Table of Contents: DSMP+ Forms

This packet contains all the required documents for DSMP+ virtual workshops.

13 Provider Letter for DSMES Order

Participants are required to submit this form along with the DSMES Order Form to their physician. Form can be customized to your site.

14 DSMES Order Form

Required at the beginning of every workshop series. Participant must submit this form to their physician for completion and return the signed document.
Used to facilitate the referral process for individuals diagnosed with diabetes to receive services.

15 Assessment/Pre-Survey Questions

Required at the beginning of every class. To be completed by participant.

22 Intervention Tracking From/Attendance Record

To be completed by RD during individual sessions, and by leaders during each group session.

24 SMART Goal Participant Sheet

To be completed by RD during individua assessment session and provided to participant.

25 Participant Post-Survey Questions

To be completed by participants during Session 7.

27 Provider Follow-Up Letter

The program coordinator submits this form along with a copy of the Participant Support Plan to the participant's physician. Form can be customized to your site.

28 Participant Support Plan

RD is to complete collaboratively with the participant during Session 8.

29 Participant Follow-Up Letter

Program coordinator sends this form along with a copy of the Follow-Up Survey to the participant post-workshop for the 3-month follow-up. Form can be customized to your site.

30 Participant Follow-Up Survey

Program coordinator sends to participant post-workshop at 3-month follow-up.

DSMP Plus Virtual Data Collection Checklist

Workshop Paperwork: Access Participant & Leader forms on the ILPTH Leader Resource Page.
Password: leaders1!

Workshop Registration

Leaders

- ☐ Register workshop- Sign in to ILPTH to register workshop.
  - **Sign-In Link** is in the upper right-hand corner on the ILPTH website: https://ilpathwaystohealth.org
  - Navigate to the "Classes" tab and click "Add Class" to register the workshop.
  - Contact AgeOptions to add new locations.
  - Ensure any changes are updated on ILPTH (new dates, different leaders, canceled, etc.).
- ☐ Screen referrals and recruit participants- Discuss program and technical details. If needed, inform participants a technical assistant will contact them to practice before the 1st session.
- ☐ Register participants using your own registration process.
- ☐ Email or mail participant **Welcome Letter** with form links & virtual class link, **Zoom Instructions** (if applicable), and workshop ID. Mail participants workshop books/materials (including forms and envelopes if using paper forms).
  - Ensure participants send a copy of their ID and Insurance Cards.
  - Ensure participant or physician returns the completed **DSMES Order Form**.

1-2 Weeks Prior to Workshop Session 1

Leaders

- ☐ Monitor ILPTH for new participant self-registrations (Sign into ILPTH, navigate to "Classes," search for your workshop, click "view" to see registered participants).
- ☐ Leaders and Technical Assistant (TA) practice.
- ☐ Email pre-workshop reminder with virtual class link and **Zoom instructions** (if applicable).

Session 1- Individual Assessment *(1-2 Weeks Prior to 1st Group Session)*

Leaders

- ☐ If participant has returned the **Assessment/Pre-Survey**, provide the RD with the completed form.
  - If Assessment/Pre-Survey has not been received, RD completes the Assessment/Pre-Survey verbally by asking the participants the questions.
- ☐ Receive completed forms from RD after RD completes the assessment.
- ☐ **No one** is permitted to join the workshop after Week 1 Assessment.

RD

- ☐ Explain evaluation forms to participants using the **Virtual Data Collection Script**.
- ☐ RD conducts Individual Assessment of each participant.
  - RD reviews assessment/pre-survey form and creates DSMP Plan and Smart Goal with participant using the **Intervention Tracking Form**.
  - If RD has not received the **Assessment/Pre-Survey**, RD completes it verbally.
- ☐ RD fills out and provides the participant with the **SMART Goal Participant Sheet**.
- ☐ Return the completed Intervention Tracking and Assessment forms to the leader.

Session 2 *(1st Group Session)*

Leaders

- ☐ Group workshop Session 1 begins.
- ☐ Follow instructions for during/after each session (see next page).

Illinois Pathways to Health by AgeOptions

DSMP Plus Virtual Data Collection Checklist

During/ After Each Session

Leaders

- ☐ Complete attendance form. Please print legibly or fill in electronically.
- ☐ Fill in the **Intervention Tracking Form**: session date, attendance, participant progress, outcomes, and initial form. Document any forms received.
- ☐ Email Action Plan reminder to participants 3 days post-session.
- ☐ Email workshop reminder the day before/morning of workshop with virtual class link.
- ☐ Contact participants who miss sessions or do not return for feedback.

Session 7 *(Last Group Session)*

Leaders

- ☐ Verify that the attendance sheet is accurately completed.
- ☐ In the last 15 min of the session, participants complete the **Post-Survey**.

