

**Education
Recognition
Program**

DSMES Recognition Symposium



Online Participant Workbook 2025

On-Demand ERP DSMES Recognition Symposium

TARGET AUDIENCE

This activity has been designed specifically for physicians, physician assistants, nurses, dietitians, pharmacists, certified diabetes educators and other health care professionals who provide diabetes self- management education and support to people with diabetes and are either part of or interested in starting an accredited DSMES service.

LEARNING OBJECTIVES

- Describe the National Standards for DSMES including develop a DSMES service, annual requirements and maintaining audit ready status.
- Differentiate the role of the professional team member and diabetes community care coordinator in a DSMES service.
- Identify best practices, templates, and resources available for the development or improvement of a DSMES service design.
- Recognize safety and equity considerations for diabetes and driving
- Integrate driving and diabetes into DSMES

PLANNING COMMITTEE

Michelle Stancil MS, BSN, RN, CDCES® ERP National Committee Chair Manager, Diabetes Management Prisma Health Greenville, SC	Jo Ellen Condon, RDN, LD, CDCES® Planning Committee Chair Certified Diabetes Care and Education Specialist RDabetes EmpowerMNT, LLC Annapolis, MD
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ACCREDITATION STATEMENTS AND CONTINUING EDUCATION CREDITS

Physicians, Nurses and Pharmacists



In support of improving patient care, the American Diabetes Association is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This activity was planned by and for the healthcare team, and learners will receive 4.75

Interprofessional Continuing Education (IPCE) credits for learning and change.

Pharmacists: The Universal Activity Number is: JA4008193-0000-20-030-L01-P

Dietitians



The American Diabetes Association is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration (CDR). Registered dietitians (RDs) and dietetic technicians registered (DTRs) will receive 3.75 continuing professional education units (CPEUs) for completion of this program/material.

Activity Number: 156956

Certified Diabetes Care and Education Specialists

To satisfy the requirement for renewal of certification by continuing education for the Certification Board for Diabetes Care and Education (CBDCE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the CBDCE List of Approved Providers.

To Claim Continuing Education Credit

Certificates of Completion/Attendance are provided to registered attendees based upon completion of the online evaluation. If you have any questions regarding continuing education, contact professionaleducation@diabetes.org.

Content Validation Statements

The American Diabetes Association accepts the following Content Validation Statements and expects all persons involved in its professional education activities to abide by these statements regarding any recommendations for clinical care.

- All recommendations involving clinical medicine are based on evidence accepted within the profession of medicine as adequate justification for their indications and contraindications in the care of patients; AND/OR
- All scientific research referred to or reported in support or justification of a patient care recommendation conforms to generally accepted standards of experimental design, data collection, and analysis.

SPEAKERS

<p>Michelle Stancil, MS, BSN, RN, CDCES® ERP National Committee Chair Manager, Diabetes Management Prisma Health Greenville, SC</p>	<p>Barbara Eichorst, MS, RD, CDCES® Vice President, Health Care Programs American Diabetes Association Arlington, VA</p>
<p>Jo Ellen Condon, RDN, LD, CDCES® Planning Committee Chair Certified Diabetes Care and Education Specialist RDiabetes EmpowerMNT, LLC Annapolis, MD</p>	<p>Uzma Quraishi, MS, RDN Managing Director American Diabetes Association Arlington, VA</p>
<p>Karen McAvoy, MSN, RN, CDCES® Diabetes Clinical Nurse Specialist/Quality Coordinator Yale New Haven Hospital New Haven, CT</p>	<p>Steven Burdette Associate Director American Diabetes Association Arlington, VA</p>
	<p>Daniel Stinnett, MS, RDN, LD, CDCES® Senior Manager American Diabetes Association Arlington, VA</p>

PLANNING COMMITTEE/SPEAKER DISCLOSURES

As a provider of continuing education, it is the Association's policy to ensure balance, independence, objectivity, and scientific rigor in all educational activities. All participating course directors and invited speakers are required to disclose to the program audience any financial relationships related to the subject matter of this program. Disclosure information is reviewed in advance to manage and resolve any possible conflicts of interest. The intent of this disclosure is to provide participants with information on which they can make their own judgments.

Planning Committee Disclosures

Michelle Stancil MS, BSN, RN, CDCES®

Disclosed no conflict of interest.

Karen McAvoy, MSN, RN, CDCES®

Disclosed no conflict of interest.

Victoria Bouhairie, MD, DipABLM

Disclosed no conflict of interest.

Jo Ellen Condon, RDN, LD, CDCES®

Disclosed no conflict of interest.

Joni K. Beck, PharmD, BC-ADM, CDCES®

Disclosed no conflict of interest.

Jennifer Pike, RD, LDN, CDCES®, CPT

Disclosed no conflict of interest.

Speaker Disclosures

Steven Burdette

Disclosed no conflict of interest.

Jo Ellen Condon, RDN, LD, CDCES® *Disclosed
no conflict of interest.*

Barbara Eichorst, MS, RD, CDCES®
Disclosed no conflict of interest.

Karen McAvoy, MSN, RN, CDCES®
Disclosed no conflict of interest.

Michelle Stancil MS, BSN, RN, CDCES®
Disclosed no conflict of interest.

Daniel Stinnett, MS, RDN, LD, CDCES®
Disclosed no conflict of interest.

Uzma Quraishi MS, RDN
Disclosed no conflict of interest

PROGRAM SCHEDULE- Friday, March 21, 2025

11:00 a.m.-11:15 a.m.	Welcome and Guided ERP Website Resources Tour Steve Burdette
11:15 a.m.-11:30 a.m.	Recognition Requirements and 2022 Standards Overview Michelle Stancil MS, BSN, RN, CDCES® Jo Ellen Condon, RDN, LDN, CDCES®, CPT
11:30 p.m.-12:00 p.m.	Administrative Standards 1, 2, and 4 Karen McAvoy, MSN, RN, CDCES® Daniel Stinnett, MS, RDN, LD, CDCES®
12:00 p.m.-12:30 p.m.	Standard 3: DSMES Team Michelle Stancil MS, BSN, RN, CDCES® Uzma Quraishi MS, RDN
12:30 p.m.-12:50 p.m.	Stretch and Hydrate Break
12:50 p.m.-1:50 p.m.	Standard 5: Person Centered DSMES Uzma Quraishi MS, RDN (DSMES cycle) Jo Ellen Condon, RDN, LDN, CDCES®, CPT (HW chart) Karen McAvoy, MSN, RN, CDCES®
1:50 p.m.-2:00 p.m.	Stretch and Hydrate Break
2:00 p.m.-2:15 p.m.	Standard 6: Measuring and Demonstrating Outcomes for DSMES Michelle Stancil MS, BSN, RN, CDCES®
2:15 p.m.-3:15 p.m.	Integrate driving and diabetes into DSMES Barbara Eichorst, MS, RD, CDCES®

2025 Symposium Packet

We encourage all attendees to review and print this packet by March 21, 2025, **but it is not required** – answers will be discussed during the symposium. **No homework or CEUs credits will be granted for reviewing this section.** You can utilize the chart review form included in this packet for questions 16 – 36.



The DSMES service's anniversary date can be found on their Recognition certificate. This services anniversary year date is Dec 7.

- Please review the documents as if you are an ADA ERP Auditor reviewing current period operations. You will assume the audit date is **Jan 20, 2025**. Below is an explanation of the dates for the documents that will be accepted for **current period**.
 - **Standard 1, 2, 4, and 6:**
 - Documents dated **up to 12 months** prior to the audit date of Jan 20, 2025, will be acceptable for standards 1,2,4 and 6.
 - **Standard 3:**
 - Professional team members' credentials must be always **current**.
 - Professional team members who are not CDCES or BC-ADMs must have 15 hours of CEUs, and diabetes community care coordinators (DCCCs) formerly known as paraprofessional team members must have 15 hours of training and documentation reflecting, they are competent in the topics they teach annually. Since Jan 20, 2025, falls in the Anniversary year Dec 7, 2024-Dec 7, 2025, and the year is still not finished, documents of all 15 hours of CEUs from the **previous DSMES service anniversary year**, which is Dec 7, 2023, to Dec 7, 2024, will need to be present.
 - **Standard 5:**
 - For the participant complete initial DSMES chart, **at least one** of the A – I points of the DSMES cycle items must have occurred in the **past 6 months of the audit date**.

These are the questions that will be answered during the symposium. It may be beneficial to view and answer them ahead of time, **but it is not required. An answer sheet, staff tracker and chart review form are provided to document your answer if you choose to use them.**

1. Does the document on page 19 of the symposium workbook meet Standard 1's indicator 1.1?
2. Does the document on page 19 of the symposium workbook meet Standard 1's indicator 1.2?
3. Does the document on pages 21-22 of the symposium workbook meet Standard 2's A. a. requirement?
4. Does the document on pages 21-22 of the symposium workbook meet Standard 2's A. b. requirement?
5. Does the document on pages 21-22 of the symposium workbook meet Standard 2's A. c. requirement?
 - . Does the documents on pages 21-22 of the symposium workbook meet Standard 2's A. d. requirement?
 - . Does the document on pages 23-24 of the symposium workbook meet Standard 2's B. 1 requirement?
8. Does the document on pages 23-24 of the symposium workbook meet Standard 2's B. 2 requirement?
9. Does the document on page 26 of the symposium workbook meet Standard 4.A.h and 4.B requirements?
10. Does the documentation on page 26 of the symposium workbook meet Standard 4.C requirements?
11. Does the documentation on page 26 of the symposium workbook meet Standard 4.D. requirements?

Review the documents on pages 29 thru 53 and evaluate if they meet Standard 3's requirements. Credentials (licenses and certificates) need to be current at the time of audit. For non CDCES/ BC-ADM team members, 15 hours of CEUs for the previous DSMES service year (Dec 7, 2023, to Dec 7, 2024) need to be present. Filling out the DSMES Team Tracker yourself on page 14 of this packet will help you identify if the CEU certificates are valid for the last service year of Dec 7, 2023, to Dec 7, 2024, and if the licensures and credentials are current for the audit date of Jan 20, 2025.

12. Do the documents on pages 32 35 reflect that Standard 3's requirements were met for Quality Coordinator Mary Edwards?
13. Do the documents on pages 36 38 reflect that Standard 3's requirements were met for Paula Rivera?
14. Do the documents on pages 39 49 reflect that Standard 3's requirements were met for Kelsey Smith?
15. Do the documents on pages 50 and 51 reflect that Standard 3's requirements were met for Jamie Wahl?

Review the DSMES participant chart on pages 56 thru 74 and indicate on the Chart Review Form on page 16 of this packet if all the items are present.

Please indicate on the form in the last right column the page number that the items are found on and any notes you may have.

Remember a complete DSMES chart must have each item (A-I) of the complete DSMES cycle which can be found on page 15 of this packet. A-I is indicated on the chart review form.

16. Does the chart meet the DSMES cycle element A requirement?
17. Does the chart meet Standard 5's A.1.a requirement?
18. Does the chart meet Standard 5's A.1.b requirement?
19. Does the chart meet Standard 5's A.1.c requirement?
20. Does the chart meet Standard 5's A.1.d requirement?
21. Does the chart meet Standard 5's A.1.e requirement?
22. Does the chart meet Standard 5's A.1.f requirement?
23. Does the chart meet Standard 5's A.1.g requirement?
24. Does the chart meet Standard 5's A.1.h requirement?
25. Does the chart meet Standard 5's A.1.i requirement?
26. Does the chart meet Standard 5's A.1.j requirement?
27. Does the chart meet Standard 5's A.1.k requirement?
28. Does the chart meet Standard 5's A.2 requirement?
29. Does the chart meet Standard 5's B.1 requirement?
30. Does the chart meet Standard 5's B.2 requirement?
31. Does the chart meet Standard 5's B.3 requirement?
32. Does the chart meet Standard 5's C.1 requirement?
33. Does the chart meet Standard 5's C.2 requirement?
34. Does the chart meet Standard 5's D requirement?
35. Does the chart meet Standard 5's E requirement?
36. Does the document on pages 76-81 of the symposium workbook meet all elements of Standard 6's requirements?

