



March 8, 2006

Dear City of Milwaukee employees and retirees enrolled in the Basic Plan:

Re: **Diabetes Challenge**

I am pleased to announce that the City of Milwaukee has partnered with the American Pharmacists Association Foundation and network pharmacists in the Milwaukee area to implement a new approach to improve patient health care—the **Patient Self-Management ProgramSM for Diabetes**.

As an incentive for participation in this program, the City of Milwaukee will make arrangements to waive the co-pays currently required on purchases of diabetes medications, related supplies and specific diabetes related medications. In addition to the immediate cost-savings, participants will benefit from the health care services that will be provided to them by the specially trained project pharmacists in the Milwaukee area.

As the title indicates, the program is targeted to a population of people with diabetes who will be engaged in an educational/health monitoring program to learn how to self-manage their condition. The desired goal of this 12-month program is to demonstrate that individuals who participate in the program can learn how to successfully self-manage their own diabetes treatment, and by doing so, improve and maintain their good health while reducing the need for expensive medical services.

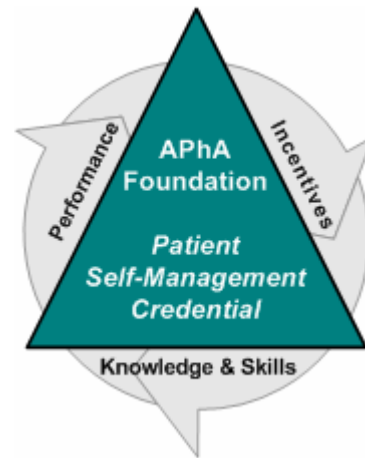
The City of Milwaukee is quite excited about the value of such an innovative program--both in terms of the improved quality of life that it offers employees, retirees and dependents and the potential savings in overall health care costs for participants and the City.

You can get **information about signing up** for the program from Katrina Whittley in DER, at 286-3380, e-mail, kwhitt@milwaukee.gov or by going to the City of Milwaukee web site, www.milwaukee.gov/der.

If you have an interest in **learning more about the clinical aspects** of the Patient Self-Management ProgramSM for Diabetes please contact Julie Whipple, Pharm.D., Use Your Medications Wisely, LLC., at 414-630-3872 or e-mail at JulieWhipple1@milwpc.com.

Any inquiry, as well as your future participation in the project, will be strictly confidential.

Sincerely,
Michael Brady
Employee Benefits



Welcome to the Patient Self-Management Program for Diabetes that is being sponsored by the City of Milwaukee. This project introduces a new type of health care program that has been carefully organized for you and your fellow employees who have diabetes.

The Patient Self-Management Program (PSMP) for Diabetes

What is exciting and different about this new health care program is that the success of the program, in large part, depends on your active participation in your own care. The program is designed to help you maintain good control over your diabetes by helping you learn how to better self-manage your diabetes care.

Over a 12-month period, you will be meet at regularly scheduled times with the health care team -- your physician, pharmacist, and other diabetes specialists. You will be a full-fledged member of this team and will help develop a treatment and education support plan that (a) meets your individual health care needs and (b) provides the education and skill training that you need to earn your patient self-management credential in diabetes.

Each member of the health care team will be responsible for keeping each other informed about actions taken on your behalf, including those responsibilities that you must fulfill. For instance, your pharmacist will keep your physician informed about services provided and their outcomes. Your physician, in turn, will notify your pharmacist when a change in your treatment plan is indicated. Should you be referred to a Diabetes Education Center (DEC) for additional education and training, the DEC will send progress reports to your pharmacist and physician. And you will be expected to keep the team informed as to your progress or problems that you encounter in self-managing your diabetes.

Completing your enrollment in the PSMP for Diabetes

To complete the enrollment process, you need to fill out and sign a number of forms. Descriptions of each form are provided in the following paragraphs. At the end of each description, you will be directed to the pertinent form that you also need to complete, download, and sign. The completed forms are to be returned to the Katrina Whittlely at the City of Milwaukee, 200 East Wells, Room 701, Milwaukee, WI 53202

PSMP for Diabetes *Consent to Participate* Form

By completing this form, you acknowledge that you have been fully informed about the program, including:

1. Your right to confidentiality

In order to assure the confidentiality of the information you provide, a computer generated identification (ID) code will be used to identify you and data resulting from your participation in the program. Further, coded information and data will only be shared with those parties who have a need to know and for whom you give authorization to have access. Parties who will need to have access are trusted health professionals who provide care, pharmacy benefit managers who handle claim forms, and data processing personnel who will aggregate coded data about you and your progress with similarly coded data collected from other patients participating in the same program. Aggregated data will be used to evaluate the overall success of the PSMP for Diabetes. Your name will not be associated with any published results.

2. Employee incentive

As a participant in the program, the co-pays that you are now required to make when purchasing your diabetes medications and related supplies will be waived.

3. Clinical measurements and laboratory tests

To assure that your diabetes is controlled, at regular intervals your physician and pharmacist will conduct certain clinical measurements and laboratory tests. The exact nature of these measurements and tests will be explained to you as you begin participating in the program.