Session 8- Individual Follow-Up Session

RD

- ☐ RD creates **Participant Support Plan** collaboratively with each participant.
- ☐ Scan and make 2 copies of the completed Support Plan.
- ☐ Provide one copy of completed Support Plan to participant.
- ☐ Submit one copy of the Support Plan to your program coordinator, who will forward it to the participant's physician.

After Last Session

Leaders

- ☐ Immediately after the last session concludes, enter participants, attendance, survey data and upload all legal documents to ILPTH OR send all paperwork to Joan Fox at AgeOptions: joan.fox@ageoptions.org
  - The **ILPTH User Guide** provides instructions for data entry.
  - If you input all data in ILPTH, email the Health Promotion Team at AgeOptions to confirm completion of the workshop. Ensure that you save the forms.
  - If you are an AgeOptions facilitator, you must send all paperwork to Joan.

P.C.

- ☐ Contact leader if you have not received the Participant Support Plan.
- ☐ Send the **Provider Follow-Up Letter** and a copy of the completed Participant Support Plan to the provider/physician.
  - Customize the Physician Cover Letter with your site contact info and logo.

3 Month Follow-Up

P.C.

- ☐ Mark your calendar for program follow-up.
- ☐ Navigate to the "Classes" tab, locate the workshop, and view participant contact info.
- ☐ Mail each participant the **Participant Follow-Up Letter** and **Follow-Up Survey**.
- ☐ Once completed surveys are received, send to Joan Fox at AgeOptions: joan.fox@ageoptions.org
  - When emailing forms, send confidential.

Revised April 2024

Dear Participant,

Welcome and thank you for joining the Take Charge of Your Diabetes Plus Workshop! We are excited to have you participate with us and others in the community as we learn skills to better manage our condition. This packet contains information to support your success in the workshop and helps us gather participant data crucial to secure future funding.

- **Registration Forms: Registration Form, Privacy Policy Acknowledgment, Liability Waiver, Insurance Authorization & Release of Information, and Media Release** – Sign and return all documents to remain in the workshop. **Enclose a copy of your State ID and Medical Ins Card.**
- **DSMES Order Form** and **Physician Letter** – Provide forms to physician for completion. Return with participant registration forms or have physician email completed form.
- **Assessment/Pre-survey** – Complete and return with the participant registration forms.
- **Post-survey** – Complete and return at the conclusion of the workshop.
- ***Living a Healthy Life with Chronic Conditions*** book.
- **Handouts: Workshop Overview and Homework, Menu Planning #1, Menu Planning #2 and combined copy of Charts 9 and 10.**
- **Two pre-stamped return envelopes** – One to return the registration forms and Pre-Survey; the other to return the Post-Survey.

Thank you for taking a few minutes to answer some brief questions. While you may leave any questions blank on the survey, we encourage you to complete it. Summarized information from all participants will help us demonstrate how this program is serving people. Your responses are extremely helpful.

Illinois Pathways to Health by AgeOptions is committed to protecting your privacy. The Privacy Policy Acknowledgment states that you agree to the terms outlined in our privacy policy regarding how your personal information will be collected, used and protected. Please sign and return upon receipt of the document.

The Liability Waiver confirms that you are participating in the workshop at your own risk and AgeOptions is not held liable. Please sign and return upon receipt of the document.

If you have any questions about the surveys or forms, please ask your facilitators or contact the Health Promotion Team at AgeOptions at (800)699-9043 or email info@ilpathwaystohealth.org.

Welcome and thank you for participating!

Evaluation Description Script

****Read aloud before participants complete evaluation and consent forms****

- We are now handing out a packet of information to include several documents. You are getting a privacy policy, liability form, workshop paperwork and a session 1 survey to complete.

- The privacy policy shares how we will use your information and our HIPPA secure practices for both data collection and retention. The data we collect for our health promotion programs is stored in a HIPPA secure platform and any paper copies are stored in locked file cabinets and shredded. Only staff who have received HIPPA training will handle workshop attendance sheets and your survey forms. Data is shared as an aggregate with grant administrators, the National Council on Aging.

- The liability waiver confirms that you are participating in this workshop at your own risk and AgeOptions is not held liable.

- By participating in this session, you are agreeing that you have signed these documents and turned them into your workshop facilitator.

- If you do not feel comfortable signing these documents, please exit the session at this time.

- In this packet you also received a survey, this workshop is made possible through a grant from the U.S. Administration on Community Living (ACL) to AgeOptions. This form asks for demographic information, such as your name, age, and address. It will also ask about your health conditions and weekly or daily activities.

- This information is very valuable to us. We use it to learn who the program is reaching and how to improve our services. It also helps the organizations who are paying for these workshops know that they are spending their money wisely.

- Your information will be shared with The National Council on Aging, who is collecting this data to determine whether the workshops are effective in improving people's quality of life and their ability to manage their ongoing health conditions. This organization is highly regarded and will take great care to protect your information.