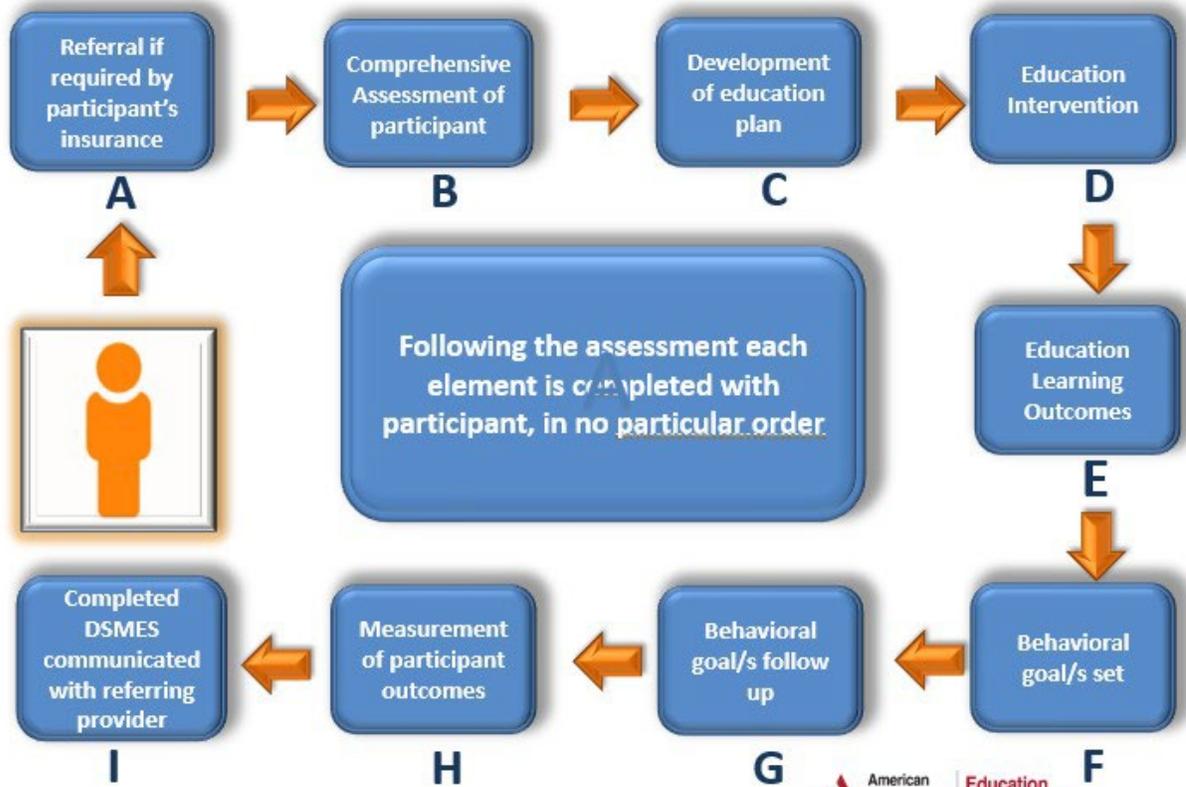
ERP Virtual Symposium Answers

Indicate Yes or No	Notes
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Initial Comprehensive DSMES Cycle—Standard 5



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Standard 5 DSMES Chart Review Form 11 th Edition	DSMES Cycle	Charts		
		Yes	No	Page this element is found on and notes
Provider referral if insurance requires one. Medicare requires a referral	A			
Participant assessment: on the 11 topics areas				
1. Clinical: Health history	B			
2. Cognitive: Functional health literacy and numeracy	B			
3. Ability to describe Diabetes Pathophysiology	B			
4. Ability to incorporate Healthy Eating into lifestyle	B			
5. Ability to incorporate Being Active into lifestyle	B			
6. Ability to Take Medications safely (if applicable)	B			
7. Ability to Monitor Glucose and other parameters, interpreting and using results	B			
8. Ability to prevent detect and treat Acute Complications	B			
9. Ability to prevent detect and treat Chronic Complications	B			
10. Ability adapt Lifestyle for Healthy Coping	B			
11. Ability to recognize Diabetes Distress and identify Support options.	B			
Education Plan based on participant concerns and assessed needs	C			
Summary of education intervention with date, content taught and instructor's name	D			
Education learning outcomes	E			
Participant selected behavioral goal set	F			
Participant selected behavioral goal follow up	G			
Clinical or Quality of Life outcome/s measured	H			
Documentation reflecting communication with referring provider or HCP outside of the DSMES service regarding education plan, or education provided and outcomes	I			
Audit ready Tip: Identify 5 completed DSMES charts per multisite at a minimum every 6 months or identify one chart every month.		11 th Edition – revised 02/2022		

Additional Notes:

Administrative Standards 1, 2, and 4

Standard 1: Support for DSMES Services

The Diabetes Self-Management Education and Support (DSMES) team will seek leadership support for implementation and sustainability of DSMES services.

Interpretive Guidance	Indicator	Yes	No
<p>1. Support can also be from expert stakeholders, who can provide purposeful input and advocacy to promote awareness, value, access, increase utilization, and quality.</p>	<p>1. The DSMES service will identify external service stakeholders and how each may provide purposeful input and/or advocacy.</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>2. This selection of external stakeholders will be reviewed/revised annually.</p>	<input type="checkbox"/>	<input type="checkbox"/>

Document for Standard 1

Name	Title	Role/Contributions to DSMES program
Stephan Jackson, AVP	AVP, Clinical Services	Provides leadership support & guidance
Sonya Bond MD	Director of Endocrinology	Medical director for DSMES program – works with educators to create protocols and provide clinical guidance and oversight
Robert Stuve	Director of Clinical Operations	Navigates centralized referral and scheduling processes
Barbara Hughes	Senior Manager, Endocrinology	Directly responsible for program operations and budget
Jana Dominguez	Diabetes Program Coordinator	Assess, plan and coordinate the clinical & clerical operations of the program. Responsible for recruitment/retention of the educator team. Maintains ADA Recognition and ensures compliance with the National Standards for DSMES.
Lana Bradley	Outcomes Specialist (IM/FM)	Provides guidance on establishing CQI and outcomes goals
Lucy Smithson	Outcomes Specialist (Endo)	Provides guidance on establishing CQI and outcomes goals
Kent Johnson	Application Specialist, Team Lead	IAS support for outcomes and CQI reporting

Reviewed February 2024

Standard 2: Population and Service Assessment

The DSMES service will evaluate their chosen target population to determine, develop, and enhance the resources, design, and delivery methods that align with the target population's needs and preferences.

Interpretive Guidance	Indicator	Yes	No
<p>A. <i>The DSMES service will identify their target population DSMES needs, preferences, and barriers and have a plan to address.</i></p>	Documentation exists that reflects annual assessment of:	<input type="checkbox"/>	<input type="checkbox"/>
	a) The demographics of the target population	<input type="checkbox"/>	<input type="checkbox"/>
	b) The target population's diabetes type	<input type="checkbox"/>	<input type="checkbox"/>
	c) The DSMES preferences and needs, and	<input type="checkbox"/>	<input type="checkbox"/>
	d) Target population's barriers to DSMES services.	<input type="checkbox"/>	<input type="checkbox"/>
<p>B. <i>The DSMES service will use resources and delivery methods that align with the target population's needs and preferences.</i></p>	<p>1. Documentation exists that reflects annual assessment of DSMES service resources relative to the target population.</p> <p><i>(e.g. physical space, staffing, scheduling, equipment, interpreter services, multi-language culturally relevant education materials, low literacy materials, large font education materials, mobile devices, upload devices and DSMES clinic portal accounts, virtual education equipment and platforms)</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>2. Annual documentation exists reflecting a plan to address any DSMES gaps to serve the target population.</p>	<input type="checkbox"/>	<input type="checkbox"/>

Standard 2 Target Population

Annual Assessment Review/Revision Date: January 26, 2024

Key: The % can be estimates rather than actual numbers. 0 = No 1= ~25% or less 2 = ~ 50% or less 3 =~>50%	DSMES Target Population Assessment
Race of Population	
American Indian or Alaskan Native	1
Asian/Chinese/Japanese/Korean/Pacific Islander	1
Black/African American	2
Hispanic/Chicano/Cuban/Mexican/Puerto Rican/Latino	1
White/Caucasian	2
Middle Eastern	1
Age of Population	
19 years or less	1
19-44 years	2
45 – 65 years	1
>65 years	1
Type of Diabetes	
Pre-Diabetes Age up to 19 years	0
Pre-Diabetes > 19 years	1
Type 1 Diabetes 0-18 years	1
Type 1 Diabetes >18 years	1
Type 2 Diabetes 0 – 18 years	1
Type 2 Diabetes > 18 years	2
Pregnancy with Pre-existing DM	1
Gestational Diabetes	2
Diabetes Treatments	
Oral Anti-Diabetes Medication	Yes
Insulin	Yes
Concentrated Insulin – U-500, U-300	Yes
Inhaled Insulin	Yes
Injectable Anti-Diabetes Medications other than Insulin	Yes
Insulin Pumps	Yes
CGM	Yes
Unique Needs of Population	
Hearing Impaired (Requiring Sign language)	Yes
Visual Impaired (Requiring Print augmentation)	Yes
Low Literacy Population	Yes
Physical Facility Needs (Classroom space, ramps, elevators, etc....)	Yes
Technical Savvy Participants	Yes
Insured	Yes
Uninsured	No
DSMES Barriers	
Transportation Barriers	Yes
Technology Barriers for Virtual Visits	Yes
Technology Barriers for sending Remote Data (Insulin pump data, BG meter data, CGM data)	Yes

Standard 2 document con't

Uninsured	Yes
Co Pay Barriers	No
Language Barrier (Requiring Interpreters)	Yes
Languages that require interpreter services:	
Spanish	
Arabic	
Russian	
Mandarin	
French	
Vietnamese	
Nepali	
American Sign Language	

Standard 2 document con't

Using the DSMES target population data assess the service's design and resources and develop a plan to serve any gaps identified.		
DSMES Locations	Service's current resources and assets	Plan to address identified needs
19 Locations in the surrounding Charlotte area	Scheduling teams attempt to schedule visits at location most convenient for patient.	No gaps identified
DSMES Hours	Service's current resources and	Plan to address identified
7:30 am to 5:00 pm Monday through Friday	Schedules at each location are dependent on registration desk hours at each space – meeting the scheduling needs of our patients.	No plans for weekend/ evening hours due to offices closed weekends/evenings.
Physical Space	Service's current resources and	Plan to address identified
Each location has private office for educator to use	All visits are completed in private office that can accommodate patient and at least one visitor with patient	No gaps identified
Staffing	Service's current resources and	Plan to address identified
Total of 11.4 FTE (11 RDN, 2 RN)	With all educator positions filled, we are meeting the scheduling needs of our patients	No gaps identified
Scheduling	Service's current resources and	Plan to address identified
Designated referral coordinators assigned to schedule initial visit from referral	Educators schedule their own follow-up visits with patients	No gaps identified
Equipment	Service's current resources and assets	Plan to address identified needs
All educators have desktop PC or laptop.	All locations provide printer access and have video camera for virtual visits.	No gaps identified
Interpreter Services	Service's current resources and assets	Plan to address identified needs
Video/phone interpreter available at all locations	All languages available	No gaps identified
Education Materials (Ed. Mat.) Languages	Service's current resources and assets	Plan to address identified needs
DSMES materials available in Spanish.	DSMES materials available on all content areas for Russian, French, Arabic, Chinese, Spanish, Nepali, and Vietnamese.	Continue to collaborate with the other Atrium diabetes programs and patient education committee to investigate additional options
Ed. Mat. - Cultural Designs	Service's current resources and assets	Plan to address identified needs
Portion Plates (ADA and NovoCare)	Team is interested in additional education on meal planning for various cultures (such as Asian Indian)	No gaps identified

Standard 2 document con't

Ed. Mat. - Low Literacy	Service's current resources and assets	Plan to address identified needs
	We have diabetes education materials approved by our Patient Education Committee for low literacy on all DSMES content areas.	No gaps identified
Ed. Mat. - Large Print	Service's current resources and assets	Plan to address identified needs
	PRIDE toolkit on the Atrium Patient Ed Sharepoint offers diabetes/nutrition information in larger print – however they likely need updating	Collaborate with Patient Ed committee and other Atrium diabetes programs to have resources updated or obtain new large print materials
Electronic Education Materials	Service's current resources and assets	Plan to address identified needs
	Many of our DSMES materials are available in PDF format and can be emailed to patient through EHR portal	No gaps identified
Ability to offer Virtual or Telehealth Services	Service's current resources and assets	Plan to address identified needs
	Virtual visits are available at all 19 locations if patient is in North Carolina	Unable to provide virtual visits to South Carolina patients due to state laws.
Remote monitoring resources and portal	Service's current resources and assets	Plan to address identified needs
	Our team can communicate with patients via health record message portal. We also have access to clinic accounts to monitor CGM and insulin pump devices if patient is set-up with this on mobile device.	No gaps identified

Standard 4: Delivery and Design of DSMES Services

DSMES services will utilize a curriculum to guide evidence-based content and delivery, to ensure consistency of teaching concepts, methods, and strategies within the team, and to serve as a resource for the team. Providers of DSMES will have knowledge of and be responsive to emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies relevant to the population they serve.

