

# BUILD AN ACCOUNTABLE DIABETES TEAM



The organization creates a diabetes team that accepts accountability for overall performance and achievement of goals. The team consists of engaged, multi-disciplinary participants who will address all aspects of diabetes care. Team composition is flexible and adapted to each organization and its culture.

## STEP 1: ESTABLISH A TEAM

- Assemble a core team that consists of 8-10 members across the organization. Find those with an interest and/or skills who will be committed throughout the campaign. The team may consist of a patient or family member, Primary Care Physician, Advanced Practice Provider, Endocrinologist, Nurse, Certified Medical Assistant, Office Manager, Quality Manager, Information Technologist, Certified Diabetes Educator, and/or Dietitian.
- Identify extended team members (e.g., Pharmacist, Administrator, Podiatrist, Optometrist, Dentist, Health Coach, Specialty Provider, Behavioral Health Practitioner, Community Liaison) to support the core team at different intervals.
- Identify project management support to oversee campaign activities and responsibilities.

## STEP 2: SCHEDULE THE FIRST TEAM MEETING

- Prepare or review a charter that identifies performance goals and related measures and an action plan that includes specific measureable objectives and related activities; responsibility for each objective; timeframe to complete each objective; and resources available or needed (e.g., support staff, data reports, financial).
- Appoint a leader who can generate internal support and secure commitment and resources from senior leadership.
- Select a “physician champion” who will gather support from the other physicians.
- Schedule regular team meetings, at least monthly.

- Commit to transparency and sharing of results throughout the organization.

## STEP 3: HOLD ONGOING MEETINGS

At each meeting, the team will:

- Evaluate current procedures and guidelines for diabetes management to evaluate if processes are effective.
- Review and discuss data reports to evaluate the team’s progress toward improvement.
- Review the action plan and have each member report on their specific objective(s).
- Identify early indicators of success and challenges preventing the team from meeting objectives.
- Determine process changes that need to occur as a result of successful interventions.
- Invite extended team members (as needed) to the meetings to build collaboration.
- Ensure development and implementation of internal communication plan.

## STEP 4: CELEBRATE SUCCESS

- Communicate your team’s progress and success to the rest of the organization through various channels (e.g., employees, department meetings, board meetings).
- Acknowledge the members of the team and others who contributed to the success of the program.

# TOOL: CLINIC TEAM ROLES

## INTERMOUNTAIN HEALTHCARE

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### COLLABORATIVE PHARMACY MANAGEMENT

The collaborative pharmacy model of disease management is an emerging program to help providers achieve clinical goals and improve satisfaction for patients with dyslipidemia, diabetes, and/or hypertension.

This program allows providers to partner with a pharmacist for support in selecting, titrating, and monitoring medications. For more information on this program, contact [jeff.olson@imail.org](mailto:jeff.olson@imail.org).

### PROPOSED ORDERS

iCentra will have the following advisories and the MA should propose orders to assist with the following advisories if they fire:

- Creatinine blood test (yearly)
- B-12 blood test
- ACE/ARB
- HbA1c (every 6 months, or every 3 months if HbA1c is greater than 9)
- Urine ACR (yearly)
- See ophthalmology for 2-year exam, or enter date of last eye exam for eye professional

