March 10, 2022

Program Coordinator Name
DSMT Program Name
Street Address
City, State, Zip Code

RE: Diabetes Self-Management Training (DSMT) entity audit program

Dear ______________:

The Social Security Act mandates that the Centers for Medicare and Medicaid Services (CMS) provide oversight activities to ensure that the DSMT accreditation organizations and the DSMT programs they accredit meet the 2017 National Standards for Diabetes Self-Management Education and Support (NSDSMES) standards.

CMS has awarded the DSMT Oversight and Validation contract us at Integrated Management Strategies (IMS). As an agent on behalf of CMS, we will be conducting oversight and validation of the DSMT accreditation organizations. The goal of the project is to validate the performance of the DSMT accreditation organizations (i.e. – the ADA and the ADCES). We do this by reviewing records of 30 randomly selected DSMT programs that are accredited by each accreditation organizations annually.

Your DSMT program has been selected as one of the 30 entities accredited by the ADA to be audited in 2022. Therefore, we are requesting that you provide us with copies of all the information listed below. You have the authority to disclose protected health information, without patient authorization to Quality Improvement Organizations (QIOs) under the HIPAA Privacy Rule at 45 CFR § 164.512(d).

No later than ____________, please provide electronic copies of the documents requested below to your personalized, confidential SharePoint site ____________. The link will only work for you. Should additional people need access, please don’t hesitate to ask.

PLEASE BE SURE THAT ALL DOCUMENTS PROVIDED HAVE DATES AND TITLES OR TOPIC HEADINGS, as we cannot give you credit for documents that are not dated and that are not identified by a title or topic headings.

REQUESTED INFORMATION
1. An organizational chart which shows your program’s organizational structure, and also shows how your organization fits within the larger organization.
   - Your organizational chart must show the internal structure of your DSMT program;
   - If you are a DSMT program within a hospital, your organizational chart must show also how your program fits within the hospital structure;
   - If you are a DSMT program within a pharmacy, your organizational chart must show how your program fits within the pharmacy structure;

2. Your DSMT program’s mission statement;

3. Your DSMT program’s mission-related goals;

4. A letter of support from a person related to the larger organization or from an administrative person involved with the advisory process.
   - If you are a DSMT program that is within a hospital, your letter of support must be from a someone from the hospital organization;
   - If you are a DSMT program that is within a pharmacy, your letter of support must come from someone from the pharmacy.
   - While it is preferable to provide a letter of support from someone related to the larger organization, if this is not possible, you may provide a letter of support from a member of your Advisory Committee.

5. Oversight/Advisory committee meeting minutes.
   - All minutes must include meeting date(s), and the names and titles of all meeting attendees).

6. Documentation reflecting your annual assessment of the population served by your program.
• This is the assessment in which you identify the target population being served by your program as well as the population your program plans to serve in the future.

• You can obtain demographic information about the population your program serves from the following websites:
  - Centers for Disease Control and Prevention (CDC) website at [https://www.cdc.gov](https://www.cdc.gov)
  - U.S. Census Bureau website at [https://www.census.gov](https://www.census.gov)

7. Information about any services your program provides for clients with barriers to education such as physical and mental disabilities, mobility issues, low literacy, language barriers, transportation problems, financial hardships and for those who cannot attend classes during normal working hours.

**For example:**

• Are foreign language and sign language interpreters available?

• Do you have teaching materials for persons with visual impairments, language barriers or low literacy?

• Do you have special accommodations and equipment available for persons with disabilities?

• Do you have accommodations for persons with financial hardships?

• Is transportation provided for persons who do not have a way to get to your location?

• Is your program location easily accessible by public transportation?

• Are special meeting rooms and spaces available?

• Are services available in the evening and weekends for people that cannot attend during working hours?

• Are group sessions available?
• Are telephone, video and internet sessions available for person who are unable to leave their homes?

• Do your instructors make house calls?

8. A written job description for the Program/Quality Coordinator (person who manages the DSMT program).

9. A resume of Curriculum Vitae (CV) for the Program/Quality Coordinator (person who manages the DSMT program).

10. Verification (if applicable) that the Program/Quality Coordinator holds certification as a CDCES or BC-ADM.

11. If the Program/Quality Coordinator has CDCES or BC-ADM certification, provide a copy of his or her current CDCES or BC-ADM certificate and all previous CDCES or BC-ADM certificates to cover the time period back to the date of hire as Quality Coordinator or since the DSMT supplier’s last accreditation renewal date (whichever occurred later in time).