Interpretive Guidance	Indicator	Yes	No
A. A written curriculum guides evidence-based content and delivery of DSMES services.	An evidence-based curriculum with content, learning objectives, method of delivery and criteria for evaluating learning is in place and covers the following 9 topics.	<input type="checkbox"/>	<input type="checkbox"/>
	a) Diabetes pathophysiology	<input type="checkbox"/>	<input type="checkbox"/>
	b) Healthy eating	<input type="checkbox"/>	<input type="checkbox"/>
	c) Being active	<input type="checkbox"/>	<input type="checkbox"/>
	d) Taking medications – oral, injectable, insulin pump, inhaled	<input type="checkbox"/>	<input type="checkbox"/>
	e) Monitoring glucose	<input type="checkbox"/>	<input type="checkbox"/>
	f) Acute complications prevention, detection, and treatment including hypoglycemia, hyperglycemia, diabetes ketoacidosis, sick day guidelines and severe weather or situation crisis and diabetes supply management	<input type="checkbox"/>	<input type="checkbox"/>
	g) Chronic complications prevention, detection, and treatment including immunizations and preventative eye, foot, dental care, and renal screens and examinations as indicated per the individual's duration of diabetes and health status	<input type="checkbox"/>	<input type="checkbox"/>
	h) Lifestyle and healthy coping	<input type="checkbox"/>	<input type="checkbox"/>
	i) Diabetes distress and support	<input type="checkbox"/>	<input type="checkbox"/>
<i>Note: Problem solving is person centered and addressed within each topic area when appropriate.</i>			
B. There is evidence that the teaching approach is interactive, patient centered, and incorporates problem solving.	The curriculum or other supporting documents are tailored/individualized and involves interaction and problem solving.	<input type="checkbox"/>	<input type="checkbox"/>
C. The curriculum and/or supporting materials are reviewed/revised to ensure they align with current evidence.	There is documentation reflecting at least annual review/revision of the curriculum and/or supporting materials by the DSMES team and/or the DSMES service stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>
D. For services outside of the scope of practice of the DSMES team or services, the DSMES team should document communication with referring providers and/or other qualified healthcare professionals to support person -centered care.	There must be documentation reflecting a procedure for meeting participants' needs when they are outside the scope of practice of the DSMES team or service.	<input type="checkbox"/>	<input type="checkbox"/>

Standard 4 document

Diabetes Distress and Support

Purpose: To provide information about diabetes distress, identifying diabetes distress, and finding support to manage this.

Objectives: At the end of the session (s), the participant will be able to:

1. Define diabetes distress
2. Differentiate between diabetes distress and depression
3. List the potential impacts of diabetes distress on physical and emotional health
4. Identify signs of diabetes distress
5. Identify options to assess one's own personal level of diabetes distress
6. Identify resources for finding support to manage diabetes distress
7. List at least three strategies to help reduce diabetes distress

Method of instruction:

Discussion

Handouts

Question & answer

Content:

1. What is diabetes distress?
2. Signs of diabetes distress
3. Physical and emotional symptoms of excessive stress
4. Depression
5. How the body responds to stress and effects on blood glucose
6. How diabetes distress may affect physical health and/or emotional well-being
7. How to identify diabetes distress
8. Coping
9. Finding Support
10. Examples of healthy coping and stress management
11. Support
 - a. Diabetes Distress Assessment and Resource Center
www.diabetesdistress.orgDiabetes Distress
 - b. Professional.diabetes.org/meetings/mentalhealthworkbook
Behavioral Diabetes Institute
 - c. www.behavioraldiabetes.org
Diabetes Sisters
 - d. www.diabetessisters.org

Methods of evaluation:

Responses to questions asked by instructors

Questions asked by participants

Participation in discussions or group activities

Self-reporting to educator of diabetes distress (feelings, assessment, support) Assessment of progress towards behavioral goals (if set in this topic area)

Standard 3: DSMES Team

All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement. At least one team member will be identified as the DSMES quality coordinator and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes. Other members of the DSMES team must have proper qualifications to provide DSMES services.

Interpretive Guidance	Indicator	Yes	No
A. The DSMES service has a designated coordinator who oversees the planning, implementation, and evaluation of the service at all sites.	There is documentation of one quality coordinator as evidenced by a position description or performance appraisal tool.	<input type="checkbox"/>	<input type="checkbox"/>
B. The DSMES team includes one or more healthcare professional with current credentials: Registered Nurse (RN), Registered Dietitian Nutritionist (RDN), pharmacist, Board Certified Advanced Diabetes Management professional (BC-ADM®), or Certified Diabetes Care and Education Specialist (CDCES®).	1. At least one DSMES team member is a RN or RDN, or pharmacist or BC-ADM®, or CDCES®.	<input type="checkbox"/>	<input type="checkbox"/>
	2. All healthcare professional DSMES team members must have current licensures and/or registration	<input type="checkbox"/>	<input type="checkbox"/>
C. Professional team members must demonstrate mastery of diabetes knowledge and training.	Professional team members must demonstrate ongoing training in DSMES topics per the CBDCE examination content areas. a) BC-ADM® and CDCES® team member credentials must be current.	<input type="checkbox"/>	<input type="checkbox"/>
	b) Non-BC-ADM® or non CDCES® professional team members must have documentation reflecting 15 hours of continuing education (CE) from the Certification Board for Diabetes Care and Education (CBDCE) approved CE providers annually per the DSMES service's anniversary month.	<input type="checkbox"/>	<input type="checkbox"/>

Interpretive Guidance	Indicator	Yes	No
	c) Non-BC-ADM® or non CDCES® professional team members who do not have 15 hours CE within the 12 months prior to joining the DSMES team must accrue the 15 hours of CE within the first four months of joining the DSMES service as a professional team member.	<input type="checkbox"/>	<input type="checkbox"/>
D. <i>Diabetes Community Care Coordinators (DCCC), previously referred to as paraprofessionals, must be qualified and provide diabetes care and education within their scope of practice and training.</i>	1. DCCC team members must have evidence of previous experience or training in: diabetes, chronic disease, health and wellness, healthcare, community health, community support, and/or education methods as evidenced by a resume or certificate. (e.g., community health worker, health promotor, pharmacy, lab or diet technician, medical assistant, peer education, trained peer leader)	<input type="checkbox"/>	<input type="checkbox"/>
	2. DCCC team members must have supervision by a professional DSMES team member. Supervision can be demonstrated by a position description or performance appraisal tool.	<input type="checkbox"/>	<input type="checkbox"/>
	3. DCCC team members must have documentation reflecting competency and 15 hours of training prior to providing DSMES services and annually per the DSMES service's anniversary month. (e.g., documented in-service training, medication or device training, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATE OF RECOGNITION

The American Diabetes Association
recognizes the education service of

Diabetes on the Go Center

Diabetes Self-Management Education Services

Charlotte, NC

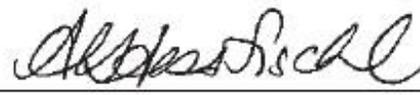
AS MEETING THE NATIONAL STANDARDS FOR DIABETES
SELF-MANAGEMENT EDUCATION

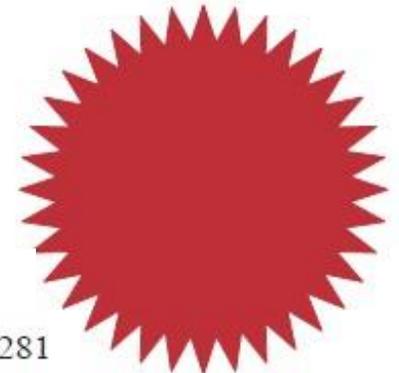
AWARDED FOR THE PERIOD OF

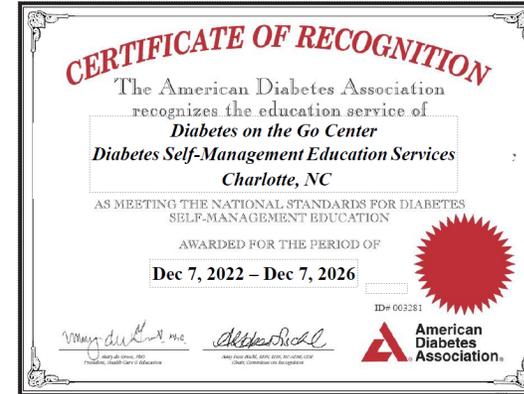
Dec 7, 2022 – Dec 7, 2026

ID# 003281


Mary de Groot, PhD
President, Health Care & Education


Amy Hess Hsieh, RDN, LDN, BC-ADM, CDE
Chair, Committee on Recognition





Standard 3:

- Professional team member's credentials **must be always current**
- Professional team members who are not CDCES or BC-ADM must earn 15 hours of CEUS annually per their service's anniversary year. Diabetes community care coordinators (DCCCs), formerly known as paraprofessional team members, must earn 15 hours of training and documentation reflecting they are competent in the topics they teach before they can teach and annually per their service's anniversary year. When auditors look at CEUs or training hours for the current year, they will need to see 15 hours from the **immediate previous anniversary year as team members still have time to complete for current anniversary year. In this case CEUs will need to be for anniversary year Dec 7, 2023- Dec 7, 202 (immediate past anniversary year).**

Job Description: **Coordinator/Diabetes Program**

7/22/2018

Job Description:

Assesses, plans and coordinates the clinical and clerical operations and functions of the Diabetes Center. Oversees day-to-day operations of the OSME at all sites and ensures that the National Standards (NSDME) are met and maintained at all times. Promotes a safe environment and performs all related Job responsibilities in a safe manner. Maintains clinical and professional competency as appropriate to the age, developmental stages, and special needs of the patients served.

Essential Functions

- Assesses, plans and coordinates the clinical and clerical operations and functions of the Diabetes Center to ensure quality, cost effective healthcare is provided by an educated and qualified staff.
- Ensures that Diabetes Center operations and teammates are in compliance with the National Standards (NSDME), Nursing Practice Act, Dietitian Licensure Act, regulatory agency standards, and policies and procedures as defined by Medical Center Department of Ambulatory Services.
- Organizes and coordinates all the activities of the Advisory Group, and serves as a liaison between the Advisory Group, other departments, and administration to provide for a smooth, efficient operation.
- Maintains ADA recognition and participates in the evaluation of the program's effectiveness.
- Maintains responsibility and accountability for total quality of care provided at the Diabetes Center and also, functions as a primary Instructor.
- Assumes responsibility in the recruitment and retention of qualified personnel. Conducts staff meetings at regular intervals to exchange information and to promote dialogue.
- Coordinates the collection, analysis, and presentation of clinical statistical data.
- Demonstrates knowledge of diabetes management and educational principles. Allocates resources to meet area needs and to achieve goals.
- Collaborates with the staff, the Medical Director, the CDC Advisory Board, and Administrative Manager to fulfill the goals and mission of the Center.

Education, Experience and Certifications

Current licensure to practice as a RN required. Registered Dietitian in the state of NC preferred. BSN required. 2 years' experience preferred. Completion of a minimum of 24 hours of education in diabetes management, including educational principles and psychosocial assessments. Certification by the National Certification Board of Diabetes Educators required. Previous management experience preferred. Basic Life Support for Healthcare Provider (BLS HCP) from AHA required.

Patient Population Served

Demonstrates knowledge of the principles of growth and development and demonstrates the skills and competency appropriate to the ages, culture, developmental stages, and special needs of the patient population served.