- We will not share your individual information for any other reason without your consent. Your information will be combined with other people's information and shared as a group, but it will not be able to be traced back to you individually.

- While completing the form, you may ask us to explain any questions that you find confusing. You may skip any questions that you do not want to answer. Completing the evaluation form is **entirely voluntary**. If you decide not to complete it, you can still participate in this program and it will not affect your relationship with us, your facilitators.

Evaluation Description Script

- Please take time now to read the evaluation form and let us know if you have any questions.

If you have any questions after completing the evaluation form or consent form, you can ask your workshop facilitator or contact the Health Promotion Team at AgeOptions (800)699-9043.

Illinois Pathways to Health by AgeOptions

Registration Form

Workshop ID: _____

First Name*: _____ Last Name*: _____

Email Address: _____

Phone Number*: _____ Date of Birth*: _____

Address*: _____

City*: _____ State*: _____ Zip Code*: _____

Emergency Contact Name: _____ Phone Number: _____

HEALTH INSURANCE INFORMATION

Most Health Promotion programs offered through the Illinois Pathways to Health Initiative are available at no cost to the participant through grants and federal funding. We will NOT bill your insurance without your consent. Listing the information below helps us to know who we are reaching to secure funding for future programs.

From what health system do you receive your primary healthcare care services?

Advocate Aurora Health	☐	Mercy Health Corporation	☐
Amita Health	☐	NorthShore University Health System	☐
Blessing Health System	☐	Northwestern Memorial Health Care	☐
Carle Health	☐	OSF Health Care	☐
Cook County Health	☐	Presence Health	☐
Edward-Elmhurst Health	☐	Rush	☐
Hospital Sisters Health System	☐	Sinai Chicago	☐
Kindred Healthcare	☐	Southern Illinois Healthcare	☐
Loyola Medicine	☐	Swedish American Health System	☐
Memorial Health System	☐		

What type of health insurance do you have? Check all that apply.

☐ Medicare ☐ Private Insurer of Employer ☐ Decline to Provide

☐ Medicaid ☐ Uninsured/ Self-pay

	Insurance Plan Info *(Primary)*	**Insurance Plan Info *(Secondary)***
Insurance Plan Name:		
Group ID #:		
Member ID #:		

Acknowledgment of Receipt of Notice of Privacy Policy

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in the Illinois Pathways to Health by AgeOptions Notice of Privacy Practices. AgeOptions is permitted to revise their Notice of Privacy Practices at any time. We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

Participant's Printed Name: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient:

_____

Participant/Representative Signature: _____ Date: _____

Entity Use Only

I, _____, attempted to obtain the participant's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____

_____

Signature: _____ Date: _____

Illinois Pathways to Health by AgeOptions

Release and Waiver of Liability Agreement

Workshop ID: _____

As a participant in this class, the undersigned agrees to indemnify and release and hold harmless AgeOptions and organizations affiliated with Illinois Pathways to Health, their directors, officers, employees, and agents from any loss, liability, injury, cost, or damage they may incur resulting from such class participation.

In addition, by signing below, the undersigned agrees:

- Information provided in the class does not replace the advice of medical professionals;
- To address concerns with the undersigned's medical provider if the undersigned believes the information in the class conflicts with the advice of the undersigned's medical provider;
- The undersigned has been informed that the sessions may include light to moderate exercise, including stretching, balance, and range of motion exercises;
- The undersigned assumes full responsibility for and risk of bodily injury, death, or property damage due to negligence or releasees or otherwise while participating in any class affiliated with Illinois Pathways to Health by AgeOptions; and
- To work within their own comfort zone and agrees to stop participating if they feel any pain or discomfort and will let one of the class instructors know about their condition or concerns.

Participant's Printed Name: _____

Participant Signature: _____ Date: _____

Illinois Pathways to Health by AgeOptions

Insurance Authorization & Release of Information

Workshop ID: _____

Insurance and Payment Authorization:

IL Pathways to Health programs are offered as a covered benefit by some health insurance plans. By listing the health plan name, group ID, and member ID, AgeOptions will be able to verify whether the participant is an eligible member with this covered benefit.

Payment Responsibility. I agree to pay for all services furnished to me by AgeOptions that are not paid in full by my insurance, government program benefits or other third-party payors, upon receipt of a statement, except as prohibited by AgeOption's contract with my health plan or applicable law.

Payment Authorization. I authorize AgeOptions to directly bill my health plan or third-party payor for services rendered to me by or on behalf of AgeOptions but acknowledge that AgeOptions is not obligated to submit claims to third-party payors on my behalf unless required by law or by its contract with a particular third-party payor. I also authorize any third-party payor through which I may have benefits to make payment directly to AgeOptions for such services. I understand I am financially responsible to AgeOptions for charges not covered by my insurance, government program benefits or other third-party payors.

