Chronicle Diabetes (CD)

Initial Comprehensive

DSMES Cycle
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Accessing Chronicle Diabetes (CD)

Program Coordinator(s):

- Only the program coordinator can grant themselves and staff members access to CD through ERP Portal [https://erp.diabetes.org](https://erp.diabetes.org)
- The Program Coordinator will manage the CD access and will be required to send staff members their login credentials.

*Full setup instructions can be found at [www.diabetes.org/erp](http://www.diabetes.org/erp) under the Chronicle Diabetes tab.*

Staff Members:

- The Program Coordinator will assign you access to CD and provide you with your login credentials
- Once you have been assigned login credentials, you can access CD through the link below:

  **Chronicle Login:** [https://edu.chroniclediabetes.com](https://edu.chroniclediabetes.com)

For assistance with Chronicle Diabetes please contact ADA staff at Chronicle@diabetes.org or 888-232-0822.
Initial Comprehensive DSMES Cycle

After the assessment each item must be completed in no specific order

A. Referral if required by pt's insurance
B. Assessment of all 12 content areas
C. Education Plan per pt's assessed needs and concerns
D. Education Intervention Encounters
E. Education Learning Outcomes
F. Behavioral Goal/s Set
G. Behavioral Goal/s Follow up
H. DSMS Plan Set & Communicated to other HCP
I. Outcomes Measured
J. Communication with referring provider or HCP outside of the DSMES Service regarding education plan or education provided and outcomes.
**Chronicle Diabetes Initial Comprehensive DSMES Cycle**

- **A** Referral if required by pt's insurance
- **B** Assessment of all 12 content areas
- **C** Education Plan per pt's assessed needs and concerns
- **D** Education Intervention Encounters
- **E** Education Learning Outcomes
- **F** Behavioral Goal/s Set
- **G** Behavioral Goal/s Follow up
- **H** DSMS Plan Set & Communicated to other HCP
- **I** Outcomes Measured
- **J** Communication with referring provider or HCP outside of the DSMES Service regarding education plan or education provided and outcomes.

**Key:**
- Patients Tab
- Education Tab
- General Information Tab
- Documents Tab to upload
- DSME Assessment Tab
- Health Status Tab
- DSME & Follow-Up Tab
- Group or 1:1 Encounter
- DSME & Follow-Up Tab
- DSME & Follow-Up Tab
- DSME & Follow-Up Tab
First Step
Create a New Patient Record

- Click on the **Patients** tab at the top of the page, and then the **Create New Patient** button.
- Fill in as much information as you have. Fields marked with a red dotted line under the field are required. Click **Save Changes**.
Referrals can be uploaded to the patient record through the **Documents** section of the patient record. Referrals may also be filed in an EMR/HER or a paper chart.
The Initial Assessment is completed through the **DSME Assessment** and the **Health Status Section** of the Patient Record.
Initial Assessment
Documenting Hospital and ER visits Pre Education Part 2 of 2

Pre Education Hospital Admissions and Emergency Room Visits are documented within the Health Status section of the Patient Record.
Step 1) Create a new Group or 1:1 Class
The Education Intervention is documented within the appropriate 1:1 Class or Group Class.

1:1 Classes can be documented within the Education Tab or in the DSME & Follow Up section within the patient record.

Group Classes are documented within the Education Tab.

Note: Chronicle names education Interventions “Class” whether it is a 1:1 or Group
Step 2) Enter the General Group Class Information

Once you have created a new group class, you can begin by adding the general class information by clicking the Edit pencil link above the Class Information box.

Enter the Location, Language, instruction methods and any materials you are using, and click Save Changes.
Step 3) Create Group class sessions

Click the **Add Sessions** link above the Class Schedule box to bring up the entry window. Enter a name for the session. **Tip:** Choose a name that you will logically associate with your class session.

**Note:** Each class must have one or more sessions.
Step 4) Update Group Class Roster

A) Above the Class Roster and Attendance box: Click **Update Roster** to bring up the patient selector.

B) In the left recently Added Patients list find each patient that will be in the class and click on the patient to move her to the Current Roster list.

C) When you have selected all the patients in the class; click Save Changes.
Step 5) Create the Group Class Lesson Plan

The Learning Objectives are documented within the Lesson Plan section of the Education Record for both Group and 1:1. Click on the Edit Lesson Plan link to create the class lesson plan and to assign educators to the appropriate session and topic.
Group Class Snapshot of a Complete Group Class

On the **General Information page** of the record, the Class Roster and Attendance table lists each patient’s attendance. Each colored column represents a specific class session as listed in the Class Schedule section.

**Note:** By default all patients are marked as being in attendance (ATT) at each session.
Once a patient has at least one education session documented or scheduled, the **Pre Assessment** can be documented.