Physical Requirements

This position requires walking, sitting, standing, reaching, bending, pushing and pulling. Must be able to lift and support the weight of 35 pounds. Must have Intact sense of sight, hearing, smell, touch, and finger dexterity.

Protected Health Information

- Will limit **access** to protected health information (PHI) to the information reasonably necessary to do the job.
- Will share information only on a need-to-know basis for work purposes.
- Access to verbal, written and electronic PHI for this job has been determined based on Job level and job responsibility within the organization. Computerized access to PHI for this job has been determined as described above and is controlled via user ID and password.

Machines, Tools, and Equipment

Audiovisual equipment and supplies. Medical and surgical equipment instruments and supplies. Education/training reference materials. Patient medical records.

Approval

Name: _____ Title: _____ Date: 9/18/2018

The above statements are intended to describe the general nature and level of work being performed by people assigned this Job classification. They are not to be construed as an all-inclusive list of all duties, skills and, responsibilities of people so assigned.



Commission on Dietetic Registration

the credentialing agency for the
Academy of Nutrition and Dietetics



CDR certifies that
Mary S Edwards
has successfully completed
requirements for dietetic registration.

PDF Copy

Signature

Registration I.D. Number

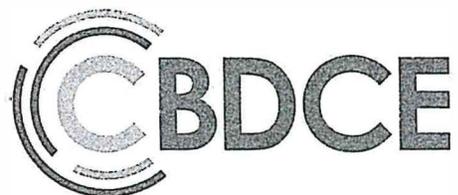
0073010

Registration Payment Period
9/01/23 - 8/31/25

Registered Dietitian (RD)
Registered Dietitian
Nutritionist (RDN)

 Rosa Hand,
PhD, RDN, LD, FAND
Chair, Commission on Dietetic Registration

Certification Board for Diabetes Care and Education



hereby certifies that

Mary Edwards

has met the requirements for board certification and merits the designation of

Certified Diabetes Care and Education Specialist

Certification valid through December 31, 2025

Certificate No. 00000703

Examination Date: July 3, 2019



Chair 

View Report

Primary Source Board of Nursing Report Summary for

Paula Rivera

Tuesday, October 17 2023 10:00:45 AM

For a more accurate search, select [Search by License Number](#) or [Search by NCSBN ID](#) above. Partial name searches are accepted.

This report is not sufficient when applying to another board of nursing for licensure. Use the [Nurse License Verification](#) service to request the required verification of licensure.

[Contact the board of nursing](#) for details about the Nurse Practice Act.

Board of Nursing - Temporary and Permanent (Post Exam) Licenses

Name on License	Board of Nursing - License Type	License Number	License Status	Original Issue Date	Current Expiration Date	Compact Status
RIVERA, PAULA	RN	1111111	Active	07/11/2000	07/30/2024	Multistate

Board of Nursing - Grad Permits (Pre Exam)

Name on License	Board of Nursing - License Type	License Number	License Status	Original Issue Date	Current Expiration Date	Compact Status
RIVERA, PAULA	RN	20000000	Lapsed	08/21/2008	02/17/2009	N/A

Primary Source Board of Nursing Messages & Notifications

- This Provisional License is issued until the applicant meets all of the licensure requirements for a permanent license.

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information



NC AHEC CONTINUING PROFESSIONAL DEVELOPMENT

Continuing professional development events and credits in this section have been verified by the North Carolina AHEC Program. The following CPD events have been designated for the listed credits. Please allow 5 days for events to appear unless instructed otherwise by an NC AHEC representative. (Note: Some NC AHEC CPD events prior to 2006 may not be included in the NC AHEC database. Session name is omitted where identical to Event name.)

Event: 36th Annual Diabetes Conference: Reducing the Burden and Living Well with Diabetes
Session: LIVE WEBINAR - 36th Annual Diabetes Conference: Reducing the Burden and Living Well with Diabetes
Location: Concord, North Carolina
Date: Apr 19, 2024
Presenter(s): Zeleka Benton, Kelly Desmond, Jeffrey Ellison, Emily Gwynn, Tamara Hawkins, Caroline McDaniel, Donald Nuzum, Shawn Taylor
Credit: 6.00 ACPE
0.60 CEU (1 CEU = 10 Contact Hours)
6.00 Contact Hours
6.00 CPEUs
6.00 Nursing Contact Hours

NC AHEC CREDIT TOTALS

6 ACPE
0.6 CEU (1 CEU = 10 Contact Hours)
6 CPEUs
6 Contact Hours
6 Nursing Contact Hours

Statement of Credit

Name: Paula Rivera License #: _____ State of License: _____

Has completed the requirements to receive continuing education credit for the program entitled:

Putting Continuous Glucose Monitoring

Enduring Material

9/7/2024



JOINTLY ACCREDITED PROVIDER
INTERPROFESSIONAL CONTINUING EDUCATION

In support of improving patient care, the Association of Diabetes Care & Education Specialists is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC) to provide continuing education for the healthcare team

Accreditation Council for Pharmacy Education

The Universal Activity Number is JA4008258-0000-24-018-H01-P. This application -based activity has been approved for 12.000 contact hour(s). This statement contains information provided to NABP from the Accreditation Council for Pharmacy Education (ACPE) via CPE Monitor®. ACPE policy states paper and/or electronic statements of credit may no longer be distributed directly to learners as proof of ACPE credit. The official record of credit may be located in the learner's e-profile in CPE Monitor.

American Medical Association (AMA)

Association of Diabetes Care & Education Specialists designates this activity for a maximum of 12.000 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

American Nurses Credentialing Center (ANCC)

Association of Diabetes Care & Education Specialists designates this activity for a maximum of 12.000 ANCC contact hours. This activity discusses 0 contact hours of pharmacotherapeutic content.

The Association of Diabetes Care & Education Specialists is approved by the California Board of Registered Nursing, Provider Number 10977, for 12.000 contact hours. RNs must retain this document for 4 years after the activity concludes.



The Association of Diabetes Care & Education Specialists has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for 12.000 AAPA Category 1 CME credits. PAs should only claim credit commensurate with the extent of their participation.

Commission on Dietetic Registration

the credentialing agency for the
Academy of Nutrition and Dietetics

Commission on Dietetic Registration (CDR): CDR Credentialed Practitioners will receive 12.000 Continuing Professional Education units (CPEUs) for completion of this activity. Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU). If the activity is dietetics-related but not targeted to RDs or DTRs, CPEUs may be claimed which are commensurate with participation in contact hours (One 60 minute hour = 1 CPEU). RDs and DTRs are to select activity type 102 in their Activity Log. Sphere and Competency selection is at the learner's discretion.

As a Jointly Accredited Organization, the Association of Diabetes Care & Education Specialists is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The Association of Diabetes Care & Education Specialists maintains responsibility for this course. Social workers completing this course receive 12.000 continuing education credits.



Certified Diabetes Care and Education Specialists: To satisfy the requirements for renewal of certification for the Certification Board for Diabetes Care and Education (CBDCE), continuing education activities must be diabetes related and approved by a provider on the CBDCE list of Approved Providers (<http://www.cbdce.org>). CBDCE does not approve continuing education. The Association of Diabetes Care & Education Specialists is on the CBDCE list of Approved Providers.

Other Health Professionals: It is the responsibility of each participant to determine if the program meets the criteria for re-licensure or recertification for their discipline.

Paulina N. Duker, MPH, BSN, RN, CDCES
Vice President of Practice and Learning, ADCES

9/7/2024

RD state license:



NORTH CAROLINA
BOARD OF DIETETICS/NUTRITION

License Verification

Name:	Kelsey Smith	License Number: ABABCD
License Status:	Active	License Type: Licensed Dietitian/ Nutritionist
Issue Date:	10/12/2023	Confirmation #: ZZMIKLM7
Expire Date:	03/31/2025	Date of Verification: 00/00/2024
Discipline:	No Discipline	

Academy of Nutrition and Dietetics(AND) Membership card:

Academy of Nutrition and Dietetics

MEMBERSHIP CARD FOR:
Kelsey Smith

Membership year June1, 2023-May 31, 2024

Category ACRIVE Member # 000025

Your Signature *KELSEY SMITH*

Donna S. Martin, Eds, RD, LD, SNS Treasurer

CERTIFICATE OF COMPLETION

Women's Health Program

March 20, 2024

CPEUs: 2.00 CDR
Date: March 20, 2024
Activity ID: xxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

**Commission on
Dietetic Registration**
the credentialing agency for the
right. Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).
If the activity is dietetics-related but not targeted to RDs or DTRs, CPEUs may be claimed which are commensurate with participation in contact hours (One 60 minute hour = 1 CPEU).
RD's and DTRs are to select activity type 102 in their Activity Log. Sphere and Competency selection is at the learner's discretion.

To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved Providers.

CERTIFICATE OF COMPLETION

Diabetes is Primary (DIP) CE Certificate Program 2023

November 30, 2023

CPEUs: 9.25 CDR

Date: November 30, 2023

Activity ID:

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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RD's and DTRs are to select activity type 102 in their Activity Log. Sphere and Competency selection is at the learner's discretion.

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CERTIFICATE OF COMPLETION

Analyzing Data from Insulin Delivery Systems and Integrating the Information

March 22, 2024

CPEUs: 0.50 CDR

Date: March 22, 2024

Activity ID: xxx

Presented to:

Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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CERTIFICATE OF COMPLETION

Continuous Glucose Monitoring Technology : The Implantable and Wearable

March 21, 2024

CPEUs: 0.50 CDR
Date: March 21, 2024
Activity ID: xxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved Providers.

CERTIFICATE OF COMPLETION

Gathering the Data

March 22, 2024

CPEUs: 0.50 CDR

Date: March 22, 2024

Activity ID:

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved Providers.

CERTIFICATE OF COMPLETION

How Continuous Glucose Monitoring Can Improve Patient Outcomes

March 21, 2024

CPEUs: 0.50 CDR
Date: March 21, 2024
Activity ID: xxxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

**Commission on
Dietetic Registration**

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

If the activity is dietetics-related but not targeted to RDs or DTRs, CPEUs may be claimed which are commensurate with participation in contact hours (One 60 minute hour = 1 CPEU).

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To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved Providers.

CERTIFICATE OF COMPLETION

Maximizing Continuous Glucose Monitoring Utilization in Your Practice

March 21, 2024

CPEUs: 0.50 CDR
Date: March 21, 2024
Activity ID: xxxx

Presented to:
Ketsy Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the accrediting agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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CERTIFICATE OF COMPLETION

Setting up a CGM-Friendly Clinical Practice

March 21, 2024

CPEUs: 0.50 CDR
Date: March 21, 2024
Activity ID: xxxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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To satisfy the requirement for renewal of certification by continuing education for the National Certification Board for Diabetes Educators (NCBDE), continuing education activities must be diabetes related and approved by a provider on the NCBDE List of Approved Providers (www.ncbde.org). NCBDE does not approve continuing education. The American Diabetes Association is on the NCBDE List of Approved Providers.

CERTIFICATE OF COMPLETION

The Burden of Hypoglycemia

March 22, 2024

CPEUs: 0.50 CDR
Date: March 22, 2024
Activity ID: xxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

If the activity is dietetics-related but not targeted to RDs or DTRs, CPEUs may be claimed which are commensurate with participation in contact hours (One 60 minute hour = 1 CPEU).

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CERTIFICATE OF COMPLETION

Using CGM and Ambulatory Glucose Profile Data to Optimize Care

March 22, 2024

CPEUs: 0.50 CDR
Date: March 22, 2024
Activity ID: xxx

Presented to:
Kelsey Smith



Robert Gabbay MD, PhD
Chief Scientific and Medical Officer

Commission on Dietetic Registration

 the credentialing agency for the
Academy of Nutrition and Dietetics

Completion of this RD/DTR profession-specific or IPCE activity awards CPEUs (One IPCE credit = One CPEU).