Release of Information:

I also authorize AgeOptions to use my personal information (including health information) and/or records about me to the extent permitted by law and to disclose such information to: (i) health care or social service providers or other persons involved in my care; (ii) health plans, insurers, or other third party payors for the purpose of claims administration, benefit determinations, benefit development, or quality initiatives; and (iii) persons or organizations in connection with AgeOptions' health care operations and business management. I understand that authorizing the disclosure of this health information is voluntary, and that I can refuse to sign this authorization.

Participant's Printed Name: _____

Participant Signature: _____ Date: _____

Illinois Pathways to Health
by AgeOptions

AGEOPTIONS®

Publicity Permission and Release:

In exchange for consideration received, including any publicity I may receive, I give my full permission and authority to **AgeOptions** to use and release, worldwide, my photograph, likeness, image, name, biographical information and/or other information about my activities for any advertising, trade, promotional or commercial purposes (including, but not limited to, publication to promote or publicize its services), in any form of communication and dissemination including, but not limited to print, electronic, video, film, internet or other method of dissemination now or hereafter developed.

I do not expect, and hereby acknowledge that I am not entitled to, payment of any sort at any time from **AgeOptions**or any other person or entity using this information in exchange for the permissions and release that I am granting for the uses described herein.

I acknowledge and agree that the rights granted herein shall extend to **AgeOptions** and its licensees, subsidiaries, employees, agents, affiliates, successors and assigns, and that **AgeOptions** may assign the rights granted herein to any third party.

Signature:_____Date: _____

Please print:

_____
Name

_____
Address

_____

_____
Daytime Telephone Number

AgeOptions
Health Promotion Team
1048 Lake Street #300
Oak Park, IL 60301

Insert Date

Re: Referral for Diabetes Self-Management Education

This letter is to inform you that your patient has enrolled in the Take Charge of Your Diabetes Plus program, nationally known as the Diabetes Self-Management program developed by Stanford University. The program is proudly licensed and sponsored by AgeOptions and carries accreditation from the Association of Diabetes Care & Education Specialist, making it eligible for reimbursement.

The program consists of six weekly group sessions conducted by two trained facilitators. The sessions provide general education on topics such as healthy eating, health coping, problem solving and monitoring. Additionally, each participant will have two individual assessments, including goal planning by our Registered Dietitian, INSERT NAME.

To facilitate billing for the workshop, **we kindly request that you complete the enclosed Diabetes Self-Management Education/Training Order Form**. Following the completion of the workshop, we will promptly update you on your patient's goals and progress.

Thank you for your cooperation in supporting your patient's participation in this valuable program. If you have any questions or require further information, please do not hesitate to contact me.

_____ _____

Jaime Peña
Health Promotion Program Coordinator
708-383-0258
Jaime.pena@ageoptions.org
info@ilpathwaystohealth.org

Date

ORDER FORM

Diabetes Self-Management Education & Support (DSMES) and Medical Nutrition Therapy (MNT)

MEDICARE COVERAGE: Diabetes self-management education and support/training (DSMES/T) and medical nutrition therapy (MNT) are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes. DSMES and DSMT are the same thing: DSMT is the name of the Medicare Benefit.

DSMT: 10 hours initial DSMES in 12-month period from the date of first encounter, plus 2 hours follow-up per calendar year with signed referral from the treating qualified provider (MD/DO, APRN, NP or PA) each year.

MNT: 3 hrs initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours with change in medical condition, treatment and/or diagnosis with signed referral from any physician (MD/DO).

PATIENT INFORMATION:

Last Name	First Name	Middle	Date of Birth
Address	City	State	Zip Code
Home Phone	Cell Phone	Email Address	

DIABETES DIAGNOSIS:

☐ Type 1 ☐ Type 2 ☐ Gestational Diagnosis Code: _____

DSMES ORDERS:

If # of hours are not specified, DSMES team will default to number of hours allowed per benefit.

☒ Initial DSMES __30min_____ ☒ Follow-up DSMES ____30min____

DSMES CONTENT AREAS:

☐ ALL content as related to diabetes care plan and agreed upon by the Patient and DSMES team

OR only specific content areas:

☒ Healthy Coping ☒ Monitoring ☒ Taking Medication
☒ Healthy Eating ☒ Reducing Risk ☐ Injection Training
☒ Being Active ☒ Problem Solving ☐ Other: _____

SPECIAL NEEDS (OPTIONAL) | MEDICARE BENEFICIARIES

*Please check reason **if** more than 1 of 10 hours of INITIAL DSMT are being requested individually instead of in a group setting.*

☐ Vision ☐ Hearing ☐ Language ☐ Cognitive
☐ Physical ☐ Psychosocial ☐ Transportation ☐ Other: _____