4. Risks, inconveniences, and discomforts

As is the case with all health care programs, you are reminded that there are potential risks associated with the treatment of any disease. Specific risks associated with your diabetes care will be discussed with you as appropriate. Further, because of the time pressure that health care providers work under these days, you may have to arrange your schedule to accommodate that of the health care team. In this regard, it will be expected that you would make every effort to do so (see section on Cancellations and Missed Appointments). Lastly, medical care does have its discomforts. For instance, not too many people look forward to having blood drawn for a laboratory test. You should discuss your individual concerns with your health care team.

5. Patient Self-Management Credential for Diabetes

As you participate in this program, you will become more knowledgeable about your disease and its treatment. The program is designed to initially assess how much you know about diabetes and its proper care. The results of this initial assessment will provide information that the health care team will use to tailor a specific program to fill in the educational and training gaps so indicated. As you progress through this educational/training component of the program, you will receive continuous support from the health care team. Upon successful completion of a final assessment of (a) your knowledge of diabetes, (b) your skills at self-managing your condition, and (c) your performance as indicated by your record of maintaining good control of your diabetes, you will receive the Patient Self-Management Credential for Diabetes.

6. Right to withdraw.

Since you volunteered to participate in the program, you have the right to withdraw at any time. In the event you find that you are not able to participate in the PSMP for Diabetes, for whatever reason, you should immediately notify the Pharmacy Network Coordinator.

7. Authorization to request medical information

Giving permission to enable your pharmacist to obtain confidential information about your diabetes from your physician, or other diabetes health care specialist whom you may be seeing, is important to assure the continuity of your diabetes care.

8. Selecting your pharmacist and scheduling appointment

During the enrollment period, you will be asked to make a 1st and 2nd choice selection from a list of qualified pharmacists to be your PSMP for Diabetes pharmacist. Every effort will be made to honor your 1st choice selection. The Pharmacy Network Coordinator will notify you of the name and location of your PSMP for Diabetes pharmacist and at the same time will notify the selected pharmacist of your enrollment in the program.

9. Scheduling appointments

Your pharmacist is to contact you within one week after receiving notification of your enrollment. If you are not contacted by the pharmacist within one week, you should notify the Project Coordinator. When your pharmacist calls you, you are to schedule the time for your initial visit.

During your initial visit, the pharmacist will review the PSMP for Diabetes with you and answer your questions. Also, it is at this time that you will be asked to complete a brief set of questions that will provide the health care team an initial assessment of your knowledge of diabetes and its treatment. As indicated above, the results of this initial assessment will be used to develop an overall care plan that will state the specific treatment goals as determined by your physician, as well as the educational and skill training goals set by the entire health care team. The plan will include:

- A schedule of follow up visits at which times the pharmacist will provide indicated counseling, education and skill training
- A schedule of laboratory measurements for Hemoglobin A1C, blood glucose, (you will be provided with a glucometer and instructions on how to use it), and lipids
- Life style changes desired
- A plan for monitoring kidney, nerve and eye conditions

During the first 3 months of the program, you will meet with your pharmacist a minimum of once per month. Thereafter, you and your pharmacist will determine the frequency of visits, however it will be at least once each quarter.

10. Cancellations and Missed Appointments

Except in an emergency situation, you must give 24-hour notice if you are unable to keep a scheduled appointment with the pharmacist. (In the case of an emergency situation, you should notify your pharmacist as soon as possible.) If you do not provide the appropriate notice, you will be contacted by the pharmacist to determine the reason for the missed appointment. If you miss a second appointment without giving 24-hour notice, you will be contacted by the Project Coordinator to discuss your continuing in the program.

In those instances when the pharmacist may need to schedule, or re-schedule, an appointment with you, the pharmacist will immediately contact you. If you are not available, the pharmacist will leave a message for you. It is very important that you respond to any message promptly. A second failed attempt to contact you will be reported to the Coordinator who will place a call to you. If you fail to respond to the Coordinator, it will be assumed that you do not want to continue and will be notified that you have been dropped from the program.

I, _____, understand what will be required of me to become a participant in the Patient Self-Management Program for Diabetes. I agree to follow the stated policies and procedures as stated in this document and understand that my failure to do so may result in my being dropped from the program.

Participant Signature _____ Date _____
 (Or Parent /Guardian)
 Coordinator's Signature _____ Date _____



Patient Self-Management Program for Diabetes Sign-up Form

Personal Information

Name: _____ Gender: Female Male Birth Date: _____

Ethnicity: African American Asian Caucasian Hispanic Native American Pacific Islander Other

Primary Language: _____

Highest Grade Completed: 8th Grade or Less
 Some High School
 High School Graduate
 Some College
 College Graduate
 Post-Graduate Education

Address: _____ Phone: Work: _____

City, State: _____ Home: _____

Zip Code: _____ Attending Physician: _____

Have you been through a formal diabetes education program? Yes No

If yes, name of program and date attended: _____

Have you visited your physician within the last year regarding your diabetes? Yes No

If yes, name of physician and date of visit: _____



Medical/Health Information Disclosure Consent

To Whom It May Concern:

I am voluntarily participating in the Patient Self-Management Program for Diabetes, a health management program sponsored by my employer, the City of Milwaukee, which will necessitate that my pharmacist and/or certified diabetes educator obtain certain medical/health information about my condition from my physician and/or diabetes care specialist to facilitate the continuity of my care. By signing this form, I am giving my consent to having information about my condition released to the pharmacist and/or certified diabetes educator named on this form to be used specifically and confidentially for my care. Further, I give my consent that appropriately blinded data as to my identity and condition/ treatment may be aggregated with similarly blinded data from other patients enrolled in the same program for research and educational purposes.