The Pre Assessment is located in the **DSME & Follow up** section.
The **Post Education Evaluation** is located under the patient tab. This allows each patient's education learning outcome to be captured individually.
Behavioral Goal/s Set

Behavior Change Objectives are documented through the Behavior Change Objectives section of the Pt. Record. Click on the Add New Objective link to create a new objective.
Behavioral Goal Follow-up is documented through the Behavior Change Objectives section of the Pt. Record. Click on the Update This Objective link to document the Pts. Follow-up success.
The DSMS Plan is documented within the DSME & Follow Up Section of the Patient Record. Click on **New DSMS Plan** to enter data.
Initial and Post Education Lab Values are documented through the **Clinical and Lab Data** section of the Patient Record. Click on the appropriate lab value to enter initial and/or post lab value.
Post Education Hospitalizations and ER Visits are documented thorough the **Follow-Up Summary** within the **DSME & Follow Up tab** of the **Patient Record**.
Communication with other HCP (Pt's DSMS Plan and other DSME Matters)  
Part 1 of 3

Patient Reports for Communication to HCP

1. **Patient Snapshot Report**
2. **DSME Record Report**

These reports are located under the **Patient Reports** tab within the patient record.

Examples of the two reports are on the next two pages.
Communication with other HCP (Pt's DSMS Plan and other DSME Matters)
Part 2 of 3

Patient Reports for Communication to HCP
1. Patient Snapshot Report
2. DSME Record

<table>
<thead>
<tr>
<th>Current Medications</th>
<th>HbA1c</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glipizide 10MG</td>
<td></td>
</tr>
<tr>
<td>Glucophage 500MG</td>
<td></td>
</tr>
<tr>
<td>Lipitor EQ 10MG BASE</td>
<td></td>
</tr>
<tr>
<td>allergies: No Data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recent Interventions</th>
<th>Result / Date</th>
<th>Date</th>
<th>Value(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Exam</td>
<td>Yes as of 4/06/2016</td>
<td>A</td>
<td>5.8</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Yes as of 4/04/2016</td>
<td>B</td>
<td>6.2</td>
</tr>
<tr>
<td>Foot Exam</td>
<td>No Data</td>
<td>C</td>
<td>6.7</td>
</tr>
<tr>
<td>Urine Protein</td>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urine microalbumin</td>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Vaccine</td>
<td>Vac as of 4/04/2016</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia Vaccine</td>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EKG</td>
<td>No Data</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational Topics Addressed</th>
<th>Most recently covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease Process</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Nutritional Management</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Being Active</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Taking medications</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Monitoring</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Acute complications</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Chronic complication</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Psychosocial Adjustment</td>
<td>5/03/2015</td>
</tr>
<tr>
<td>Promote health</td>
<td>5/03/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Behavior Change Objectives</th>
<th>Current Level</th>
<th>Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Foot Checks</td>
<td>100% (All)</td>
<td>4/04/2016</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>25% (Very Little)</td>
<td>5/06/2015</td>
</tr>
<tr>
<td>Carb Counting</td>
<td>75% (Most)</td>
<td>5/01/2015</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DSMS Plan</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>
Patient Reports for Communication to HCP
1. Patient Snapshot Report
2. DSME Record

Communication with other HCP (Pt's DSMS Plan and other DSME Matters)  Part 3 of 3

<table>
<thead>
<tr>
<th>Topics/Learning Objectives</th>
<th>Pre-Session Assessment</th>
<th>Comments</th>
<th>Instr. Date</th>
<th>Post-Session Evaluation</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes disease process and Treatment options</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Incorporating nutritional management into lifestyle</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Incorporating physical activity into lifestyle</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Using medications safely</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Monitoring blood glucose, interpreting and using results</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Prevention, detection and treatment of acute complications</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Prevention, detection and treatment of chronic complications</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Developing strategies to address psychosocial issues</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Developing strategies to promote health/change behavior</td>
<td>1</td>
<td></td>
<td>05/03/2015</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

Ratings:  1 = Needs instruction  2 = Needs review  3 = Comprehends key points  4 = Demonstrates competency  N/A = Not applicable

Education Plan:
Education Plan has been created — Test  [Source: aarwsaafsl (06/10/16)]

Instruction Method:
Lecture/Discussion, Video, Demonstration  [Source: aarwsaafsl (05/03/16)]

Education Materials/Equipment Provided:
Medical Interpreter, Printed materials, Written instructions  [Source: aarwsaafsl (06/03/16)]

Identified Barriers to learning/adherence to self management plan:

DSMS Plan:
- Diabetes Forecast— 800-342-2383— www.diabetesforecast.org
- Weight Watchers—800-621-6000—www.
De-Identified Participant Record

Four CD de-identified patient reports are required to reflect a DSMES chart

On left menu within the Patient Record:
1. DSME Assessment (Print Current Page)
2. Health Status (Print Current Page)
3. Patient Snapshot Report (Left Menu Dropdown)
4. Diabetes Self-Management Education Record (Left Menu Dropdown)