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Certificate of
Diabetes Distress Management
and Emotional Wellness

Coach
Jamie Wahl

Completed 15 hours of Diabetes Emotional Health
Wellness and Diabetes Distress Management
Coaching Training

Completion Date: February 24th, 2014

123certificates

Diabetes Community Care Coordinators (DCCC) Jamie Wahl Annual Training

- DCCC team members require 15 hours of training each DSMES service recognition year or the previous 12 months prior to a service's new or renewal application.
- DCCC team members require annual documentation reflecting competency in the areas of DSMES they teach.
- DSMES services must have documentation reflecting DCCC's experience prior to joining the Service.
- DCCCs cannot perform the participant assessment or establish the education plans.
- DCCCs should be trained to defer questions outside of their scope, documented competency, or all clinical questions back to a professional team member.
- The professional team member does not have to be present for the DCCC to teach within their scope of practice per their annual documented training
- DCCC team members do not determine if a DSMES service is a single discipline or multi-discipline service

DSMES Service Recognition Year: 12/7/2023 to 12/7/2024

Date	Training Topic, Method, and Provider	Hours	DSMES Category C= Competent
01.01.2022 <i>Example</i>	<i>Sweet BG Meter Rep provided training on their meters that our DSMES service participants use. Training included meter set up (time, date, participants BG parameters), using the meters, and uploading the meters and meter reports. The Sweet BG Meters reviewed were: (list meters).</i>	2.5 hrs.	5 C <i>Competency noted as team member presented back all tasks.</i>
03/02/2024	Diabetes education 101	3	C.1.6.7 knowledge on different types of diabetes and risk factors
03/25/2024	Community Health Worker Diabetes Education Program	4	C .1.8 Knowledge on different types of diabetes, signs and symptoms of depression, anxiety and diabetes distress
08/12/2024	Exploring Mental Health and Diabetes Through Case Studies	4	C .8 Knowledge to work with people from a variety of cultures
09/01/2024	Seated Yoga positions for Destressing	2	C.3.9 Knowledge of physical activity and stress relief
10/23/2024	Understand unconscious bias in DSMES	1	C.8 Knowledge of unconscious bias

DCCC DSMES Training Category Key

- 1 – Diabetes Pathophysiology
- 2 – Healthy Eating
- 3 – Being Active
- 4 – Taking Medications
- 5 – Monitoring Glucose

- 6 – Acute Complications
- 7 – Chronic Complications
- 8 – Lifestyle and healthy coping
- 9 – Diabetes distress and support

Signature and date indicating that the supervising team member attests to the above training and competencies:

Mary Edwards

12/01/2024

Referring Provider: Ann



QuickConfirm License Verification Report

Name on License	Type	License State	License	Active	License Status	License Original Issue Date	License Expiration Date	Compact Status
BROWN, ANN	RN	NORTH CAROLINA	321123	YES	UNENCUMBERED	04/13/1987	01/31/2027	MULTISTATE

Name on License	Type	License State	License	Active	License Status	License Original Issue Date	License Expiration Date	Compact Status
BROWN, ANN	CERTIFIED NURSE PRACTITIONER	NORTH CAROLINA	1234231	YES	UNENCUMBERED	07/14/2019	01/31/2026	N/A
Advanced Practice license/recognition information <ul style="list-style-type: none">• Focus/Specialty: Pediatrics• Prescription authority: YES• Certification expiration date: 02/28/2026• Focus/Specialty expiration date: NOT SUPPLIED								

Ann Brown's CEUS for 2024			
1/11/2024	Making Diabetes Technology Work	ADA	7
1/18/2024	Unraveling Challenging Type 2 Diabetes Cases	ADA	2
1/24/2024	Women's Health:Gestational Diabetes	ADA	2
1/25/2024	Standards of Care in Diabetes 2024-Update for Early Career Professionals	ADA	1
1/25/2024	Diabetes and Weight Management Part 2	ADA	1
1/26/2024	Words Matter: Leveraging the Power of Communication in Clinical Visits	ADA	1
1/26/2024	Diabetes Technology and Nutrition: Getting the Conversation Started	ADA	1
1/31/2024	Nutrition for Diabetes - Unlocking the Potential for Better Management		1
2/1/2024	The Pivotal Shift: Weight Management and Type 2 Diabetes	ADA	1
2/6/2024	Optimizing AID Systems: CASE- Based Strategies for Individualization	ADA	1
			18

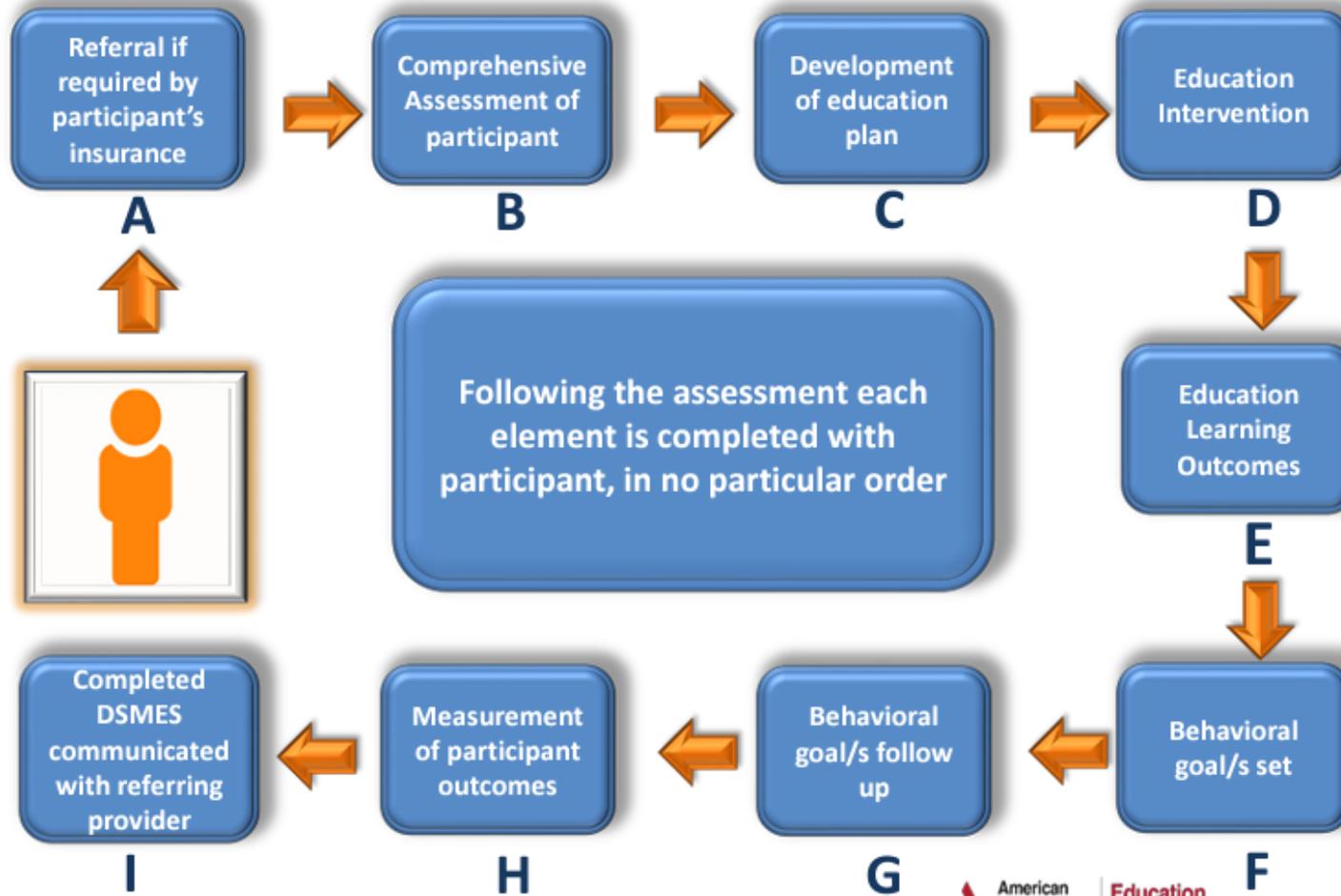
Standard 5: Person-Centered DSMES

Person-centered DSMES is a recurring process over the life span for a PWD. Each person's DSMES plan will be unique, based on their concerns, needs, and priorities collaboratively determined as part of a DSMES assessment. The DSMES team will monitor and communicate the outcomes of the DSMES services to the diabetes care team and/or referring provider.

Review Criteria	Indicator	Indicate Findings		
<p><i>A. Participants receive a comprehensive assessment that includes baseline diabetes self-management knowledge, skills, and readiness for behavioral change.</i></p>	1. An assessment of the participant is performed in the following areas to develop the person centered DSMES plan.			
	a. Diabetes pathophysiology and treatment options	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	b. Healthy eating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	c. Being active	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	d. Taking medications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	e. Monitoring glucose	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	f. Acute complications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	g. Chronic complications	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	h. Lifestyle and healthy coping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	i. Diabetes distress and support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	j. Clinical history (diabetes and other pertinent clinical history)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	k. Health literacy (ability to understand and interpret) <i>(e.g. glucose targets, A1C target, carb awareness, carb counting, carb choices etc.)</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	2. Parts of the initial assessment may be deferred if applicable and the rationale for deferment is documented.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Interpretive Guidance	Indicator	Yes	No
<p><i>B. Each DSMES participant has a person centered DSMS plan with outcomes measured</i></p>	<p>1. Participant's DSMES plan is documented in the medical record.</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>2. Each DSMES session is documented in the medical record.</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>3. The outcome evaluation of the DSMES is documented for the topic areas covered during each session.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>C. Each participant will develop an action oriented behavioral change plan to reach their personal behavioral goal/s.</i></p>	<p>1. DSMES participants will develop at least one action oriented behavioral change goal.</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>2. The outcome of the behavioral change goal/s will be measured and documented. The outcome measurement timing will vary based on the individual and the outcome to be measured.</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>D. Clinical outcome measures reflect the impact of the DSMES services on the health status of the participant.</i></p>	<p>The DSMES service will determine at least one participant clinical, or quality of life outcome and it will be measured at baseline and post DSMES for each participant. The outcome assessment timing will vary based on the individual and the outcome to be measured.</p> <p><i>(e.g. clinical, quality of life, hospital days, ER visits, baby weight, C-section delivery rates, DKA, A1C, missed school work or school days etc.).</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p><i>E. The DSMES team will monitor and communicate the outcomes of the DSMES services to the participant's diabetes care team.</i></p>	<p>There is evidence that the DSMES planned or provided, and outcomes will be communicated to the referring provider and/or other members outside of the DSMES service of the participant's diabetes care team.</p> <p><i>Note: The outcomes may include one or more of the following: education, behavioral goal/s, and/or other outcome/s.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>

Initial Comprehensive DSMES Cycle–Standard 5



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03/13/2024 -

Other Orders

Outpatient Referral

Ambulatory referral to Diabetic Education (Active)

Electronically signed by: Thomas [redacted] MD on 03/13/24 1717

Status: Active

Ordering user: Thomas [redacted] MD 03/13/24 1717

Ordering provider: Thomas [redacted] MD

Authorized by: Thomas [redacted] MD

Ordering mode: Standard

Frequency: Routine 03/13/24 -

Class: Internal Referral

Quantity: 1

Diagnoses

New onset type 2 diabetes mellitus (CMD) [E11.9]

Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMD) [E11.65]

Questionnaire

Question	Answer
Type of training services requested? Select one	Initial DSME (Diabetes Self Management) Training 10 hours in 1st year of training
Does patient need MNT?	No
Additional Services Requested:	None
All 9 DSME content to be covered	Yes
Please indicate any barriers to group learning that necessitate individual follow up for DSME (select all that apply)	No group session within 2 months of order

Referral Details

Referred By	Diagnoses	Referred To	Type	Priority
Thomas [redacted] MD [redacted] [redacted] NC [redacted] Phone [redacted] Fax [redacted]	New onset type 2 diabetes mellitus (CMD) Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMD) Order: Ambulatory Referral To Diabetic Education Reason: Diabetes Education	[redacted] Birk [redacted] NC [redacted] Fax [redacted] Specialty: Diabetes Services	ANCILLARY REFERRAL	Stat

Indications

New onset type 2 diabetes mellitus (CMS/HCC) [E11.9 (ICD-10-CM)]

Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMS/HCC) [E11.65 (ICD-10-CM)]

Ⓐ Referral

Diagnoses

	Codes	Comments
New onset type 2 diabetes mellitus (CMS/HCC)	E11.9	
Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMS/HCC)	E11.65	

Reason for Visit

Reason for Visit History

Vitals

Smoking Status
Former

Progress Notes

Progress Notes by [REDACTED] RD at 3/25/2024 10:30 AM

Author: [REDACTED] RD Author Type: Registered Dietitian Filed: 3/25/2024 11:57 AM
Note Status: Signed Cosign: Cosign Not Required Encounter Date: 3/25/2024
Editor: [REDACTED] RD (Registered Dietitian)

Diabetes Education

Visit Type: Initial Follow Up
Visit Duration: 60 mins

Referral Date: 3/13/24
Referring Provider: Dr. [REDACTED]
Diabetes Diagnosis: Type 2
Diabetes Duration: New onset
This visit was conducted as a: Visit Type: Office visit

(B) Assessment

New onset T2DM with A1c 11.4% TG 2618
Patient shares he owns his own business, has been traveling quite a bit. No known family history of diabetes. In recent weeks he has started to reduce carbs. Avoids red meat, eating more fish. Stays fairly active when not traveling. Wife attended session today for support.