### ADDITIONAL SUPPORT FROM THE CARE MANAGEMENT TEAM

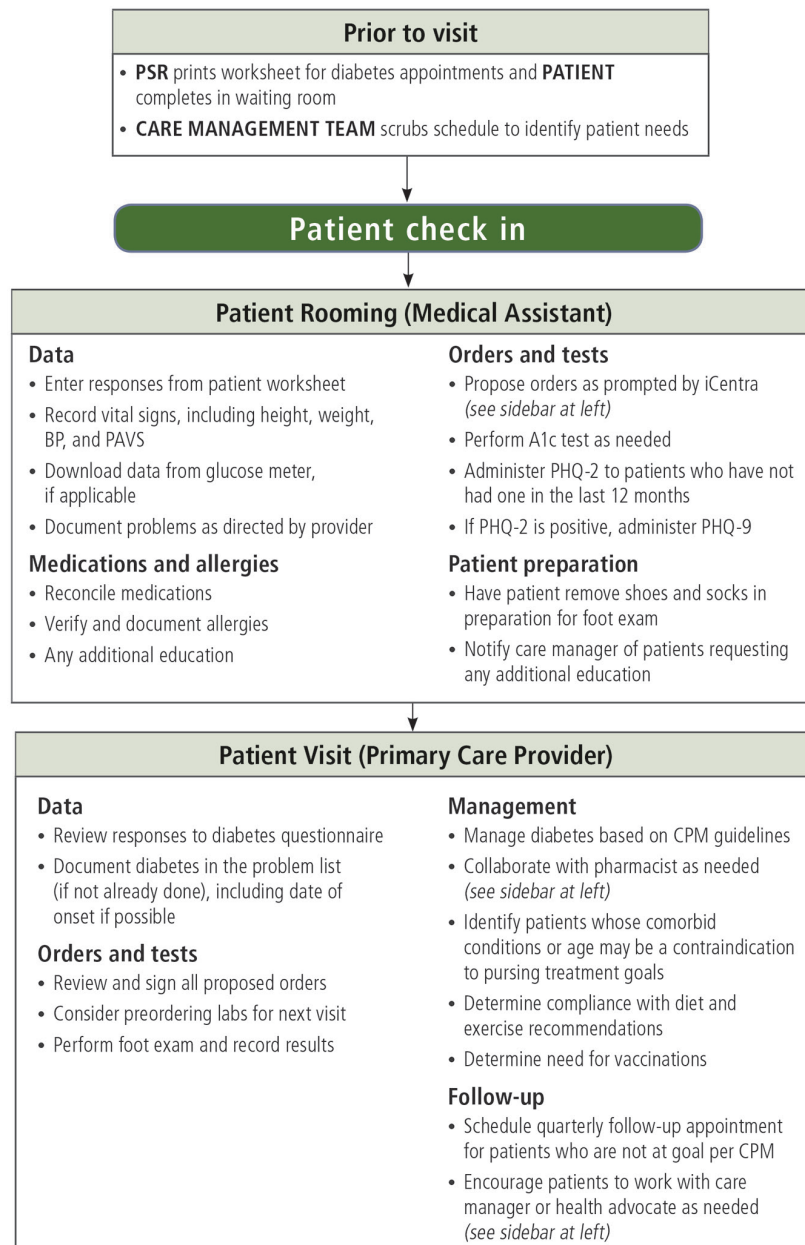
The care management team should support the team by:

- Collaborating with physician on patient management and education
- Collaborating with physician to identify and refer patients who need specialty care
- Working the diabetes bundle reports

## ► CLINIC TEAM ROLES

A clinic visit for a patient with diabetes requires the support of the entire team to assure comprehensive care. The following algorithm suggests general responsibilities to help a clinic team share accountability for diabetes management.

### ► ALGORITHM: PATIENT VISIT



# TOOL: DIABETES CARE STANDING ORDERS

## COMMUNITY PHYSICIAN NETWORK

**COMMUNITY HEALTH NETWORK**  
Community Physician Network  
Indianapolis, Indiana

**Add Protocol #**

**Page 1 of 3**  
**EFFECTIVE: 1/01/2012**

**Practice Name:** Add practice Name

**Protocol Title:** Diabetes Care Standing Orders

**Purpose:** Establish a process by which healthcare team members may perform or order selected tests for care of patients with diabetes that meet specific criteria.

**Scope:** Applies to all staff members of this practice.

**Procedure:**

<i>Test</i>	<i>Criteria</i>	<i>Action</i>
<b>A1c</b>	A1c result is > 6 months old	Perform or order A1c test
<b>Lipid Panel</b> (Patients >12 yrs)	Lipid panel > 12 months old	Order fasting lipid panel
<b>Lipid Panel</b> (Patients 2-12 yrs)	Pts 2-12 yrs with unknown history or positive family history of hypercholesterolemia or premature CVD event	Draw lipid panel at diagnosis
	If none of above, then at age 12 yrs	Draw lipid panel at diagnosis and repeat every 5 yrs. If abnormal results, repeat every 1 yr.
<b>Microalbumin</b> (Omit if dx kidney disease stage IV or V or ESRD)	Microalbumin result > 12 months old  If Type 1 – initiate at 10 years old or after 5 yrs diabetes duration.  If Type 2, begin at diagnosis.	Perform or order microalbumin test.
<b>Serum Creatinine</b>	Serum creatinine > 12 months old	Perform or order creatinine