MEDICAL NUTRITION THERAPY

☐ Initial MNT ☐ Follow-up MNT ☐ Additional hours MNT for change in: (choose one)
☐ medical condition ☐ treatment ☐ diagnosis

SIGNATURE OF QUALIFIED PHYSICIAN OR ADVANCED PRACTICE PROFESSIONAL:

Signature and NPI# of qualified provider certify that they are managing the beneficiary's diabetes care for DSMT referrals. Date of signature:

`

Practice Name and Contact Info

Last Revised 04/01/24

Take Charge of Your Diabetes Plus
Participant Assessment & Pre-Survey

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/24)

ABOUT YOU

1. How did you hear about this class?
   - ☐ Physician or member of my healthcare team
   - ☐ Insurance Company
   - ☐ Community Organization
   - ☐ Care Coordinator
   - ☐ Family member/friend
   - ☐ Flyer
   - ☐ Facebook
   - ☐ Instagram
   - ☐ Twitter
   - ☐ Other social media
   - ☐ Health fair/ community event
   - ☐ Congregate/ home delivered meal notification
   - ☐ Information Session/ presentation
   - ☐ Email
   - ☐ Newsletter/ mass communication
   - ☐ Print ad/ newspaper
   - ☐ Radio/ pod cast
   - ☐ Religious Institution
   - ☐ Other: _____

2. Did your doctor or other health care provider suggest that you attend this program?
   ☐ Yes ☐ No

3. How old are you today? _____ years

4. Do you live alone? ☐ Yes ☐ No

5. Are you of Hispanic, Latino, or Spanish origin? ☐ Yes ☐ No

6. What is your race? **Check all that apply.**
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Some other race (please specify): _____

7. What is your current gender? **Select ONE**.
   - ☐ Man
   - ☐ Woman
   - ☐ Non-binary
   - ☐ _____(please specify)
   - ☐ Prefer not to answer

8. Do you consider yourself to be transgender?
   ☐ Yes ☐ No ☐ Prefer not to answer

9. Which of the following best represents how you think of yourself? **Select ONE**.
   - ☐ Lesbian or gay
   - ☐ Straight, that is, not gay or lesbian
   - ☐ Bisexual
   - ☐ [If respondent is AIAN:] Two-Spirit
   - ☐ I use a different term (please specify) _____
   - ☐ Don't know
   - ☐ Prefer not to answer

10. What is the highest grade or year of school you completed?

☐	Some elementary, middle, or high school	☐	Some college or technical school
☐	High school graduate or GED	☐	College (4 years or more)

11. Have you ever served in the military? ☐ Yes ☐ No

12. During the past year, did you provide regular care or assistance to a friend or family member who has a long-term health problem or disability? ☐ Yes ☐ No

13. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
   - ☐ Yes- Please describe: _____
   - ☐ No

14. How confident are you in filling out medical forms by yourself?
   ☐ Extremely ☐ Somewhat ☐ Not at All

REDUCING RISK

15. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____

16. When were you diagnosed with diabetes? _____

17. Have you had diabetes self-management education (DSMES) before? ☐ Yes ☐ No ☐ Unsure

18. How often do you have high blood sugar?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

19. How often do you have low blood sugar?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

20. Do you smoke? ☐ Yes ☐ No

21. Do you drink alcohol? ☐ Yes ☐ No

22. In the past 12 months have you been to the emergency room because of diabetes? ☐ Yes ☐ No

23. In the past 12 months have you been admitted to the hospital because of diabetes? ☐ Yes ☐ No

HEALTH HISTORY

24. In general, would you say that your health is:
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

25. Has a health care provider ever told you that you have any of the following chronic conditions (i.e., one that has lasted for three months or more)? **Please use an X to indicate your response Yes or No.**

	YES	NO		YES	NO
Alzheimer's Disease or other Dementia			Kidney Disease		
Anxiety Disorder			Malnutrition		
Arthritis/Rheumatic Disease			Obesity		
Asthma/Emphysema/Other Chronic Breathing or Lung Problem			Osteoporosis (Low Bone Density)		
Cancer or Cancer Survivor			Post-Traumatic Stress Disorder		
Chronic Pain			Schizophrenia or other Psychotic Disorder		
Depression			Stroke		
Diabetes (High Blood Sugar)			Substance Use Disorder		
Heart Disease			Urinary Incontinence		
High Cholesterol			Other Chronic Condition		
Hypertension (High Blood Pressure)					

26. Please use an **X** to indicate your response to the following questions.

	YES	NO
a. Are you deaf or do you have serious difficulty hearing?		
b. Are you blind or do you have serious difficulty seeing, even when wearing glasses?		
c. Do you have serious difficulty walking or climbing stairs?		
d. Do you have difficulty dressing or bathing?		
e. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?		
f. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?		