I understand that I may revoke this consent at any time upon giving written notice to the City of Milwaukee. Were that to be the case, I understand and agree that actions taken by any party related to the conduct of the Patient Self-Management Program for Diabetes during the period that relied upon my consent would stand. Also, I understand that this consent will expire automatically should I discontinue my participation in the program.

Date: _____ Patient _____
Signature
 Patient _____
Printed name
 Patient's date of birth _____

If additional consent is required, have the authorized person sign below

 Signature Printed name

 Relationship to patient



ID Code: _____ - _____ - _____

Date Completed: ____/____/_____
MM DD YYYY

Patient Satisfaction with Diabetes Care Survey

The following questions ask your opinion about the quality of diabetes care you receive from your current health care providers (e.g., physicians, nurses, dietitians, pharmacists). Check a box on each line to indicate your ratings with regard to:

	Poor	Fair	Good	Very Good	Excellent
1. Basic information about diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Information about how to prevent or slow complications from diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Information about your diabetes medications.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Information about how to manage your diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Information about how to monitor diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Being able to get answers to your questions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Your health care providers' respect for your opinions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Your health care providers helping you find solutions to your diabetes-related problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Your health care providers caring about you.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Having a convenient location to see your health care providers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Being able to see a health care provider in a timely fashion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

This question asks your overall opinion of the health care you have received for diabetes.

Circle any number from 1 to 10 wherein higher numbers mean better care. For example, you could circle 1 if you feel that you had the “worst possible care,” or circle 10 if you feel you had the “best possible care,” or circle a number between the two extremes.

Worst Possible Care											Best Possible Care
1	2	3	4	5	6	7	8	9	10		



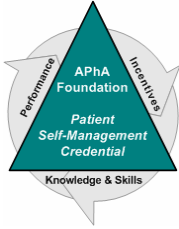
Patient Self-Management ProgramSM for Diabetes Initial Patient Visit

Overview of First Visit

This visit will focus on individual patient knowledge assessment and planning.

Initial Patient Visit Checklist

- File program enrollment and medical information disclosure forms
- Patient history ([see sample form](#))
- Pharmacist gives patient PSMID Code (000-000-000) and patient chooses a PIN Code (XXXX)
- Review participant policies and procedures
- Conduct review of baseline knowledge assessment (six M's)
- Review health care team members, roles, and communication expectations
- Review previous health goals established by the patient's physician and/or other providers
- Review role of Diabetes Education Center in patient's process of care ([where indicated](#))
- Agree on consistent procedures for obtaining objective clinical measures (Lab Results) for the duration of participation in the program (A1C, BP, Glucose, Height & Weight, Lipids)
 - Ensure that patient has a downloadable glucose meter (Network provides Pharmacist with free meters so that patients can get one if necessary) and understands how to use it
- Complete the Patient Visit Form ([see sample Encounter and Monitoring Form](#))
- Initiate the patient education process:
 - Establish Patient Self-Management ProgramSM goals ([see goals worksheet](#))
- Provide patient with a copy of the [PSMP for Diabetes Credential status card](#)
 - Review Lab Results (testing can be conducted at initial visit or be a result obtained in the last 60 days)
 - Review strategies for medication adherence
 - Review strategies for nutrition
 - Review strategies for exercise
 - Review strategies for stress management
 - Review treatment, referral and follow-up plan for patient
- Set up follow up appointment in 30 days
- Enter data into patient database (from completed PSMP for Diabetes Credential status card)
- Prepare and fax Physician communication regarding patient appointment:
 - Cover letter with bullet points for significant findings, suggested changes, and reference attachments:
 - Objective test results (including glucose meter printout)
 - [Progress notes](#) (be concise and [intervene as required](#))
 - Send copy of patient's medical information authorization release with fax (if requesting any additional specific information required for patient's care)
- Create and send bill for services (as determined by Employer and Pharmacist Network)



History of Diabetes Initial Patient Assessment

Please fill out this form and bring with you to your first appointment with your pharmacist.