**COMMUNITY HEALTH NETWORK  
Community Physician Network  
Indianapolis, Indiana**

**Add Protocol #**

**Page 2 of 3  
EFFECTIVE: 1/01/2012**

<b>Dilated Retinal Eye Exam</b>	No report of dilated retinal eye exam in 12 months  Type 1 - begin within 3 - 5 years of diabetes diagnosis; Type 2 – begin at diagnosis).	Refer to eye care provider for DILATED eye exam (explain test must include dilation of the pupils and is not just a visual acuity test.
<b>Foot Exam</b>	Ask about any foot problems.  Remove shoes and socks.	Perform a visual foot inspection each visit for abnormalities.  If abnormalities exist or comprehensive foot exam not documented in the past year, alert provider.
<b>Influenza Immunization</b> (unless contraindicated or allergic to eggs)  <i>Resource: National immunization hotline 1-800-232-2522 or <a href="http://www.vaccines">http://www.vaccines</a></i>	If age $\geq$ 6 months old	Offer "inactivated" (no live virus, no flu mist) vaccine annually beginning each October.
<b>Pneumococcal Pneumonia Immunization</b> (unless contraindicated or allergic to eggs)  <i>Resource: National immunization hotline 1-800-232-2522 or <a href="http://www.vaccines">http://www.vaccines</a></i>	If age $\geq$ 2 yrs old  OR  *At age 65 IF first dose given before age 65 and 5 or more years have passed since that dose	Offer pneumonia vaccine (PPV 23) once in a lifetime*
<b>Self-Management Goals:</b>	Ask the patient if he/she has any self-management goals (self-care practices that the patient completes, or is working toward, to improve their diabetes care).	If the patient has no goals, alert the provider (or Nurse Care Manager) to discuss and assist the patient with setting reasonable goals.

**Source:** 2006 American Diabetes Association's Clinical Practice Recommendations.



**TOOL: DIABETES CARE STANDING ORDERS (CONTINUED)****COMMUNITY PHYSICIAN NETWORK**

**COMMUNITY HEALTH NETWORK**  
**Community Physician Network**  
**Indianapolis, Indiana**

**Add Protocol #**

**Page 3 of 3**  
**EFFECTIVE: 1/01/2012**

**Practice Name:** \_\_\_\_\_

**Protocol Title:** Diabetes Care Standing Orders

**Protocol Owner:** Director Nurse Care Managers

**Approved by:** Clinical Excellence Committee

**Approved by:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(See ADM 03 for designated approval.)

NOTE: Office Based Protocols/Standing Orders approval must be obtained from local MD leadership.

**Next review due:** \_\_\_\_\_

NOTE: Evidence Based policies/protocols must be reviewed annually otherwise review bi-annually.