Diabetes Medications: Metformin 500 mg BID

Monitoring: Rx for Contour Next sent to pharmacy

Physical Activity: tennis, bike, golf 2 x week - more active in warmer months

Eating Patterns: 3 meals + snacks. Dines out when traveling

Food Recall:

Breakfast: Tends to fast until lunch - drinks water

Lunch: Jersey Mike's Mini sub + chips
Chipotle bowl w/ rice & beans

(B) Assessment

Dinner: Chicken soup - black bean, corn mix

Snack: banana, berries. Shake with Greek yogurt w/ berries, whey powder

Beverages: (1-2) Diet coke, lots of water,

Alcohol: 2 x week - social

Food Allergies: none reported

Food Intolerances: none

Other food restrictions (cultural/religious): none

Food Insecurity: No Food Insecurity (3/12/2024)

Hunger Vital Sign

- Worried About Running Out of Food in the Last Year: Never true
- Ran Out of Food in the Last Year: Never true

Risk Reduction:

Eye Exam: due

Foot Exam: due

Nephropathy Screening: due

Dental Exam: due

DSME quickpick:

Diabetes - Patient Level

Diabetes type: Type 2

Patient has received previous education on Diabetes Self Management: No

Patient's feeling toward having diabetes: Other (concerned)

Patient identifies the hardest part of caring for diabetes as: knowing what to eat

How do you rate your stress level: High

Patient handles stress associated with diabetes by: Stress management plan

Patient identifies the following members as their support system: Family, Spouse/Significant other

How does the patient rate their health: 4 (Good other than diabetes)

Medic alert ID: No

Objective:

Wt Readings from Last 3 Encounters:

03/13/24 80.6 kg (177 lb 12.8 oz)

03/12/24 80.5 kg (177 lb 6.4 oz)

02/23/21 88.9 kg (196 lb)

Lab Results

Component	Value	Date
HGBA1C	11.4 (H)	03/12/2024

Lab results related to diabetes have been reviewed.

Education Topics Discussed Today:

(D) Education Intervention

1. Diabetes Pathophysiology: explained insulin resistance and insulin deficiency and relationship to elevated glucose levels. Risk factors
2. Nutrition Recommendations: Identified CHO dense foods to limit. Reviewed methods of CHO

① Education Intervention

counting using food labels and measuring cups. Suggest low end of carbohydrates for next 2-3 weeks = 30 grams per meal and 10-15 grams per snack. May slowly increase carbs once more active - limit 60 grams per meal, 20 g per snack in near future. Provided MET diet shopping list with lower carbohydrate food products to choose. Avoid added sugar, white rice, white flour carbs, fast foods, red meat and excessive alcohol.

3. Physical Activity: Reviewed effects of exercise on BG control and stress management. Encouraged daily exercise 30 mins
4. Medications: MOA of current diabetes medications.
5. Monitoring: Recommended check 1-2 times daily: Discussed BG and A1c targets per ADA. Rx for Contour Next meter sent to pharmacy
6. Hyperglycemia: Symptoms, prevention and management. Discussed when to contact provider.
7. Hypoglycemia: symptoms, prevention and treatment
8. Chronic Complications & Risk Reduction: reviewed effects of stress and illness on BG control.
9. Healthy Coping
10. Diabetes Support: attend diabetes education

Plan:

Follow-up scheduled in May

② Education Plan

Education Topics to Discuss During Next Visit: reviewed meal plan, complications/risk reduction

Patient verbalized understanding of goals discussed here today. Thank you for using our services.

③ goals set

Activity Goals Does the patient have a goal of being active: 1 Goal, 1st Activity Goal: engage in 30 mins active movement daily

Monitoring Goals Does the patient have a goal of monitoring: 1 Goal, 1st Monitoring Goal: spot check BG fasting and two hour after main meal, Behavioral Outcome Objective: Nutritional management

Support Plan Support Plan(s): Regular doctor visits; Attend diabetes education

This visit was conducted as a: Appointment Type: an individual appointment. individual Appts: No class appropriate for patient at this time.

DSME Learning

Patient has received previous education on Diabetes Self Management: No

Patient identifies that they learn best through: Listening; Reading

Language Preferred: English

Topics of Knowledge Assessment

Pathophysiology: Needs reinforcement

Healthy Eating: Needs reinforcement

Being Active: Needs reinforcement

Taking Medications: Needs reinforcement

Home glucose monitoring: Needs reinforcement

Lifestyle & Healthy Coping: Needs reinforcement

Diabetes Distress & Support: Needs reinforcement

Post education self-management support (ie. support groups, community programs, PCP follow up): Yes

Patient has completed comprehensive DSME group class series. All topics of education covered in group class series: No

Acute Complications: Needs reinforcement

Chronic Complications: Needs reinforcement

④ Assessment of Topics

Education Materials Provided: Living with Diabetes – Adults; A1c Chart

Education Given

Diabetes pathophysiology: Yes

Specific Topic: Type of diabetes

Acute Complications/Problem Solving: Yes

Topic: Hypoglycemia prevention, detection & treatment,; Hyperglycemia prevention, detection &

⑤ Education Intervention

① Education Intervention

treatment,
 Lifestyle & Healthy Coping: Yes
 Topic: Stress management & emotional well-being tools
 Healthy Eating: Yes
 Topic: Carb counting; Carb food sources; Food labels; Portion Sizes
 Being Active: Yes
 Topic: Impact of physical activity on glucose levels
 Taking Medications: Yes
 Topic: Mechanism of action; Orals
 Monitoring Glucose: Yes
 Topic: Use of glucometer
 Diabetes Distress and Support: Yes
 Topic: Managing Stress
 Chronic Complications: Yes
 Topic: Know your numbers (A1c, blood pressure, cholesterol)

✎ Medications Ordered This Encounter

	Disp	Refills	Start	End
blood-glucose meter (Contour Next Meter) misc Use daily to check blood sugr Dx E11.9	1 each	0	3/25/2024	—
glucose blood (Contour Next Test Strips) test strip Use 1-2 times daily to check blood sugar Dx E11.9	50 each	3	3/25/2024	3/25/2025
Lancets misc Use 1-2 times daily to check blood sugar Dx E11.9	100 each	3	3/25/2024	—

📄 All Flowsheet Templates (all recorded)

- Social Needs
- Diabetes
- Diabetes Education
- Education Assessment
- Interfaced Flowsheet Data
- Patient Goals

① Communication to referring provider

Chart Review Routing History

Recipients	Sent On	Sent By	Routed Reports
Thomas ■ ■ MD In Basket Ph: 704-801-7310	3/25/2024 11:57 AM	■ RD	Clinical Support on 3/25/2024 with ■ ■ RD

03/25/2024 (continued)

Flowsheets

B Assessment

Diabetes

Row Name 03/25/24 1031

Diabetes - Patient Level

Diabetes type Type 2 -JG

Patient has No -JG

recieved previous education on Diabetes Self Management

Patient's feeling toward having diabetes Other concerned - JG

Patient identifies the hardest part of caring for diabetes as knowing what to eat -JG

How do you rate your stress level High -JG

Patient handles stress associated with diabetes by Stress management plan -JG

Patient identifies the following members as their support system Family,Spouse/Significant other -JG

How does the patient rate their health 4 Good other than diabetes -JG

Medic alert ID No -JG

Diabetic complications and symptoms

Diabetes Symptoms Polyuria,Visual change,Weight loss -JG

Medications

Understands mechanism of action No -JG

Patient reported X missed doses in the last 7 days 0 -JG

Difficulty affordin medications No -JG

Does the patient take insulin No -JG

Monitoring regimen

Home blood tests Not monitored -JG

Physical activity

Does the patient do any physical activity currently Yes -JG

Type of exercise Cardio -JG

Number of minutes of physical activity this past week? 60 -JG

Number of days of physical activity 2 -JG

03/25/2024 -

(continued)

Flowsheets (continued)

this past week?

OTHER

Weight trend Decreasing steadily
-JG

Acute Complications

Acute Needs
Complications reinforcement -JG

Hypoglycemia 0 -JG

Frequency During
the Past Three
Months

Appropriate No -JG
Treatment of

Hypoglycemia?

Recognition of No -JG
Hyperglycemia

Symptoms:

Appropriate No -JG
Treatment of High

Glucose

Chronic Complications

Home Foot No -JG
Checks

Lifestyle and Healthy Coping

Patient identifies Listening, Reading -
that they learn JG
best through

Patient has No -JG
completed

comprehensive
DSME group
class series. All
topics of
education
covered in group
class series

Diabetes Education

Row Name 03/25/24 1138

Education Given

Diabetes Yes -JG

pathophysiology

Specific Topic Type of diabetes -JG

Acute Yes -JG

Complications/Pr
oblem Solving

Topic Hypoglycemia
prevention,
detection &
treatment, Hypergly
cemia prevention,
detection &
treatment, -JG

Lifestyle & Yes -JG
Healthy Coping

Topic Stress management
& emotional well-

03/25/2024 -

(continued)

Flowsheets (continued)

	being tools -JG
Healthy Eating	Yes -JG
Topic	Carb counting, Carb food sources, Food labels, Portion Sizes -JG
Being Active	Yes -JG
Topic	Impact of physical activity on glucose levels -JG
Taking Medications	Yes -JG
Topic	Mechanism of action, Orals -JG
Monitoring Glucose	Yes -JG
Topic	Use of glucometer -JG
Diabetes Distress and Support	Yes -JG
Topic	Managing Stress -JG
Chronic Complications	Yes -JG
Topic	Know your numbers (A1c, blood pressure, cholesterol) -JG

OTHER

Education Materials Provided	Living with Diabetes - Adults, A1c Chart -JG
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Education Assessment

(B) Assessment of Topic Areas

Row Name 03/25/24 1031

DSME Learning

Language Preferred	English -JG
--------------------	-------------

Topics of Knowledge Assessment

Pathophysiology	Needs reinforcement -JG
Healthy Eating	Needs reinforcement -JG
Being Active	Needs reinforcement -JG
Taking Medications	Needs reinforcement -JG
Home glucose monitoring	Needs reinforcement -JG
Lifestyle & Healthy Coping	Needs reinforcement -JG
Diabetes Distress & Support	Needs reinforcement -JG
Post education self-management support (ie support groups,	Yes -JG

03/25/2024 -

(continued)

Flowsheets (continued)

community programs, PCP follow up)

Acute Complications Needs reinforcement -JG
Chronic Complications Needs reinforcement -JG

Interfaced Flowsheet Data

Row Name 03/25/24.1026

OTHER

PDMP NARCOTICS 000 -I
PDMP STIMULANTS 000 -I
PDMP SEDATIVES 000 -I
PDMP OVERDOSE 000 NARxCHECK scores -I

Patient Goals

(F) goal set

Row Name 03/25/24.1139

Activity Goals

Does the patient have a goal of being active 1 Goal -JG
1st Activity Goal engage in 30 mins active movement daily -JG

Monitoring Goals

Does the patient have a goal of monitoring 1 Goal -JG
1st Monitoring Goal spot check BG fasting and two hour after main meal -JG
Behavioral Outcome Objective Nutritional management -JG

Support Plan

Support Plan(s) Regular doctor visits, Attend diabetes education -JG

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Provider Type	Discipline
JG	[Redacted] RD	Registered Dietitian	[Redacted]
I	Intf,Ah Flowsheet In 1088231	-	-

Diagnoses

	Codes	Comments
Type 2 diabetes mellitus with hyperglycemia, without long-term current use of insulin (CMS/HCC) - Primary	E11.65	

Reason for Visit

Reason for Visit History

Vitals

Smoking Status
Former

Progress Notes

Progress Notes by [REDACTED] RD at 5/17/2024 8:00 AM

Author: [REDACTED] Author Type: Registered Dietitian Filed: 5/17/2024 9:58 AM
RD
Note Status: Signed Cosign: Cosign Not Required Encounter Date: 5/17/2024
Editor: [REDACTED]
RD (Registered Dietitian)

Diabetes Education

Visit Type: Initial Follow Up
Visit Duration: 30 mins

Referral Date: 3/13/24
Referring Provider: Dr. [REDACTED]
Diabetes Diagnosis: Type 2
Diabetes Duration: new onset
This visit was conducted as a: Visit Type: Office visit

(B) Assessment

PlwT2DM A1c improved to 7.2% (11.4%) TG 599 (2618)
Patient states he has been reducing carbohydrates. Tennis season started back up and he is more active now. Overall feel good. Vision has improved.

