Other (describe)

Education Program Resources (check if resources are adequate or limited.)

<i>Education Resource</i>	<i>Adequate</i>	<i>Limited</i>	<i>Please provide comments for each limited response</i>
Space			
Staffing			
Budget			
Instructional Material			
Staff Training (diabetes)			

Access to Diabetes Education Program

(Attach program brochure or other marketing materials.)

Briefly describe how your community gains access to the diabetes education program:

Please describe at least one strategy your program has used to improve access:

Curriculum (Attach copy of curriculum if not on list of curriculums approved by IHS.)

Approved IHS curriculums include: Life with Diabetes (ADA), Basics (IDC), Claremore Model Diabetes Program, Albuquerque Model Diabetes Program, Muscogee (Creek Nation) Diabetes Program and Gila River Model Diabetes Program.

Name of curriculum used: _____

Does the IHS National Diabetes Program have your permission to share the diabetes education curriculum, materials and forms included in this application with other diabetes education programs? Yes No

Briefly describe any modifications you made to curriculum or educational materials to meet the needs of your community:

Instructional Methods

What percent of participants receive diabetes education services in:

- Group (2 or more people) sessions only
- Individual sessions only
- Combination group and individual

Please tell us if any of the following methods of sharing and learning about diabetes information are used in your community? (check all that apply)

- Talking Circles
- Traditional food and fitness practices
- Storytelling (community member)
- Invited Speakers (elders, tribal leaders, CHR, etc.)
- Traditional healer/religious leader
- Other (describe):

Are interpreters oriented on a regular basis? Yes No Not applicable

Client Records and Documentation

(Attach forms used to document education process in your community.)

Do your facility education records include all of the following? ___Yes___ No

- Individualized needs assessment (covering elements described in Standard 8)
- Education plan
- Educational interventions
- Periodic evaluation of progress
- Collaboration with team

Does your facility use the diabetes education codes for RPMS? ___Yes ___No

Diabetes Education Program Impact and Outcome Evaluation

Check all data elements used:

- | | |
|---|---|
| <input type="checkbox"/> General Registry | <input type="checkbox"/> Diabetes Care and Outcomes Audit |
| <input type="checkbox"/> Complications Registry | <input type="checkbox"/> Educational Audit (RPMS generated) |
| <input type="checkbox"/> Gestational Registry | <input type="checkbox"/> Other (describe): |

Briefly describe diabetes program evaluation and/or CQI activities during the past year:

What **behavioral outcome(s)** does your program track annually? (check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Food and nutrition related | <input type="checkbox"/> Foot care |
| <input type="checkbox"/> Fitness related | <input type="checkbox"/> Sick day care |
| <input type="checkbox"/> Self blood sugar monitoring | <input type="checkbox"/> Tobacco use |
| <input type="checkbox"/> Medication use | <input type="checkbox"/> Follow-up services |

What **clinical outcomes** does your program track annually?

- All elements in IHS Diabetes Care and Outcomes Audit
- Some elements in IHS Diabetes Care and Outcomes Audit (please list elements tracked)

(Attach report for one (1) clinical and one (1) behavioral outcome tracked in past year.)

The information in this application is true and accurately describes the Diabetes Self-Management Education services for which the sponsoring organization is seeking recognition.

_____	_____	_____	_____
Chief Administrative Officer	Date	Coordinator	Date
Sponsoring Institution		Diabetes Education Program	

Diabetes Coordinator Profile

Name of Diabetes Education Program: _____

Coordinator Name: _____

Date started as Coordinator: _____

Total hours **per week** spent working in the Diabetes Education Program: _____

Certified Diabetes Educator: Yes ___ No ___ If CDE, date of last certification: _____

Please attach a CV or Resume with the following items clearly documented:

___ Academic Degree(s)

___ Professional License or Registration

and/or

___ Other certification(s)

List specific experience in the past three years in program management and care of persons with chronic disease (if not on CV or resume):

List continuing education credits received in past year (if not on CV or resume):

Program Title	Sponsoring Organization	CE Hours
---------------	-------------------------	----------

Are you also a Program Instructor? Yes ___ No ___

(If yes, it is not necessary to complete an instructor profile)

Instructor Profile

Name of Diabetes Education Program: _____

Instructor Name: _____

Position Title: _____ Date started as Instructor: _____

Total hours **per month** spent working in the Diabetes Education Program: _____

List curriculum content areas you taught in the past year:

Certified Diabetes Educator: Yes ___ No ___ If CDE, date of last certification: _____

Please attach a CV or Resume with the following items clearly documented:

___ Academic Degree(s)

___ Professional License or Registration

and/or

___ Other certification(s)

List specific experience in the past three years in diabetes education (if not on CV or resume):

List continuing education credits received in past year (if not on CV or resume):

Program Title	Sponsoring Organization	CE Hours
---------------	-------------------------	----------

Education Program Profile

Name of Diabetes Education Program: _____

The data period for this profile may be any 12-month period ending within three months of this application. Information in the profile should be from the data period you choose.

Data Period: _____(month/day/year) to _____(month/day/year)

Total number enrolled in program*: a _____
 Number completing comprehensive** program: b _____
 Number completing only partial*** program: c _____

*Include total number of participants enrolled in the diabetes education program seeking recognition.

**Comprehensive includes needs assessment, educational interventions per education plan, periodic follow-up evaluation.

***Partial includes only some of the components of comprehensive program.

Average number of hours of diabetes self-management education received by a participant who:

Completed comprehensive program: d _____
 Completed only partial program: e _____

For each category below, enter the number of participants served during the data period who completed a comprehensive program. Total number equals “b” above.

Classification and Age	<-19 years	20-44 years	45-64 years	>-65 years
Type 1	_____	_____	_____	_____
Type 2	_____	_____	_____	_____
Gestational	_____	_____	_____	_____
Total number each age	_____	_____	_____	_____
				Total number all ages _____ (=b)

Additional classifications of program participants (IGT, family members, etc) and Age

Other (describe) _____

Age and sex	<-19 years	20-44 years	45-64 years	>-65 years
Male	_____	_____	_____	_____
Female	_____	_____	_____	_____

Total number males: _____ Total number females: _____ Total number male and female: _____ (= b)

Education Setting

Please tell us the number of participants in primarily 1:1 (individual), OR primarily in group education sessions during the data period.

	1:1	Group
Clinic or hospital setting		
Freestanding Clinic	_____	_____
Hospital Outpatient	_____	_____
Hospital Inpatient	_____	_____
Other (describe)	_____	_____
 Community-based setting		
Community Education Center	_____	_____
Elder Center	_____	_____
Community Wellness Center	_____	_____
Other (describe):	_____	_____
 Total number each setting	 _____	 _____
 Total number all settings	 _____ (= b)	

Race/Ethnicity

American Indian and Alaska Native	_____
Non-Indian	_____
 Total	 _____ (= b)