27. How often do you feel lonely?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

28. How often do you feel isolated from those around you?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

29. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure 1 2 3 4 5 6 7 8 9 10 Totally sure

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

30. Which of the following have you had or done in the past year?

☐	Dilated eye exam	☐	Cholesterol
☐	Dental Exam	☐	Blood Pressure Check
☐	Had Feet Checked	☐	Stopped Smoking
☐	A1C		

HEALTHY COPING

31. Who supports you in coping with the daily demands of managing diabetes?

☐	Family	☐	Diabetes Care & Education Specialist
☐	Friends/ Coworkers	☐	Health Care Professional
☐	Support Group	☐	Other: _____

32. Respond to the following by answering often true, sometimes true, or never true.

	Often True	Sometimes True	Never True
a. Diabetes gets in the way of the rest of my life:	☐	☐	☐
b. Feeling overwhelmed by taking care of my diabetes:	☐	☐	☐
c. Feeling that I am often failing with my diabetes care:	☐	☐	☐

BEING ACTIVE

33. On how many of the last 7 DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking): _____ days

34. How often do you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part your work?
☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

HEALTHY EATING

35. Do you follow a specific eating plan?
☐ Yes- How many of the last 7 DAYS did you follow your eating plan? _____ days
☐ No

36. How many of the last 7 DAYS did you eat 5 or more servings of fruit and vegetables? _____ days

37. How many of the last 7 DAYS did you miss taking one or more of your medications or injections? _____ days

TAKING MEDICATION

38. Do you take diabetes medication?
☐ Yes- Check all that apply: ☐ Pills ☐ Injections ☐ Insulin ☐ Supplements
☐ No

39. How many of the last 7 DAYS did you take your medication and/or injections? _____ days

40. How many of the last 7 DAYS did you miss taking one or more of your medications or injections? _____ days

MONITORING

41. Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?
☐ Yes- How often do you usually check your blood sugar? _____
☐ No

42. Have you kept a food or activity log before? ☐ Yes ☐ No

PROBLEM SOLVING

43. Please rate your agreement with the following statements:

	Yes	No	Unsure
a. I know what to do when my blood sugar goes higher or lower than it should be:	☐	☐	☐
b. I know when changes in my diabetes mean I should visit the doctor:	☐	☐	☐
c. I know I can manage my diabetes so that it does not interfere with the things I want to do:	☐	☐	☐

SOCIAL DETERMINANTS OF HEALTH

44. Respond to the following by answering often true, sometimes true, or never true.

Within the last 12 months:	Often True	Sometimes True	Never True
a. I worried whether our food would run out before we had money to buy more:	☐	☐	☐
b. The food we bought just did not last and we didn't have money to get more:	☐	☐	☐

45. How often does this describe you?

	Often True	Sometimes True	Never True
a. I don't have enough money to pay my bills:	☐	☐	☐
b. I put off or neglect to go to the doctor because of distance or lack of transportation:	☐	☐	☐
c. I am worried or concerned that I may not have stable housing soon:	☐	☐	☐

46. I have a job: ☐ Yes ☐ No

DSMES PLAN

47. Please check all areas that you are most interested in learning about:

☐	What is Diabetes	☐	Reducing Risk (ex. make an action plan such as setting achievable weight loss goal, communicate better with my doctor)
☐	Healthy Coping (ex. increase support from family or friends, manage depression)	☐	Monitoring (ex. increase blood sugar monitoring)
☐	Healthy Eating (ex. eat healthier/follow a meal plan)	☐	Problem Solving (ex. treat complications such as foot pain, low vision & energy)
☐	Being Active (ex. increase exercise/physical activity)	☐	Other: _____
☐	Taking Medications (ex. give myself injections correctly)		

48. List goals, questions, or concerns for your DSMES Team:

Illinois Pathways to Health by AgeOptions

Take Charge of Your Diabetes Plus Intervention Tracking Form

Participant Name: _____

Date of DSMES Assessment: _____ **Workshop ID:** _____

DSMES PLAN

WHAT TOPICS: ☑Healthy Coping ☑Healthy Eating ☑Being Active ☑Taking Medication ☑Monitoring ☑Problem Solving ☑Reducing Risks

HOW: ☑Group ☑Individual (Special Needs: _____)