Diabetes Medications: Metformin 1000 mg BID

Monitoring:
Fasting 129, 130 at highest

Physical Activity: Tennis - almost daily, weight training - few days per week

Eating Patterns: 3 meals - may dine out 2-3 days per week for lunch when traveling . Low to Moderate Carbohydrate intake

B Assessment

Food Recall:

Breakfast: Pure protein bars (20 g carbs)

Lunch: Salads/ Wraps

Chipotle - green bowls - avoids rice / beans

Dinner: Mostly Protein (poultry/fish) with salad or vegetables - may add sweet potato

Snack: Strawberries , berries, maybe a banana if playing tennis

Beverages: Water, 1-2 Diet Cokes per day

Alcohol: social only

Food Allergies: None

Food Intolerances: None

Other food restrictions (cultural/religious): None

Food Insecurity: No Food Insecurity (3/12/2024)

Hunger Vital Sign

- Worried About Running Out of Food in the Last Year: Never true
- Ran Out of Food in the Last Year: Never true

Risk Reduction:

Eye Exam: due

Foot Exam: self care

Nephropathy Screening: due

Dental Exam: yearly exams

B Assessment

DSME quickpick:

Diabetes - Patient Level

Diabetes type: Type 2

Patient has recieved previous education on Diabetes Self Management: Yes

Patient's feeling toward having diabetes: Neutral

How do you rate your stress level: Medium

Patient handles stress associated with diabetes by: Stress management plan

Patient identifies the following members as their support system: Family, Spouse/Significant other

How does the patient rate their health: 4

Medic alert ID: No

Objective:

Wt Readings from Last 3 Encounters:

05/08/24 81.4 kg (179 lb 6.4 oz)

03/27/24 81 kg (178 lb 9.6 oz)

03/13/24 80.6 kg (177 lb 12.8 oz)

Lab Results

Component	Value	Date
HGBA1C	11.4 (H)	03/12/2024
POCA1C	7.2 (A)	05/08/2024

Lab results related to diabetes have been reviewed.

Education Topics Discussed Today:

D Education Intervention

1. Diabetes Pathophysiology: explained insulin resistance and insulin deficiency and relationship to elevated glucose levels.
2. Nutrition Recommendations: Minimal 100 g to max 200 g carbs per day due to activity level Push fiber in diet 25-30+ grams. Try 1 cup black beans at Chipotle, edamame or chick peas added to

① Education Intervention

- salad, medium size sweet potato for added fiber
3. **Physical Activity:** Reviewed effects of exercise on insulin resistance
 4. **Medications:** MOA of current diabetes medications.
 5. **Monitoring:** Recommended check 2 times week - spot check some 2 hours post meal. Discussed BG and A1c targets per ADA.
 6. **Hyperglycemia:** Symptoms, prevention and management. Discussed when to contact provider.
 7. **Hypoglycemia:** symptoms, prevention and treatment
 8. **Chronic Complications & Risk Reduction:** reviewed foot/eye/kidney/oral care & sick day management. Schedule Eye Exam
 9. **Healthy Coping**
 10. **Diabetes Support:** attend diabetes education as desired.

Plan:

② Education Plan

Follow-up scheduled as desired. Patient has met self care and A1c goal. Patient verbalized understanding of written, verbal patient centered goals discussed here today. Thank you for using our services.

③ goal set

Activity Goals Does the patient have a goal of being active: 1 Goal, 1st Activity Goal: engage in 30 mins active movement daily, Was Goal Met: Met

④ goal follow-up

Monitoring Goals Does the patient have a goal of monitoring: 1 Goal, 1st Monitoring Goal: spot check BG fasting and two hour after main meal, Was Goal Met: Met

⑤ goal Follow-up

Support Plan Support Plan(s): Regular doctor visits

This visit was conducted as a: Appointment Type: an individual appointment. individual Appts: No class appropriate for patient at this time.

DSME Learning

Patient has received previous education on Diabetes Self Management: Yes

Patient identifies that they learn best through: Listening; Reading

Was an interpreter used?: No

Topics of Knowledge Assessment

Pathophysiology: Understands key points

Healthy Eating: Understands key points

Being Active: Understands key points

Taking Medications: Understands key points

Home glucose monitoring: Understands key points

Lifestyle & Healthy Coping: Understands key points

Diabetes Distress & Support: Understands key points

Post education self-management support (ie. support groups, community programs, PCP follow up): Yes

Patient has completed comprehensive DSME group class series. All topics of education covered in group class series: No

Acute Complications: Understands key points

Chronic Complications: Understands key points

⑥ Education Learning Outcomes

Education Materials Provided: A1c Chart

Education Given

Acute Complications/Problem Solving: Yes

Topic: Sick day guidelines

Monitoring Glucose: Yes

Topic: Interpreting glucose trends

Chronic Complications: Yes

Topic: Prevention Exams - Foot, eye, dental, kidney; Know your numbers (A1c, blood pressure, cholesterol)

☰ All Flowsheet Templates (all recorded)

- ████████ Social Needs
- Diabetes
- Diabetes Education
- Education Assessment
- Interfaced Flowsheet Data
- Patient Goals

Chart Review Routing History

Recipients	Sent On	Sent By	Routed Reports
Thomas ██████████ ████████ MD In Basket Ph: 704-801-7310	5/17/2024 9:58 AM	████████ RD	Clinical Support on 5/17/2024 with ██████████ ████████, RD

① communication with referring provider

05/17/2024 -

(continued)

(B) Assessment

Flowsheets

Diabetes

Row Name 05/17/24 0801

Diabetes - Patient Level

Diabetes type Type 2 -JG

Patient has Yes -JG

received previous education on Diabetes Self Management

Patient's feeling Neutral -JG

toward having diabetes

How do you rate your stress level Medium -JG

Patient handles stress associated with diabetes by Stress management plan -JG

Patient identifies the following members as their support system Family, Spouse/Significant other -JG

How does the patient rate their health 4 -JG

Medic alert ID No -JG

Medications

Understands mechanism of action Yes -JG

Patient reported X missed doses in the last 7 days 2 -JG

Difficulty affordin medications No -JG

Does the patient take insulin No -JG

Monitoring regimen

Home blood tests 1-2 times per week -JG

Physical activity

Does the patient do any physical activity currently Yes -JG

Type of exercise Cardio, Strength training -JG

Number of minutes of physical activity this past week? 60 -JG

Number of days of physical activity this past week? 7 -JG

OTHER

Weight trend Stable -JG

Acute Complications

Acute Understands key

05/17/2024 -

(continued)

Flowsheets (continued)

Complications points -JG

Hypoglycemia 0 -JG

Frequency During
the Past Three
Months

Frequency of 0 -JG

Hyperglycemia
(glucose above
300 mg/dl)

Recognition of Yes -JG

Hyperglycemia
Symptoms:

Appropriate Yes -JG

Treatment of High
Glucose

Chronic Complications

Home Foot Yes -JG

Checks

Lifestyle and Healthy Coping

Employed Yes -JG

Patient identifies Listening;Reading -
that they learn JG
best through

Patient has No -JG

completed
comprehensive
DSME group
class series. All
topics of
education
covered in group
class series

Diabetes Education

Row Name 05/17/24 0948

Education Given

Acute Yes -JG

Complications/Pr
oblem Solving

Topic Sick day guidelines
-JG

Monitoring Yes -JG

Glucose

Topic Interpreting glucose
trends -JG

Chronic Yes -JG

Complications

Topic Prevention Exams -
Foot, eye, dental,
kidney;Know your
numbers (A1c, blood
pressure,
cholesterol) -JG

OTHER

Education A1c Chart -JG
Materials

05/17/2024 -

(continued)

(B) Assessment and (E) Education Learning Outcomes

Flowsheets (continued)

Provided

Education Assessment

Row Name 05/17/24 0801

DSME Learning

Was an interpreter used? No -JG

Topics of Knowledge Assessment

Pathophysiology Understands key points -JG

Healthy Eating Understands key points -JG

Being Active Understands key points -JG

Taking Medications Understands key points -JG

Home glucose monitoring Understands key points -JG

Lifestyle & Healthy Coping Understands key points -JG

Diabetes Distress & Support Understands key points -JG

Post education self-management support (ie support groups, community programs, PCP follow up) Yes -JG

Acute Complications Understands key points -JG

Chronic Complications Understands key points -JG

Interfaced Flowsheet Data

Row Name 05/17/24 0800

OTHER

PDMP NARCOTICS 000 -J

PDMP STIMULANTS 000 -J

PDMP SEDATIVES 000 -J

PDMP OVERDOSE 000  NARXCHECK scores -J

Patient Goals

Row Name 05/17/24 0949

Activity Goals

Does the patient have a goal of being active 1 Goal -JG

05/17/2024 -

(continued)

Flowsheets (continued)

1st Activity Goal engage in 30 mins active movement daily -JG

Was Goal Met Met -JG

Monitoring Goals

Does the patient have a goal of monitoring 1 Goal -JG

1st Monitoring Goal spot check BG fasting and two hour after main meal -JG

Was Goal Met Met -JG

Support Plan

Support Plan(s) Regular doctor visits -JG

User Key

(r) = Recorded By, (t) = Taken By, (c) = Cosigned By

Initials	Name	Provider Type	Discipline
JG	[REDACTED], RD	Registered Dietitian	[REDACTED]
I	Intf,Ah Flowsheet In 1088231	—	—

Visit Date	Initial or F/U Year	Educator	Last Name	First Name	MRN	Referring Provider	Nutrition Goal Met?	Monitoring Goal Met?	Activity Goal Met?	Pre A1C	Post A1C (if preA1c ≥ 8)	EDD	Birthweight (grams)	Next Provider Follow up	Comments
3/25/2024	Initial	IND									11.4				
6/30/2024	initial						YES	YES			7.2				

(H) clinical outcome measured

Standard 6: Measuring and Demonstrating Outcomes of DSMES

DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services. Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services redesign and optimization.