Patient Name: _____ Phone Number: _____ E-Mail Address _____

Primary Care Physician: _____ Phone Number: _____

Dietician: _____ Phone Number: _____

Date of Birth: _____

Allergies: _____

Past Medical History:

DO YOU HAVE, OR HAVE YOU EVER BEEN TOLD THAT YOU HAD:

(Circle)

- | | | |
|-----|----|---|
| Yes | No | Heart disease (heart attack, angina, heart surgery, arrhythmia) |
| Yes | No | Lung disease |
| Yes | No | High blood pressure |
| Yes | No | Thyroid problems |
| Yes | No | Kidney problems |
| Yes | No | Cancer |
| Yes | No | Liver or gallbladder trouble |
| Yes | No | Head trauma |
| Yes | No | Osteoporosis |
| Yes | No | Arthritis |
| Yes | No | Stroke or TIA |
| Yes | No | Migraine Headaches |
| Yes | No | Seizures |
| Yes | No | Anxiety disorder, panic attacks |
| Yes | No | Depression |
| Yes | No | Glaucoma, macular degeneration or other eye problem |
| Yes | No | Other. Describe: _____ |
| Yes | No | Serious infections. Describe: _____ |

Current Medications (include over-the-counter medicines and herbal remedies):

<u>DRUG</u>	<u>DOSE</u>	<u>DIRECTIONS</u>	<u>PRESCRIBING DOCTOR</u>	<u>USED FOR?</u>	<u>STARTED WHEN ?</u>
<u>1</u>					
<u>2</u>					
<u>3</u>					
<u>4</u>					
<u>5</u>					
<u>6</u>					
<u>7</u>					

Have you ever had any problems with your medication?

History of Diabetes:

Age when diagnosed: (age/year) _____	
Hospitalization(s) or ER visits for treatment of diabetes in the last 12 months <i>(Dates/reasons/duration/outcome)</i>	Physician office visits for diabetes for the last 12 months <i>(Date/reason/outcome)</i>

Diabetes Education:

Any previous diabetes education? <input type="checkbox"/> NO <input type="checkbox"/> YES (When) _____ (Where) _____	
What is the most difficult part of having diabetes?	Do you believe your family members understand the conditions of your diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO (why not?)
Do you belong to any diabetes associations or support groups? <input type="checkbox"/> NO <input type="checkbox"/> YES (organizations)	

Diet/Nutrition:

Current Height?	Current weight?
Any recent weight changes? (Describe)	Any recent changes in your appetite? (Describe)
What special diet plan do you follow?	Other diet plans previously followed (Plan/Reason for termination)
Have you met with a dietitian to discuss a diet plan? <input type="checkbox"/> NO <input type="checkbox"/> YES Dietitian/phone: _____	
What do your daily meals consist of?	When do you eat your meals?

Exercise Plan:

What are your usual daily activities:	Do you have a regular exercise schedule? <input type="checkbox"/> NO <input type="checkbox"/> YES (Type and Frequency)
Are you exercising more or less than a year ago? <input type="checkbox"/> MORE <input type="checkbox"/> LESS (Why?)	What things keep you from exercising?

Lab Values (Complete if known):

MOST RECENT LAB VALUE	DATE/TIME	RESULT
Blood Glucose		
HbA1c		
Total Cholesterol		
LDL		
HDL		
TG		
Microalbumin/Urine Test		

Complete this next section only if you are currently taking insulin.

Insulin Regimens:

I am not currently taking insulin.

	BREAKFAST	LUNCH	DINNER	BEDTIME
Time				
Insulin Type				
Dosage (units)				
Number of Missed doses				
Do you administer your own insulin? If not, who administers your insulin?	Syringe size: Needle size: How do you dispose of used syringes?			
Are you having any problems with your insulin?	Describe what is meant by rotating sites?			
How do you store your insulin?	How do you carry your insulin?			

Blood Glucose Monitoring:

How do you check your blood glucose levels? <input type="checkbox"/> Do not test <input type="checkbox"/> Visual (<i>test name</i>) _____ <input type="checkbox"/> Urine test (<i>test name</i>) _____ <input type="checkbox"/> Blood Glucose Monitor (<i>meter name</i>): _____	How often do you monitor your blood sugars? (<i>Tests per day</i>)
What do you like about it? What do you dislike about it? Are you having any problems/difficulties with the meter? (<i>Describe</i>)	
Based on the results you get from your meter, what do you consider to be high, normal, and low sugar values? HIGH: _____ NORMAL: _____ LOW: _____	

Hypoglycemia Awareness:

<p>Have you ever experience low blood sugars?</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES (<i>date of last episode</i>): _____</p> <p>(<i>How often does this occur?</i>): _____</p>	<p>Which of these symptoms have you experienced?</p> <p><input type="checkbox"/> Shakiness/trembling</p> <p><input type="checkbox"/> Tiredness</p> <p><input type="checkbox"/> Confusion/Disorientation</p> <p><input type="checkbox"/> Hunger</p> <p><input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> Sweating</p> <p><input type="checkbox"/> Increase heart rate</p> <p><input type="checkbox"/> Faintness or fainted</p> <p><input type="checkbox"/> Nausea/vomiting</p> <p><input type="checkbox"/> Drowsiness/weakness</p>
<p>How do you usually treat this?</p>	

Self Care:

<i>Foot Care</i>	
<p>Why is it important to check your feet on a regular basis?</p>	<p>How often do you inspect your feet?</p>
<p>What type of care do you do for your feet?</p> <p><input type="checkbox"/> Moisturize</p> <p><input type="checkbox"/> Keep toe nails trim</p> <p><input type="checkbox"/> Clean and dry feet</p> <p><input type="checkbox"/> Daily inspection</p> <p><input type="checkbox"/> Always wear shoes, no bare feet</p>	<p>Are you having any problems with your feet?</p>
<p>Do you see a podiatrist for foot care? <input type="checkbox"/> NO <input type="checkbox"/> YES (Doctor's name/phone): _____</p>	

<i>Eye Care</i>	
<p>Why is it important to have your eyes examined on a yearly basis?</p>	<p>Date of last eye exam:</p> <p>Ophthalmologist name/phone:</p>
<p>What problems are you having with your vision?</p>	<p>Any problems with the following in your vision</p> <p><input type="checkbox"/> Spots</p> <p><input type="checkbox"/> Patches</p> <p><input type="checkbox"/> Areas of no vision</p> <p><input type="checkbox"/> Blurry vision</p> <p><input type="checkbox"/> Other (Describe)</p>

Dental Care	
Why is it important to take care of your teeth and gums?	Last dentist visit: _____ Dentist name/number: _____
What problems are you having with your teeth or gums?	

Please check any symptoms you have experienced in the last 6 months and explain.

Symptoms:

<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia	<i>How often, comments</i>
<input type="checkbox"/> Dribbling <input type="checkbox"/> Overflow Incontinence <input type="checkbox"/> Impotence <input type="checkbox"/> Vaginal Dryness	<i>How often, comments</i>
<input type="checkbox"/> Orthostatic Hypotension (light headedness, pain in the neck, or visual changes) <input type="checkbox"/> Loss of Consciousness	<i>How often, comments</i>
<input type="checkbox"/> Profuse Sweating <input type="checkbox"/> Heat Intolerance	<i>How often, comments</i>
<input type="checkbox"/> Decreased Heat and Light Touch Sensation <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Intense Pain <input type="checkbox"/> Diminished Sense of Touch, Vibration, and Temperature	<i>How often, comments</i>

Sick Day Care:

How do you take care of your Diabetes when you are ill?	How often do you miss doses of your medication while you are sick?
How often do you monitor your blood sugar when you are ill?	How often do you check your urine for ketones?

Contact Information:

Is there anyone who helps you with your care that you would permit release of medical information to? This information would be limited to the scope of care provided by your pharmacist.

Name of contact: _____

Relationship: _____

Phone: _____

I agree that information related to my care may be discussed with the above-named person. I understand that I may, at any time, withdraw this permission either verbally or in writing.

Patient Signature _____ Date _____

Witness _____ Date _____

In the event of an Emergency, contact:

Name: _____

Relationship: _____

Phone number: _____

Patient Self-Management ProgramSM for Diabetes

Patient Information and Goals

Patient Results and Progress

Patient To Do List

Lipid Goals

	Result	Date/Time
LDL-C Goal (ADA / NCEP < 100): _____	_____	_____
HIGH RISK: LDL-C Goal (ADA / NCEP < 70 or 30-40% reduction): _____	_____	_____
A1C Goal (AACE Standard is 6.5): _____	_____	_____
Total Cholesterol: _____	_____	_____
Triglycerides: _____	_____	_____
HDL-C: _____	_____	_____
Microalbumin: _____	_____	_____

Blood Glucose Goals

Target Range: _____	High: _____	Average: _____	Low: _____
# Daily Measurements _____	# Daily Measures: _____		
	Device: _____		

Blood Pressure Goal:

Blood Pressure Goal: _____/_____/_____	Pulse: _____	Mean Blood Pressure: _____/_____/_____
(JNC VII <130/80)		Pulse: _____

Diet/Lifestyle Goals:

	Achievement %
Nutrition Goal: _____	_____
Exercise Goal (rec. 30 minutes daily): _____	_____
Weight Goal: _____	_____
BMI Goal: _____	_____
Tobacco Status: _____ <i>Non-smoker</i> Tobacco: _____	Y/N _____

Medication Adherence (Persistence and Compliance)

	Medication Name	Dose	Frequency	Adherence	Reason
1	_____	_____	_____		
2	_____	_____	_____		
3	_____	_____	_____		
4	_____	_____	_____		
5	_____	_____	_____		
6	_____	_____	_____		

Adherence Score: + = Persistent ✓ = Self Report 80% Plus - = Refills +/- 6 days of schedule

Illness (Describe/Code)

	Days Work Missed
At Home : _____	_____
Urgent Care: _____	_____
ED Visit: _____	_____
Hospitalization: _____	_____

Scheduled Diabetes Care Visits:

Appointment (Notations) _____ Date _____ Time _____

Flu Shot: _____

Foot Exam: _____

Eye Exam: _____

Dental Exam: _____

Scheduled Laboratory Visits:

Lab Measurement (Notations) _____ Date _____ Time _____

Self-Management Goals:

Date/Time of Next Pharmacist Visit: _____

Patient Notes:

Patient Notes:

Patient Self-Management ProgramSM

Patient Name: _____

Patient PSMID # _____ - _____ - _____

Physician: _____

Pharmacist: _____

Pharmacist Phone #: _____

DEC/Educator: _____

PSMP for Diabetes Credential Scores

Knowledge: Beginner Proficient Advanced

Skills: Beginner Proficient Advanced

Performance: Beginner Proficient Advanced





INITIAL VISIT ASSESSMENT

Patient Self-Management ProgramSM for Patients with Diabetes

Patient Name: _____ DOB: _____

Phone Number: _____

E-mail Address: _____

Patient (PSM) ID #: _____

Physician: _____

Phone No: _____ Fax No. _____

Program Introduction

- Review participant policies and procedures
- Review health care team member roles, communication, expectations
- Complete Medical History form
- Review consistent procedures for obtaining clinical test results

Pertinent Medical History

<p>How long since diagnosis of diabetes? _____</p> <p>Last physician office visit for diabetes? _____</p> <p>Last eye doctor visit (date): _____</p> <p>Hospitalizations or ED visits for tx of diabetes in the last 12 months? _____</p> <p>Any previous diabetes education? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p style="margin-left: 20px;"><i>When:</i> _____ <i>Where:</i> _____</p>	<p>Weight: _____ Calculated BMI: _____</p> <p>Waist circumference : _____</p> <p>Last foot exam (date): _____</p> <p>Pneumococcal vaccine? <input type="checkbox"/>Yes <input type="checkbox"/>No <input type="checkbox"/>N/A</p> <p>Date: _____</p> <p>Flu vaccine? <input type="checkbox"/>Yes <input type="checkbox"/>No Date: _____</p> <p>Last dental exam (date): _____</p>
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Medications

Compliance*

<p>Current Diabetes Medications</p>	<p>Insulin: _____</p> <p>Oral: _____</p> <p>None: <i>(List diet if diet-controlled)</i> _____</p>
<p>Current Non-Diabetes Medications: <i>(include herbal and OTC)</i></p>	<p>ACE-I: _____</p> <p>Antihypertensive: _____</p> <p>Peripheral neuropathy: _____</p> <p>Lipid-Lowering: _____</p> <p>Aspirin: _____</p> <p>Other: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>

*Compliance Assessment: Note next to listed medications above
 Persistent=+ Self-report 80% Plus=√ - =+/- 6 days of schedule

Compliance issues (Describe):

Clinical Data	<u>Result</u>	<u>Date/Time</u>	<u>Comment</u>
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Lipid Profile			
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LDL-C Goal (ADA / NCEP < 100): _____

HIGH RISK: LDL-C Goal (ADA / NCEP < 70 or 30-40% reduction): _____

A1C Goal (AACE Standard is 6.5): _____

Total Cholesterol: _____

Triglycerides: _____

HDL-C: _____

Blood Glucose Measurement			
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Target Range: _____ High: _____ Average: _____ Low: _____

Daily Measurements _____ # Daily Measures: _____

Device: _____

Proteinuria Measured: Yes No Dipstick/Urinalysis +/- _____ Date: _____

Blood Pressure Measurement			
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Blood Pressure Goal: _____ / _____ Pulse: _____ Blood Pressure this visit: _____ / _____ mmHg

(JNC VII <130/80) Pulse: _____

Diet/Lifestyle Assessment			
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Nutrition Goal: _____ Nutrition: _____

Exercise Goal (rec. 30 minutes daily): _____ Exercise: _____

Weight Goal: _____ Weight: _____

BMI Goal: _____ BMI: _____

Tobacco Status: *Non-smoker* Y/N _____

Other:			
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Liver function tests: _____

Serum Creatinine: _____ Date: _____ BUN: _____ Date: _____

Other: _____

Review of Systems

Hyperglycemia Signs and Symptoms
Hunger + Thirst + Urination+ Fatigue Bulurred vision Other: None Not assessed

Hypoglycemia Signs and Symptoms
Sweat + Tremor Shakiness H/A Fatigue N/V Mood changes None Not assessed

Diabetic Ketoacidosis
 Hospitalized? Yes / No (*circle one*) Date(s): _____ Note: _____

Retinopathy
Vision changes Blurring Halos in peripheral vision Other: _____ None Not assessed

Neuropathy
Gastroparesis Sexual dysfunction Incontinence Orthosatic hypotension Peripheral neuropathy
None Not assessed

Patient Self-Management Assessment	GOALS
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Knowledge	[] Beginner [] Proficient [] Advanced	
Skills	[] Beginner [] Proficient [] Advanced	
Performance	[] Beginner [] Proficient [] Advanced	

Notes



PATIENT PLAN

Patient Self-Management ProgramSM for *Patients with Diabetes*

Patient Name: _____ DOB: _____

Physician: _____

Phone No.: _____ Fax No. _____

Pharmacist Name: _____

Signature _____ Date: _____

Phone No.: _____

The following is a patient progress update from the Patient Self-Management Program for Diabetes.
Please contact me if you have any questions.