WHERE: ☐In-person ☐Virtual ☐Combination **WHEN (Group Workshop Dates):** _____

S

DATE OF SERVICE:	☐ Session #1	☐ Session #2	☐ Session #3	☐ Session #4
TIME SPENT:	DSMT 30 min	DSMT 90 min	DSMT 90 min	DSMT 90 min
CLASS TYPE:	Individual	Group	Group	Group
TOPICS COVERED:	Individual assessment with Registered Dietician	☐ Healthy Coping ☑ Healthy Eating ☐ Being Active ☐ Taking Medication ☑ Monitoring ☐ Problem Solving ☑Reducing Risks	☑ Healthy Coping ☑ Healthy Eating ☐ Being Active ☐ Taking Medication ☑ Monitoring ☑ Problem Solving ☑ Reducing Risks	☑ Healthy Coping ☑ Healthy Eating ☑ Being Active ☐ Taking Medication ☑ Monitoring ☑ Problem Solving ☑ Reducing Risks
Participant DSMES Progress and Plan:	Completed assessment/pre-survey			
Clinical or Behavioral Outcome:	Created SMART goal			
DSMES Team Initial:				

Illinois Pathways to Health by AgeOptions

Take Charge of Your Diabetes Plus
Intervention Tracking Form

DATE OF SERVICE:	☐ Session #5	☐ Session #6	☐ Session #7	☐ Session #8
TIME SPENT:	DSMT 90 min	DSMT 90 min	DSMT 90 min	DSMT 30 min
CLASS TYPE:	Group	Group	Group	Individual
TOPICS COVERED:	☑ Healthy Coping ☑ Healthy Eating ☐ Being Active ☐ Taking Medication ☑ Monitoring ☑ Problem Solving ☑ Reducing Risks	☑ Healthy Coping ☐ Healthy Eating ☑ Being Active ☐ Taking Medication ☑ Monitoring ☑ Problem Solving ☑ Reducing Risks	☑ Healthy Coping ☐ Healthy Eating ☐ Being Active ☑ Taking Medication ☑ Monitoring ☑ Problem Solving ☑ Reducing Risks	Individual follow-up session with Registered Dietician
Participant DSMES Progress and Plan:				
Clinical or Behavioral Outcome:				
DSMES Team Initial:				

Participant's SMART goal: _____

_____

Date goal set: _____ **Date of goal follow up:** _____ ○○○○○ ***Goal Progress: Never Met 1 - 2 - 3 - 4 - 5 Always Met***

Forms Received: ☐ **Registration Form** ☐ **Insurance Authorization** ☐ **Privacy policy** ☐ **Liability Waiver** ☐ **DSMES Order Form**
☐ **Assessment/Pre-Survey** ☐ **Intervention Tracking Form** ☐ **Post-Survey** ☐ **Support Plan** ☐ **ID Card** ☐ **Insurance Card**

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by AgeOptions

Take Charge of Your Diabetes Plus
Participant SMART Goal

NAME: _____

GOAL SET ON: _____

My Diabetes Self-Management Education and Support (DSMES) goal is:

_____

_____

_____

Notes:

_____

_____

_____

Last Revised 04/01/24

Take Charge of Your Diabetes Plus
Participant Post-Survey

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/24)

Program Name:

☐ Take Charge of Your Health ☐ Take Charge of Your Pain ☐ wCDSMP
☐ Take Charge of Your Diabetes ☐ Cancer: Thriving and Surviving

---

1. In general, would you say that your health is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure	1	2	3	4	5	6	7	8	9	10	Totally sure
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

3. How often do you feel lonely?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

4. How often do you feel isolated from those around you?

☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never

5. Since this program began, what have you done to manage your chronic condition(s)? **Check all that apply.**

☐ Talked to a family member or friend about my health
☐ Talked to a healthcare provider about how I can better manage my chronic condition
☐ Had my medications reviewed by a healthcare provider or pharmacist
☐ Started or continued to exercise
☐ Made changes to how I choose the food I eat
☐ Participate in or plan to participate in another health-related or exercise program in my community

6. How would you rate your overall satisfaction with the quality of the program?

☐ Very Dissatisfied ☐ Dissatisfied ☐ Okay ☐ Satisfied ☐ Very Satisfied

7. Since this program began, I have applied the skills I learned in this program to: **Check all that apply.**

☐	Manage emotions like stress, depression, anger, fear, or frustration
☐	Manage pain, fatigue, or other symptoms of my chronic condition(s)
☐	Increase my strength, flexibility, endurance, or overall physical fitness
☐	Make a medication list that includes all current medications, dosages, and dates started
☐	Solve a problem or issue I was experiencing in my life
☐	Help someone else use a technique I learned in this program

8. How likely is it that you would recommend this program to a friend or family member?

Not at all likely ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Extremely likely

9. Would you be willing to share your story to help other people gain access to these programs?
☐ Yes ☐ No

10. What was most valuable to you in this program?

_____

_____

_____

11. Please provide any thoughts or feedback about the program leader(s):

_____

_____

_____

Illinois Pathways to Health by AgeOptions

TAKE CHARGE of your health

AgeOptions
Health Promotion Team
1048 Lake Street #300
Oak Park, IL 60301

Insert Date

Attention: Insert Dr Name

Re: Follow-Up to Referral for Diabetes Self-Management Education

Patient Name: Insert Name **DOB:** Insert DOB

This letter is to update you that ten hours of diabetes education has been completed by your patient. We sincerely appreciate the referral and order that you authorized for this service.

