

ERP Application Template - all

Before continuing:

This is the template to be completed before attempting the actual on-line application for all application types except for adding expansion only site(s). Application types include *Original, Renewal, Adding Multi-sites and Failed Re-apply*. Do not proceed to the actual on-line application until you have completed this template and have all your support documentation, including all possible paper audit items.

This is a PASS or FAIL application. Once you submit the application, the fee is non-refundable whether you PASS or FAIL. To pass, you must be able to answer “yes” to all “yes/no” questions and have documentation to support the “yes” answer.

Before this application is reviewed, the ERP office must receive a support documentation package which includes a letter from your Senior Administrative Officer, license verification and CEU, BC-ADM, or CDE verification of your program staff and the assigned paper audit item.

The review process **does not** begin until this support documentation is received by the ERP staff. The review process takes approximately 90 days.

Mail that package to: American Diabetes Association, Education Recognition Program, 1701 N. Beauregard Street, Alexandria, VA 22311.

Keep copies of the completed application and all support documentation. These must be available to support your responses to the application questions if your program is randomly selected for an on-site audit.

If you do not understand what is required exit the application and review the instructions here: <http://diabetes.org/for-health-professionals-and-scientists/recognition/edrecognition.jsp#applying>

If you have not completed the application on paper, please return to “How to Apply” here: <http://diabetes.org/for-health-professionals-and-scientists/recognition/edrecognition.jsp#applying>

Payment information must also be available before submitting the application. Credit card information or a check number must be entered at the end of the application. If paying by check, mail to the American Diabetes Association, Education Recognition Program, 1701 N. Beauregard Street, Alexandria, VA 22311. Recognition Certificates will not be issued until payment has been received.

Please verify before beginning application:

I have all necessary documentation for completing the application and for payment.

VERIFICATION STATEMENT

In order to proceed with the application, you must complete this statement. By completing this page and continuing with the application, you will be held accountable for the following statements. You may not proceed with the application until this section is completed.

1. I understand that to refuse or to not respond to a paper audit if assigned at the end of the application will result in failure of this application and loss of the application fee.
2. I understand that to refuse an on-site audit at anytime during the three years of Recognition will result in immediate loss of Recognition.
3. I verify that the information contained in this application and the accompanying documentation is accurate.
4. The applicant indemnifies ADA for any damage or injury to the participant, including failure to follow protocol.

IMPORTANT

If upon review of your application and documentation, your application is deficient in any way, you shall be notified by telephone or by e-mail describing the deficient items. You shall be allowed no more than 30 days from the date of notification to submit the items to complete your application. If you do not or are unable to complete your application by 30 calendar days after notification, your application shall be failed and you shall lose your application fee. The ERP staff will contact you by phone or email to notify you of the failed status and your options.

Name _____

Title _____

Telephone number _____

APPLICATION INFORMATION

All information submitted in the following application must be from the chosen data period.

What type of application is being submitted? (Select one)

____ Original: Enter the total number of sites in this application (include primary site)

____ Renewal: Enter the total number of sites in this application

____ Expansion: number of sites

____ Multisite: number of sites

____ Additional site(s) only: Enter *only* the number of sites being added

____ Expansion: number of sites

____ Multisite: number of sites

____ Failed Reapply: Enter the total number of sites in this application

____ Expansion: number of sites

____ Multisite: number of sites

Date application submitted: _____

(Application must be submitted within 3 months of end of data period.)

ID Number: _____

ID Number is not required for original applications.

DATA PERIOD: Must Be Exactly 3 Months

Start: _____

End: _____

APPLICANT DEMOGRAPHIC INFORMATION

Name of Sponsoring Organization: _____

Only one sponsoring organization may be entered.

Name of Administrative Officer: _____

Street Address: _____

City, State, ZIP Code: _____

The Administrative overseer and DSME coordinator verify that this application includes true and accurate information that reflects all of the sites requesting Recognition and accurately reflects the DSME services offered by the sponsoring institution.

Circle one: Yes / No

DSME COORDINATOR INFORMATION

Coordinator Name: _____

Title: _____

Credentials

___ RN License # _____ Expiration date _____

___ RD CDR # _____ Expiration date _____

___ Pharmacist License # _____ Expiration date _____

___ Other Please specify _____

___ None

Certification

___ BC-ADM ID # _____ Expiration date _____

___ CDE ID # _____ Expiration date _____

___ Other Please specify _____

___ None

Program is:

___ Single-discipline

___ Multidiscipline

Please verify that the Program Coordinator has the required number of CE credits; at least 15 for a multi-discipline and 20 for a single-discipline program.

Circle one: Yes / No

Street Address: _____

City, State, ZIP Code: _____

Phone Number (Best number to reach coordinator): _____

Fax (Best fax number for coordinator): _____

Email: _____

Written job description of the DSME coordinator requires that the coordinator:

Has academic preparation and/or experiential preparation in program management.

Circle one: Yes / No

Has academic preparation and/or experiential preparation in the care of persons with a chronic disease.