Subjective:

Objective:

Assessment:

Plan:

Referral (s) made by the RPh this visit	<input type="checkbox"/> Primary Care Physician <input type="checkbox"/> CED <input type="checkbox"/> Dietician <input type="checkbox"/> Podiatrist <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Exercise Specialist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Optometrist <input type="checkbox"/> Dentist <input type="checkbox"/> Other _____
Drug therapy recommendation:	
Recommendation for Laboratory Work:	
Recommendation for Education:	
Goals:	
<u>Achieved from last visit:</u> _____	
<u>Progress from last visit:</u> _____	
<u>New goals:</u> _____	

Other:	

Follow-Up Visit Schedule:

Date:

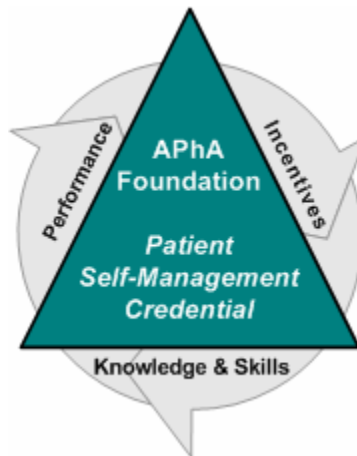
Total Time Spent this visit:

Minutes:

EMPOWER THE PATIENT. IMPROVE THE OUTCOMES. CONTROL THE COSTS. SM

DIABETES KNOWLEDGE ASSESSMENT

APhA Foundation



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DIABETES KNOWLEDGE ASSESSMENT

APhA Foundation

36 Questions

Directions:

The assessment contains a total of 36 questions. The purpose of this assessment is to determine how much you currently know about diabetes and the best ways to manage it. The results of the assessment will be helpful to developing a plan to meet your individual needs for managing your diabetes. You and the pharmacist will work together to help you learn all of the material covered in the assessment.

Your feedback about this assessment is very important because the assessment is a part of an important pilot project you are participating in. After you are finished, you will be asked to fill out a survey about the assessment to provide feedback on how to improve this assessment for use in helping others to manage their diabetes.

Each question is followed by four possible answers. Select the best answer for each question and fill in the corresponding lettered space on the answer sheet. Mark only one answer for each question.

Let the assessment administrator know when you are finished, and he/she will collect your booklet and answer sheet. He/she will then score your assessment and the pharmacist will go over the results with you to develop a plan that meets your needs for learning more about managing your diabetes.

Your score is based on the number of questions you answer correctly. There is no penalty for guessing, so try to answer every question, even if you must guess.

REMEMBER TO MARK ALL OF YOUR ANSWERS ON THE SEPARATE ANSWER SHEET, and be sure that each mark is heavy and dark and completely fills the answer space. If you change an answer, be sure to completely erase the previous mark.

1. Insulin helps your body to
 - A. turn sugar into energy
 - B. increase blood sugar
 - C. make red blood cells
 - D. make protein

2. Hyperglycemia refers to
 - A. high blood sugar
 - B. low blood sugar
 - C. high blood pressure
 - D. low blood pressure

3. Shaking and sweating are possible symptoms of
 - A. high blood sugar
 - B. low blood sugar
 - C. nerve damage
 - D. eye damage

4. To treat mild low blood sugar, you could do all of the following **EXCEPT**
 - A. take 3 glucose tablets
 - B. drink half a cup of fruit juice
 - C. eat 2 tablespoons of raisins
 - D. drink extra water

5. One of the leading complications of diabetes is
 - A. cancer
 - B. heart disease
 - C. bone damage
 - D. muscle spasms

6. Numbness and tingling in your hands or feet may be symptoms of
 - A. nerve disease
 - B. kidney disease
 - C. heart disease
 - D. liver disease

7. Pills taken for diabetes are designed to
 - A. help manage type 2 diabetes better
 - B. transform type 1 diabetes into type 2 diabetes
 - C. block the action of insulin
 - D. cure diabetes

8. You should stop taking oral medication when you
 - A. have blood sugar levels in the normal range
 - B. experience a long-term illness
 - C. change your diet
 - D. have been told to do so by your doctor

9. You are taking pills for your diabetes and you have developed a rash. What should you do?
 - A. Take fewer pills each day
 - B. Take more pills each day
 - C. Stop taking the pills
 - D. Tell your doctor or healthcare team

10. Which of the following is an appropriate way to dispose of used syringes, needles and lancets?
 - A. Place them in a convenient garbage can.
 - B. Flush them down the toilet.
 - C. Place them in a plastic bag.
 - D. Place them in an appropriate container approved by your healthcare provider.