The education sessions were conducted in small group settings, focusing on general education covering the seven self-care behaviors essential for effective diabetes management. These behaviors encompassed aspects including eating healthy, being active, monitoring, taking medication, problem-solving, healthy coping, and reducing risks.

Participant outcomes included:

_____

_____

_____

_____

_____

_____

_____

Attached for your reference, please find the participant's pre- and post-program SMART goals along with additional recommendations.

We greatly appreciate your support and collaboration in assisting your patient with this educational opportunity. Thank you!

_____ _____

RD Name Date
Registered Dietician
Insert Contact Info

Illinois Pathways to Health by AgeOptions

Last Revised 04/01/24

Take Charge of Your Diabetes Plus
Participant Support Plan

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/24)

Participant's POST-Program SMART goal: _____

_____

_____

RECOMMENDATIONS:

☐ Schedule Dentist appt _____
☐ Schedule Foot Dr appt _____
☐ Schedule appt with Dietitian _____
☐ Schedule Eye Doctor appt _____
☐ Follow-up with Social Worker
☐ Join a Support Group
☐ Get Diabetes ID bracelet
☐ Quit Smoking

☐ Pneumonia Vaccination _____
☐ A1C lab test _____
☐ HDL lab test _____
☐ LDL lab test _____
☐ Cholesterol lab test _____
☐ Triglycerides lab test _____
☐ Microalbuminuria lab test _____
☐ Other: _____

RESOURCES:

_____

_____

_____

_____

_____

Registered Dietician Signature: _____ **Date:** _____

AgeOptions: Health Promotion Team
1048 Lake Street #300
Oak Park, IL 60301

Insert Date

Dear Insert Name

We enjoyed having you in our Take Charge of Your Diabetes Plus program at Location which began DATES OF CLASS STARTED. We recently corresponded with Dr. LAST NAME sharing insights into what you gained from the program. We are interested in hearing how you are applying the information that you learned since completing the workshop sessions. Your experiences are crucial for us to assess the effectiveness of the program.

To aid us in the evaluation process, we kindly request that you complete the enclosed survey and return it using the provided pre-paid envelope. Once we review your survey feedback, we will follow up regarding any necessary additional recommendations or resources.

Thank you for your cooperation. If you have any questions, please don't hesitate to contact us.

Thank you for participating in Take Charge of Your Diabetes Plus!

_____ _____

Jaime Peña
Health Promotion Program Coordinator
708-383-0258
Jaime.pena@ageoptions.org
info@ilpathwaystohealth.org

Date

Last Revised 04/01/24

Take Charge of our Diabetes Plus
Participant Follow-Up Survey

Participant Number or Name: _____

Workshop ID: _____ **Site Name:** _____

Start date of program: _____ / _____ / _____ (e.g., 05/01/24)

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1. In general, would you say that your health is?
   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. How sure are you that you can manage your condition so you can do the things you need and want to do?

Totally unsure	1	2	3	4	5	6	7	8	9	10	Totally sure
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

3. Since this program ended, what have you done to manage your chronic condition(s)? **Check all that apply.**
   ☐ Talked to a family member or friend about my health
   ☐ Talked to a healthcare provider about how I can better manage my chronic condition
   ☐ Had my medications reviewed by a healthcare provider or pharmacist
   ☐ Started or continued to exercise
   ☐ Made changes to how I choose the food I eat
   ☐ Participate in or plan to participate in another health-related or exercise program in my community

4. How would you rate your overall satisfaction with the quality of the program?
   ☐ Very Dissatisfied ☐ Dissatisfied ☐ Okay ☐ Satisfied ☐ Very Satisfied

5. Since this program ended, I have applied the skills I learned in this program to: **Check all that apply.**

☐	Manage emotions like stress, depression, anger, fear, or frustration
☐	Manage pain, fatigue, or other symptoms of my chronic condition(s)
☐	Increase my strength, flexibility, endurance, or overall physical fitness
☐	Make a medication list that includes all current medications, dosages, and dates started
☐	Solve a problem or issue I was experiencing in my life
☐	Help someone else use a technique I learned in this program

6. How successful are you with your POST-Program SMART goal?
   ☐ Always ☐ Often ☐ Sometimes ☐ Rarely ☐ Never- What were some of the issues?

   _____

   _____

7. Did you follow through with recommendations? ☐ Yes ☐ No- If not, why?

   _____

   _____

8. Write one example of how you used what you learned about diabetes in your workshop:

   _____

   _____

9. What has changed in your diabetes care since the workshop?

   _____

   _____

10. Please provide any additional information you wish to share:

    _____

    _____