Circle one: Yes / No

Oversees the planning, implementation, and evaluation of the DSME entity at all sites.

Circle one: Yes / No

Check here if you wish to opt out of receiving any electronic notification of ADA professional education, publication and events.

DSME OVERSIGHT/PLANNING

This information must be the same for all sites of a program seeking Recognition on the application being submitted at this time.

Verify that there is documentation that an established DSME advisory system which involves at a minimum healthcare professional(s), person(s) affected by diabetes and community member(s).

Circle one: Yes / No

Verify that there is evidence that the established advisory system provides input at least annually for planning DSME operations and oversight for quality of services provided by the DSME.

Circle one: Yes / No

Methods of Oversight Involvement (Check All That Apply)

- Group Meetings
- Phone calls
- Email
- Ballots
- Surveys
- Other
- Specify

Note: This page must be printed out and completed once for each multi-site listed by the applicant earlier in the application.

INFORMATION FOR SITE 1

Site Name: _____

Street Address: _____

City/State/ZIP code: _____

Phone Number: _____

(This is the number to be listed on the ADA website)

Fax: _____

Is this a single-discipline or multidiscipline site?

Single-discipline

Multidiscipline

Note: All pages with the heading “INFORMATION FOR SITE 1” must be printed and completed once for each multi-site listed earlier on this application. Please mark application pages as “SITE 2,” “SITE 3,” etc., for each additional site after Site 1

INFORMATION FOR SITE 1

1. How many years has this site offered DSME?

- <1
- 1-2
- 3-5
- >=6

2. How many patients are seen in a year?

- <50
- 51-99
- 100-199
- 200-499
- 500-999
- >=1000
- Don't know

3. What other services are provided in addition to DSME?

- Medical/clinical (including lab)
- Exercise facility
- Foot screenings
- Other nutrition counseling
- None

INFORMATION FOR SITE 1

Below, enter the total number of participants who received DSME intervention at this site during the data period.

For this application the total number of participants (not visits) must be 10 or more per site. If you enter numbers that total less than 10, the application will not allow you to proceed).

___ Comprehensive and/or Initial
___ Post Program Instruction
___ Total (will be auto-populated by the computer when completing the actual on-line application)

Average number of hours of DSME the above participants received at this site during the data period:

___ Comprehensive and/or Initial
___ Post Program Instruction

INFORMATION FOR SITE 1

Population Receiving DSME

Enter the number of participants served at this site during the data period who were:

- ___ \geq 65 years of age
- ___ 45-64 years of age
- ___ 19-44 years of age
- ___ $<$ 19 years of age

(Each age group must have a number or a 0. The percentage for each age-group of your total number of participants will auto-populate)

- ___ Total number of participants served at this site (auto-populated)

INFORMATION FOR SITE 1

Types of Diabetes

Enter number of participants served at this site during the data period who have:

- ___ Pre-diabetes 0-18 years of age
- ___ Pre-diabetes ≥ 19 years of age
- ___ Type 1 0-18 years of age
- ___ Type 1 ≥ 19 years of age
- ___ Type 2 0-18 years of age
- ___ Type 2 ≥ 19 years of age
- ___ GDM

(Each group must have a number or a 0; % will be auto-populated by the on-line application)

- ___ Total number of participants served at this site (auto-populated)

INFORMATION FOR SITE 1

Race/Ethnicity

Identify the race/ethnicity of participants served at this site during the data period who are:

Mark with an 'X' all that apply:

- American Indian or Alaskan Native
- Asian/Chinese/Japanese/Korean/Pacific Islander
- Black/African American
- Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino
- White/Caucasian
- Middle Eastern

Identify the special needs of participants served at this site during the data period:

Mark with an 'X' all that apply:

- Physically disabled
- Visually impaired
- Hearing impaired
- Low literacy
- English as a second language
- Other
- Specify: _____

Unique features of the program to overcome barriers to learning:

Choose all that apply:

- Print augmentation
- Interpreters
- Low literacy education tools
- Physical plant enhancements
- Transportation opportunities
- Allowances for cultural diversity
- Languages other than English
- Other
- Specify

INFORMATION FOR SITE 1

What is the service area around this site considered?

Mark with an 'X' all that apply:

- Rural
- Urban
- Suburban

What is the type of setting?

Mark with an 'X' all that apply:

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

Method(s) used for DSME

Mark with an 'X' all that apply:

- 1:1
- Group

INFORMATION FOR SITE 1

Instructors at this site must include at least one (1) RN or one (1) RD or one (1) Pharmacist.

List the total number of Instructional Staff Members.

___ RD
___ RN
___ Pharmacist

Other Instructors: Y / N

(note: this does not include resource staff; only qualified instructional staff.)

If Yes:

___ Physician
___ Podiatrist
___ Physician Assistant
___ Exercise Physiologist
___ Physical Therapist
___ Social Worker
___ Total

Auxiliary Staff: Y / N

If Yes:

LPN:	No. of hours of work per week: _____	FTE: _____
Administrative Support:	No. of hours of work per week: _____	FTE: _____
Dietary Tech:	No. of hours of work per week: _____	FTE: _____
Community Health Workers:	No. of hours of work per week: _____	FTE: _____

Note: Auxiliary Staff involvement is calculated in terms of full-time equivalent (FTE) hours; 40 hours of work per week equals one (1) FTE (auto-populated).