11. The best site for an insulin injection is
 - A. the abdomen
 - B. a blood vessel
 - C. the foot
 - D. a finger

12. When you travel, your medications and supplies should be
- A. packed in your luggage
 - B. carried with you
 - C. left at home
 - D. sent ahead to your destination
13. If you take your morning insulin but skip breakfast, your blood sugar level usually will
- A. increase
 - B. decrease
 - C. stay the same
 - D. fluctuate dramatically
14. If your blood sugar is over 300 mg/dL for several tests, you should
- A. increase oral medication or insulin
 - B. stop eating carbohydrates
 - C. begin exercising more frequently
 - D. call your doctor or other healthcare professional
15. A glycosylated hemoglobin test (A1c) measures blood sugar control over the past
- A. hour
 - B. day
 - C. week
 - D. 8 to 12 weeks
16. Blood sugar monitoring indicates
- A. the level of glucose in the blood
 - B. the level of insulin in the blood
 - C. whether ketones are present
 - D. whether complications of diabetes are present
17. When should self-monitoring of blood sugar be performed?
- A. Only before breakfast
 - B. Only before lunch
 - C. Only before dinner
 - D. When directed by your healthcare professional

18. You check your blood sugar level at bedtime and notice that it is much lower than usual. You think you may have made a mistake. The best thing to do is to
- A. write down what you think it is
 - B. test again
 - C. leave a blank space
 - D. write down what it normally is
19. When should patients with diabetes be assessed by their physician?
- A. Every 3 months
 - B. Every year
 - C. Every 2 years
 - D. Only after complications develop
20. A primary goal of monitoring blood sugar is to
- A. reduce blood sugar levels
 - B. determine how much protein to eat
 - C. determine if you are taking the right amount of medicine at the right times
 - D. determine the amount of stress in your life and how to reduce it
21. In overweight patients with diabetes, losing weight may accomplish all of the following **EXCEPT**
- A. help the body use insulin better
 - B. lower blood sugar
 - C. decrease the risk of heart disease
 - D. change diabetes from type 2 to type 1
22. A “free food” is a food that has
- A. no sugar
 - B. no salt
 - C. no fat
 - D. less than 20 calories per serving

23. What effect does unsweetened fruit juice have on blood sugar?
- A. It lowers blood sugar.
 - B. It raises blood sugar.
 - C. It has no effect.
 - D. It raises and then lowers blood sugar.
24. Eating foods that are low in fat may decrease the risk of
- A. nerve disease
 - B. kidney disease
 - C. heart disease
 - D. eye disease
25. Which of the following foods contains monounsaturated, or “good,” fat?
- A. Bacon
 - B. Sour cream
 - C. Butter
 - D. Olive oil
26. All of the following foods provide fiber **EXCEPT**
- A. beans
 - B. oats
 - C. apples
 - D. milk
27. Which of the following is a good source of carbohydrates?
- A. Egg whites
 - B. Low-fat mayonnaise
 - C. Whole-grain bread
 - D. Lean roast beef
28. Regular exercise may do all of the following **EXCEPT**
- A. improve cholesterol levels
 - B. improve blood sugar management
 - C. help with weight management
 - D. decrease the action of insulin

29. If your blood sugar is less than 80 mg/dL before exercise, you should
- A. lie down
 - B. eat a snack
 - C. call your doctor immediately
 - D. exercise lightly
30. When exercising, you should always carry
- A. a snack
 - B. a spare pair of shoes
 - C. your blood sugar monitor
 - D. your diabetes medication
31. For a person with diabetes, smoking is most likely to increase the risk of
- A. skin damage
 - B. nerve damage
 - C. cardiovascular damage
 - D. eye damage
32. Which of the following is **NOT** a positive way to manage stress?
- A. Exercise
 - B. Meditation
 - C. Deep breathing
 - D. Smoking
33. You should see an eye doctor at least every
- A. 3 months
 - B. 6 months
 - C. 12 months
 - D. 24 months
34. An illness usually has what effect on blood sugar?
- A. An increase
 - B. A decrease
 - C. No effect
 - D. An increase then a decrease

35. The best way to take care of your feet is to
- A. inspect them every day
 - B. massage them with alcohol every day
 - C. soak them in warm water for 1 hour every day
 - D. buy shoes one size larger than normal
36. Ways to help cope with diabetes include all of the following **EXCEPT**
- A. reduce stress
 - B. increase exercise
 - C. change physicians
 - D. attend support groups

END OF ASSESSMENT. WHEN YOU ARE FINISHED, PLEASE COMPLETE THE COMMENT FORM. THEN, LET THE ASSESSMENT ADMINISTRATOR KNOW YOU ARE FINISHED AND RETURN ALL OF YOUR ASSESSMENT MATERIALS.

Assessment services by



Knapp & Associates International, Inc.
712 Executive Drive • Princeton, NJ 08540

Patient ID: _____ - _____ - _____



Patient Privacy Acknowledgement

To Whom It May Concern:

I am voluntarily participating in the Patient Self-Management Program for Diabetes, a health management program sponsored by my employer, the City of Milwaukee, which will necessitate that my pharmacist and/or certified diabetes educator obtain certain medical/health information about my condition from my physician and/or diabetes care specialist to facilitate the continuity of my care. By signing this form, I am acknowledging (and giving my consent) to have my personal health information used in the following way:

I understand that I may revoke this consent at any time upon giving written notice to the City of Milwaukee. Were that to be the case, I understand and agree that actions taken by any party related to the conduct of the Patient Self-Management Program for Diabetes during the period that relied upon my acknowledgement would stand. Also, I understand that this acknowledgement will expire automatically should I discontinue my participation in the program.

Date: _____

Patient _____

Signature

Patient _____

Printed name

Patient's date of birth _____