Also provide this information for any other Program/Quality Coordinators that have been leading the program back to program’s last accreditation renewal date (whichever occurred later in time).

12. If the Program/Quality Coordinator does not have CDCES or BC-ADM certification, provide verification that he or she has obtained at least 12 CEUs each year, (as required by 42 CFR 410.144) since the date of hire as Quality Coordinator or since the DSMT supplier’s last accreditation renewal date (whichever occurred later in time).

13. A list of all DSMT instructors and copies of their licenses, certifications and CEU certificates (as applicable):

   • If the instructor does not have their CDCES or BC-ADM, 15 hours of CEU are required each year.

   • Provide verification that each instructor who does not have CDCES or BC-ADM certification has obtained at least 15 CEUs each year since the date of hire or since the DSMT program’s last accreditation renewal date (which ever occurred later in time.)
14. A copy of the program’s DSMT training curriculum.

- If you have purchased a curriculum, it is not necessary to copy the entire book. Please include an outline of the curriculum and provide the name and edition of the curriculum you are using. (If you developed your own curriculum an outline is required).

15. A copy of ten (10) complete patient records:

**NOTE 1:** If utilizing electronic health records, the DSMT medical record must be reproducible for audit.

**NOTE 2:** Please redact (black out) any personally identifiable health information (PHI).

- **The ten (10) complete patient records must meet the following criteria:**

  o Five (5) of the patient education records must be from the year that your program accreditation was last renewed by the ADA, or the year that your program was first accredited, *(whichever occurred later in time.)* For your program, these charts will be dated _______ through _______.

  o Five (5) patient education records must be from the current time. For your program, these charts will be dated from _______ through the present.

  o All patient records provided must be for participants that have completed the program.

  o When uploading the charts into the folders, please identify the time frame for which they are being submitted.

- **Each patient record should include all of the following information:**

  a. Order for Diabetes Self-Management Services/Education from the patient’s Primary Care Provider (PCP), including the date, diagnosis.

  b. Comprehensive Assessment - including clinical, cognitive and psychosocial/self-care behaviors.
c. Education Plan – which is based on assessed needs and includes patient-selected objectives.

d. Educational Interventions (lessons/sessions) – which must include the following information:
   i. Dates of educational interventions/lessons/sessions;
   ii. Content taught;
   iii. Instructors name-initials

e. Documentation of educational goals.

f. Documentation of a follow-up assessment of the educational goals.

g. Documentation of a personalized ongoing support or DSMS (diabetes self-management support) plan.

h. Evidence of communication with referring physician.

16. Documentation of a Continuous Quality Improvement (CQI) plan/process.

   **Examples of CQI plans/process include:**
   
   • A plan/process to help participants get their A1C down;
   
   • A plan/process for participants to monitor their blood sugar on a regular basis.
   
   • A plan/process to help participants reduce their carbohydrate intake.
   
   • A plan/process to help establish a schedule for exercise or track weight loss.

17. Documentation of the Continuous Quality Improvement (CQI) program/process results.

   **Examples of evidence of the CQI results could include the following:**
• There is evidence that 92% of the patients in this CQI program had a reduction of A1C;

• There is evidence that 75% of the patients in this CQI program begin to monitor their blood sugar more regularly;

• There is evidence that the patients in this CQI program decreased their carbohydrate intake by 50%;

18. Evidence of application of results of the Continuous Quality Improvement (CQI) project (i.e. – what you did in response to the result received).

Examples of evidence of the application of the CQI results could include the following:

• Continuation of the program to help patients get their A1C down;

• Continuation of the program to get patients monitor their blood sugar on a regular basis since it was successful;

• Continuation of the program to get the patients to reduce their carbohydrate intake because it was successful;

• Implementation of the schedule for cleaning and calibration of the glucose monitors used by the program on a permanent basis since it led to more accurate glucose readings.


• The complete W-9 form W-9 form is required in order for you to receive payment of the $75 stipend.

• Upon completion of the audit a $75 stipend will be sent to help cover copying and mailing expenses).

Please acknowledge receipt of this notification by replying ALL to the email. Next, please upload the above-requested documents to your personal, confidential SharePoint ________________no later than ________________.
We will notify you when we have received the documents and are ready to commence your audit.

Please feel free to contact me at (386) 569-1262 or jreilly@im-strat.com if you have any questions or concerns.

Sincerely,

*Janet Reilly*

Janet Reilly  
Director of Operations  
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