INSTRUCTIONAL STAFF FOR SITE 1

Note: This page must be printed and completed once for each Instructional Staff Member listed on the previous page: RDs, RNs, Pharmacists, and other Staff Members. A new screen will appear automatically on the on-line application for each instructor based on the information entered.

Circle one:
RD / RN / Pharmacist / Other Staff

Last Name: _____
First Name: _____
MI: _____

Professional Registration (registration number or license number): _____
Expiration date: _____

No. of hours per month in DSME during data period: _____

CDE #: _____
Expiration date: _____

BC-ADM #: _____
Expiration date: _____

If this staff member is not a CDE or BC-ADM:

There is documentation to support that this Staff member has received 15 or 20 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.

Circle one: Yes / No

INFORMATION FOR SITE 1

CURRICULUM AT THIS SITE

There is a written curriculum with learning objectives in each of the following areas:

Circle one: Yes / No

Yes / No *Diabetes disease process and treatment options*

Yes / No *Incorporating nutritional management into lifestyle*

Yes / No *Incorporating physical activity into lifestyle*

Yes / No *Medication use*

Yes / No *Monitoring blood glucose and other parameters and using results*

Yes / No *Preventing, detecting and treating acute complications*

Yes / No *Preventing, detecting and treating chronic complications*

Yes / No *Developing personal strategies to address psychosocial issues/concerns*

Yes / No *Developing personal strategies to promote health and behavior change*

INFORMATION FOR SITE 1

EDUCATION RECORDS FROM THIS SITE

Each Participant's permanent record documents the following:

Circle one: Yes / No

Yes / No 1) *Referral from a primary care provider*

Yes / No 2) *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*

Yes / No 3) *An education plan which includes patient-selected behavioral objectives based on the assessed needs of the participant*

Yes / No 4) *Educational interventions which include the date of intervention, content taught and the name(s) of the Instructional Staff, or Resource Person*

Yes / No 5) *Evaluation of progress towards/or achievement of learning and behavioral objectives and related outcomes*

Yes / No 6) *Communication with referring provider, including plan for diabetes self-management support (DSMS)*

INFORMATION FOR SITE 1

Individualized Participant Behavioral Outcomes/Objectives/Goals

Mark the following behavioral outcome areas that are tracked on DSME participants. You can choose more than one.

___ **Nutritional Management/Healthy Eating**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Physical Activity/Being Active**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Medications/Taking Medications**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Monitoring**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Preventing, detecting, treating acute complications/problem solving**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Risk reduction/reducing risks**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Psychosocial adjustment/healthy coping**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ **Other (Specify: _____)**

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%

Actual Percentage: ___100% ___75% ___50% ___25% ___0%

Program Outcome(s)

Mark which other outcome measures are tracked by the DSME entity. You can choose more than one.

___ A1C
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Lipids
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Eye exam
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Weight change
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Patient satisfaction
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Provider satisfaction
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Quality of life
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Self foot exam
Degree of Achievement
Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

___ Blood pressure
Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

____ Other (Specify: _____)

Degree of Achievement

Target Percentage: ___100% ___75% ___50% ___25%
Actual Percentage: ___100% ___75% ___50% ___25% ___0%

CONTINUOUS QUALITY IMPROVEMENT (CQI) PROCESS AT THIS SITE

There is documentation that the DSME entity uses a formal continuous quality improvement process to evaluate the effectiveness of the DSME experience provided, and that the DSME entity determined opportunities for improvement based on the CQI evaluation. (within the past 12 months)

Circle one: Yes / No

PAYMENT INFORMATION – the fee will be automatically calculated based on the application type and/or number of sites entered

Method of Payment

Credit Card #: _____

Expiration date (mm/yy): _____

Name on card: _____

OR

Check #: _____

If paying by check, please make the check out to “American Diabetes Association Education Recognition Program” and mail to:

American Diabetes Association National Office
Education Recognition Program
1701 North Beauregard Street
Alexandria, VA 22311

APPLY

VERY IMPORTANT: After you hit “APPLY” the next screen will list your assigned paper audit item. You will be assigned one of the following paper audit items (all 5 if this is an original or new application). This documentation must be received in the ADA office within 14 days of the assignment.

- Program Coordinator’s Job description and CV or Resume**
- 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 full section of your curriculum**
- A copy of a de-identified patient chart showing complete education process**

PRINTABLE APPLICATION

PRINTABLE RECEIPT

Be sure to Print Application and Receipt prior to exiting. There is no other opportunity to get a copy of your completed application or to obtain a receipt for payment of the application fees. ADA staff cannot send you a copy of your application or provide a receipt for application fee payment.

The Education Recognition Program staff will contact you within approximately 90 days regarding the status of your application.

Thank you for supporting the Education Recognition process and promoting quality diabetes education.

EXIT