<p>A. To demonstrate the benefit of DSMES, members of the team track and aggregate relevant participant outcomes</p>	<p>1. At least one category (healthy eating or being active or taking medication, etc.) of participant behavioral goal outcome will be identified and aggregated at a minimum annually. <i>Note: All participants are not required to select a behavioral goal for this category but for those that did select a goal in this category the outcomes will be aggregated.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>2. At least one other participant clinical or quality of life outcome will be identified and aggregated at a minimum annually. <i>Note: For the other outcome, the DSMES provider will attempt to collect this for all participants.</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>B. Formal CQI strategies provide a framework to strive for excellence, quantify successes and identify future opportunities.</p> <p>By measuring and monitoring outcome data on an ongoing basis, the Recognized DSMES team can identify areas for improvement. They can then adjust engagement strategies and service offerings to optimize outcomes.</p>	<p>The DSMES provider will always have a documented quality improvement project and implement new projects when appropriate. The project will include:</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>a) Opportunity for DSMES service improvement or change <i>(What are you trying to improve, fix, or accomplish?)</i></p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>b) Recognized DSMES services will have baseline CQI project data</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>c) Project outcome targets</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>d) Project assessment and evaluation schedule at a minimum every 6 months</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>e) Recognized services will have project outcomes measured, assessed and evaluated at a minimum every 6 months</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>f) Recognized DSMES services will have a plan to address gaps identified or service change needs</p>	<input type="checkbox"/>	<input type="checkbox"/>

2024 Evaluation of Goals and Outcomes

Data Collection Periods

Q1 = December 1 – February 28

Q2 = March 1 – May 31

Q3 – June 1 – August 31

Q4 = September 1 – November 30

Summary

Quarter	Total Unique Patients	Total Number of Visits
Q1	901	1342
Q2	947	1487
Q3	944	1424
Q4		
Annual Total 2024	1848	
Annual Total 2023	3702	5484
Annual Total 2022	3642	5350
Annual Total 2021	3204	5144
Annual Total 2020	2203	3620

BEHAVIORAL GOALS

Goal is 75% for all categories

Program Aggregate: Behavior Outcome- Healthy Eating

Quarter	Total Patient Who Set Goal	Total Patients Who Met Goal	2024	2023	2022	2021	2020	2019
Q1	267	231	87%	88%	84%	83%	82%	82%
Q2	403	359	88%	88%	84%	81%	82%	73%
Q3	382	323	85%	89%	81%	82%	78%	73%
Q4				85%	79%	85%	82%	81%
Full Year				88%	82%	83%	81%	77%

Program Aggregate: Behavior Outcome- Monitoring

Quarter	Total Patient Who Set Goal	Total Patients Who Met Goal		2023	2022	2021	2020	2019
Q1	345	318	92%	91%	89%	85%	91%	80%
Q2	445	407	91%	93%	92%	87%	88%	82%
Q3	419	396	95%	91%	94%	91%	84%	75%
Q4				91%	88%	89%	88%	80%
Full Year				92%	91%	88%	88%	79%

Program Aggregate: Behavior Outcome- Being Active

Quarter	Total Patient Who Set Goal	Total Patients Who Met Goal	2024	2023	2022	2021	2020	2019
Q1	164	120	73%	75%	76%	80%	78%	74%
Q2	240	184	77%	83%	74%	76%	85%	58%
Q3	218	166	76%	87%	76%	83%	82%	67%
Q4				78%	81%	82%	74%	50%
Full Year				81%	77%	80%	80%	62%

CLINICAL OUTCOMES

	Outcome Measured	Goal		2023	2022	2021	2020
NonPregnant	A1c improvement	75%	83% (Q1/Q2)	83%	85%	82%	86%
Pregnant	Birthweight	93%	95% (Q1/Q2)	94%	93%	94%	93%

Program Aggregate: If PreEducation A1c \geq 8%, post-education A1c will improve

Quarter	Total Patients with PreA1c Recorded	Total Patients with PreA1c \geq 8%	Patients with PreA1c \geq 8% who had post A1c result	Post A1c improved	Post A1c $<$ 8
Q1	454	258 (57%)	230 (89%)	186 (81%)	114 (50%)
Q2	422	237 (56%)	186 (78%)	161 (87%)	91 (49%)
Q3	442	238 (54%)			
Q4					
Year End (Avg)			91%	83%	52%

Program Aggregate: Birthweight $<$ 4000 grams

Quarter	Total Patients Assessed	Total Patients Who Met Outcome Measure	2024	2023	2022	2021	2020
Q1	294	279	95%	95%	94%	94%	99%
Q2	304	290	95%	94%	89%	97%	92%
Q3				93%	93%	92%	92%
Q4				96%	94%	93%	90%
Total				94%	93%	94%	93%

2024 Outcomes and CQI Project

A. Program's one or more aggregate patient selected behavioral goal outcome

- Behavioral Goal Category:
 - Nutrition Management/Healthy Eating
 - Physical Activity/Being Active
 - Monitoring

B. Program's one or more aggregated other participant outcome

- Other Participant Outcome:
 - A1C
 - Birthweight

C. CQI Project

- Enter in line below the one aggregated outcome from A or B above or select another DSMES process or outcome that the CQI project will address
 - Reduce no show rate for Diabetes & Nutrition Care scheduled visits
- List below what your CQI project will be trying to improve fix or accomplish?
 - **Assessment:** Overall no show rate had increased in 2021, slight improvement/stabilized in 2022. Late cancellation rate + no show reports obtained in 2023 show increase from 20.9% in Q1 to 22.7% in Q4. Newer/more accurate Power BI report (no show rate only) shows no show rate increased from 13.5% in Q1 to 16.0% in Q4 (average rate of 14.9%)
Possible causes – Specific locations have higher rates than others. Many patients are set-up to receive reminder text messages/phone calls. Commons reasons for late cancellation: transportation, bad time/day. Reminder calls 24 hours prior to appt time likely result in higher late cancellation rate. Therefore, moving forward, plan to use Power BI reporting for NO SHOW RATES only.
 - **Goal:** Reduce no show rate to less than 16% with a stretch goal <14%.
 - **Purpose:** To increase visit attendance for patients who have been referred to Diabetes & Nutrition Care for diabetes education or other services. This will also help to improve schedule utilization.

D. What is the CQI project target % outcome you are trying to achieve?

Reduce no show rate to less than 16% with a stretch goal <14%

E. Determine the CQI project outcomes reporting and review cycle: monthly, quarterly, or bi-annually.

- Reporting and outcome review cycle will be quarterly.

CQI Cycle

F. Aggregate outcomes

G. Review outcomes versus target

H. Review current operations as they relate to the CQI project

I. Amend current operations to improve CQI outcomes

J. Implement improvements

Repeat cycles starting with F

Project Name	No Show/Late Cancel Rates	No Show/Late Cancel Rates	No Show/Late Cancel Rates	No Show/Late Cancel Rates
E) Reporting Review Date	12/1/23 – 2/28/24	3/1/24 – 5/31/24	6/1/24 – 8/31/24	9/1/24 – 11/30/24
D) CQI Target <i>Stretch Goal</i>	<16% <14%	<16% <14%	<16% <14%	NEW GOALS <13% <12%
CQI Outcome No Show Only (Power BI)	12.6%	14%	12.2%	
G) Review Outcomes	<p>Locations with highest rates for all of 2023: Concord 18% Museum 28% Moor 21% Mt Island 23% Steele Creek 17% University 22%</p> <p>Highest Rates for 2024 Q1: Arb 20% Moor 30% Mt Island 23% Stl Crk 15% Univ 15%</p>	<p>Lowest Rates for 2024 Q2: EOB MMP (5%) OH Link (7%) Birk (7%) COB MMP (7%) Arb (7%)</p> <p>Highest Rates for 2024 Q2: OH Prosp (32%) Museum (27%) Moor (22%, was 30%) Univ 20% (up from 15%) Mt Isl (19%, was 23%) Stl Crk (16%, up from 15%)</p>	<p>No show rates for locations with highest rates during first 2 quarters has improved:</p> <p>Highest Rates for 2024 Q2: OH Prosp (32% to 13.8%) Museum (27% to 9.5%) Moor (22% to 0%) Univ (20% to 12.9%) Mt Isl (20.6% to 6.4%) Stl Crk (16% to 13.8%)</p> <p>No Show rates increased for the following sites: Birkdale, Concord, Matthews, Pineville</p>	
H) Review current operations and consider amendments	Currently, educators call scheduled patients 24 to 48 hours ahead when schedule allows (not always consistent due to limited time)	Current process of educators doing reminder calls. Coordinator started calling highest no show sites Q1 but time is limited for this.	Referral coordinators are doing reminder calls for unconfirmed appts 48 hours in advance for above highest No Show locations.	
I) List amendments to current operations	Coordinator to begin calling patients 48 hrs ahead at locations with highest rates from 2024 Q1: Arb, Moor, Mt Island, Stl Crk Univ	Melinda Peterson confirmed that referral coordinators can do reminder calls for unconfirmed appts 48 hours in advance for above highest No Show locations.	Monitor no show rates for Birkdale, Concord, Matthews and Pineville. Consider assistance from referral coordinators with reminder calls for these locations if rates remain above 15% in Q4. Change target to <15% and stretch goal of <13%.	
J) Change Date	3/11/2024	6/11/2024	9/24/24	

Notes from huddle March 2024

5. CQI – no show rates overall increased in 2023. Limited ability to impact from within our department.
 - a. Option – selecting the three locations with highest no show rates & contacting patients 48 hours in advance.
 - b. Plan: Julia to start reminder calls during March for the following locations with high no show rates:
 - i. Arboretum, Mt Island, Mooresville, University
 - ii. Melinda advised that scheduling/referral team may be able to assist after April 1st once Nancy Smith has returned
 - c. Other CQI project options

- i. Improve goal follow-up (marking progress)
- ii. Improve A1c improvement rates
- iii. Consider percentage of patients completing postpartum GTT since process changed in 2023 (Transitioned from MFM to OB provider responsibility)

No Show Report Per Location

	Dec '23	Jan	Feb	Mar	April	May	June	July	Aug
Arboretum	26.7%	12.50%	14.29%	6.25%	0.00%	22.20%		19.23%	6.25%
Ballantyne	3.7%	2.9%	4.4%	4.8%	11.4%	7.1%	13.2%	2.8%	6.7%
Birkdale	18.2%	19.1%	4.8%	5.3%	4.6%	11.8%	8.7%	7.7%	36.4%
COB MMP	20.0%	0.0%	0.0%	11.8%	3.7%	7.7%		13.0%	6.3%
Concord	14.8%	18.2%	11.5%	7.7%	9.1%	12.5%	25.0%	23.1%	15.8%
EOB MMP	14.3%	13.3%	20.0%	0.0%	6.3%	10.0%	33.3%	0.0%	0.0%
Matthews	0.0%	9.5%	15.4%	9.1%	6.3%	15.8%	23.5%	15.4%	26.3%
Museum	11.1%	20.0%	11.1%	25.0%	30.0%	25.0%		9.1%	10.0%
OH Birkdale	8.3%	6.7%	15.4%	11.8%	8.3%	8.3%	16.0%	13.6%	18.8%
OH Link	0.0%	25.0%	0.0%	15.4%	0.0%	0.0%	0.0%	10.0%	0.0%
OH Mooresville	18.2%	41.2%	25.0%	22.2%				0.0%	0.0%
OH Mt Island	15.8%	21.7%	27.3%	5.0%	16.7%	40.0%	12.5%	6.7%	0.0%
OH Prosperity	10.5%	11.5%	18.5%	31.8%	25.9%	40.0%	17.4%	20.0%	4.0%
OH Reese	10.0%	9.5%	0.0%	22.2%	15.0%	11.8%	6.7%	30.8%	9.1%
Pied OB	3.9%	9.5%	0.0%	0.0%	18.2%	23.3%	3.7%	11.1%	0.0%
Pineville	0.0%	10.6%	10.0%	12.5%	17.2%	9.4%	21.5%	22.2%	23.9%
SouthPark	14.2%	13.9%	11.6%	12.1%	11.0%	9.8%	10.9%	8.0%	14.0%
Steele Creek	16.1%	11.4%	16.7%	18.2%	7.1%	23.7%	21.4%	7.1%	13.0%
University	17.1%	15.9%	18.5%	12.5%	22.1%	23.9%	16.4%	14.9%	7.4%

	Q1 Avg	Q2 Avg	Q3 Avg	Q4 Avg	Yearly Average
Arboretum	17.83%	11.05%	12.74%		13.43%
Ballantyne	3.7%	7.8%	7.54%		6.3%
Birkdale	14.0%	7.2%	17.58%		12.9%
COB MMP	6.7%	7.7%	9.65%		7.8%
Concord	14.8%	9.8%	21.30%		15.3%
EOB MMP	15.9%	5.4%	11.11%		10.8%
Matthews	8.3%	10.4%	21.74%		13.5%
Museum	14.1%	26.7%	9.55%		17.7%
OH Birkdale	10.1%	9.5%	16.13%		11.9%
OH Link	8.3%	5.1%	3.33%		5.6%
OH Mooresville	28.1%	22.2%	0.00%		17.8%
OH Mt Island	21.6%	20.6%	6.40%		16.2%
OH Prosperity	13.5%	32.6%	13.80%		20.0%
OH Reese	6.5%	16.3%	15.53%		12.8%
Pied OB	4.5%	13.8%	4.93%		7.7%
Pineville	6.9%	13.0%	22.53%		14.1%
SouthPark	13.2%	11.0%	11.0%		11.7%
Steele Creek	14.7%	16.3%	13.8%		15.0%
University	17.2%	19.5%	12.9%		16.5%
	12.63%	13.99%	12.19%		13.00%

Color Key

12.1% to 14.9%

≥ 15%

< 10%