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

**Next review due: 01/01/2013**

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

**Next review due: 01/01/2014**

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

**Next review due: 01/01/2015**

# TOOL: TOP TIPS FROM CARE TEAMS AND FAQs

MERITER-UNITYPOINT HEALTH



## Diabetes Update – 2015

### Top 10 Tips from Top MMG Care Teams

When	What – consistent/reliable workflows	Testimony from the trenches
<b>Chart Prep</b> 	<b>1. Clinic staff verifies that upcoming DM patients have had their labs done</b> , and if not, call them to do so. Be sure that lab orders are in place.	<ul style="list-style-type: none"> <li>• “95% of my patients have their labs done ahead of the visit. It is an expectation I set with the patients and staff.”</li> <li>• “Having lab results makes the visit much more worthwhile for me and the patient.”</li> <li>• “I can’t help manage A1c if I don’t have the info in front of me during the visit.”</li> <li>• “An after-visit call with lab results just isn’t the same as a face to face discussion.”</li> </ul>
<b>Rooming</b> 	<b>2. Consistently use the chronic disease navigator</b> for DM follow up visits. <b>3. Take shoes/socks off every visit</b> and document the full foot exam in the DM navigator at least 1x/year.	<ul style="list-style-type: none"> <li>• “The navigator quickly walks me through everything I need to ask...it’s easy to use.”</li> <li>• “My roomer uses the chronic disease navigator about 90% of the time: I count on having that info when I enter the room. It really helps the visit go more quickly and pulls the data automatically into my note.”</li> </ul>
<b>Physician Care</b> 	<b>4. <u>Everyone in care team reinforces appropriate visit and refill frequency based on A1c control:</u></b> a. NEW dx: consider 2 week – 1 month visits and a DCT referral for education. b. A1c <7: 6 month visits/refills c. A1c 7 – 8: 3 month visits/refills d. A1c >8: 1 – 3 month visits based on compliance, refer to DCT e. New/medication change – consider 1 month visit/60 day refill. <b>5. Use a tool that helps you document quickly</b> and consistently: conquer your barriers to using the smart set. Alternatively, use a smart phrase/note writer. Don’t type everything. <b>6. Medications:</b> Use refill protocol but limit to 1 month for new meds and 3 month for A1c >8. AND, use the Pharmacy referral when needed.	<ul style="list-style-type: none"> <li>• “The DM smart set has all the key elements I need. At least consider using it to order supplies and future labs.”</li> <li>• “New med scripts are limited to 1 month so I can check how they are doing.”</li> <li>• “I limit scripts to 3 or 6 months to assure patients come in for their DM visits: RNs should check A1c before giving refills.”</li> <li>• “The smart set assures that all key elements are covered but it’s not 100% intuitive until you get used to it. Then, it works great and goes faster.” “I set it up ahead of time – it only takes 30 seconds.”</li> <li>• “The pharmacists are a great resource for patients on insulin, multiple medications or out of control. It saves me time and the patients really appreciate their help.”</li> <li>• “Try one of the new medications if the old ones aren’t working well.”</li> <li>• “Lipid management IS diabetic management: be liberal with statins.”</li> <li>• “Use the attached med table (on last page) from the ADA.”</li> </ul>
<b>Patient Education</b> 	<b>7. Every visit is an opportunity to support the patient.</b> Always document patient instructions/goals in the AVS so you can engage patient and follow this info over time. <b>8. Use the “Formula for Good Health”</b> and exercise ‘prescriptions’.	<ul style="list-style-type: none"> <li>• “DM is a lifestyle disease – I tell patients they can manage this well by making good food and activity choices”.</li> <li>• “Keep a laminated copy of Formula for Good Health” handy and refer to it in patient visits.”</li> <li>• “Actively work with patient to identify barriers to lifestyle changes.” “As a physician I need to move past feeling like a ‘babysitter’ to being more of a ‘coach.’”</li> <li>• “Introduce concept of DCT consultation and Healthy Weight program and encourage them if they have acceptance.”</li> <li>• “My RN does a great job teaching glucometers, injections, etc. Saves me time.”</li> <li>• “If we can’t fit the education into a regular visit we sometimes have the patient come back for that plus a glucometer check.”</li> </ul>
<b>Reception</b>	<b>9. Schedule follow up visits</b> and include ‘DM follow up’ in reason for visit.	<ul style="list-style-type: none"> <li>• “It’s really helpful when reception can capture DM as reason for visit for all follow up visits.”</li> </ul>
<b>Outreach</b> 	<b>10. Run DM registry</b> weekly or at least monthly and contact those who are overdue for labs/visit.	<ul style="list-style-type: none"> <li>• “My nurse reviews the DM registry every week or so to reach out to patients who have A1c&gt;9 or those who are missing labs and visits. It only takes a few minutes when we do it regularly.”</li> <li>• “I give a list of patients who need appointments scheduled to our scheduling staff to reach the patient.”</li> </ul>





## Diabetes Update – 2015

### Frequently Asked Questions

**1. *I haven't been 'tightly' managing my DM patients. What will they think when I change our visit and refill expectations?***

Talk to your patients about the new ADA standards. Help them understand that there is good clinical evidence for best practices like regular A1c testing, physician visits and lifestyle changes. Let them know you are committed to providing the best possible care. You and your team can do this at patient visits or via outreach calls or a letter. Just keep your message simple and supportive.

**2. *How do we balance the need for scheduled/regular labs with insurance limitations?***

The 90-day 'rule' seems to meet most needs for monitoring glyco-hemoglobin. For 'in-between' monitoring, encourage use of home monitors and have patients bring them in to clinic visits.

**3. *I have no time to run the registry report much less do outreach to patients. What do you want me to do?***

Reaching out to patients who are overdue for labs or visits, or those who are struggling with lifestyle changes is a critical part of the service we provide. Registries are our best tool to identify those top priority patients. Physicians and staff must make it a priority. Just start somewhere: choose a day/time of the week and hold your team accountable to getting it done. EG start with DM patients without visits in the past 6 months, or those with A1c >9.

**4. *We have no time to do patient education during regular visits: the MD and RN are too busy.***

For patients who are having trouble controlling their DM, or just need more personal attention, schedule an additional office visit with the specific purpose of providing education, discussing individual barriers and goals. Also, seek out the skills of your nursing staff and our pharmacists and DCT to provide the individualized care your patients need.

**5. *I don't find the smart set to be useful – why should I use it at all?***

Use the MeriterCare tools that work best for you AND be sure that you always incorporate the critical elements. This can be done via the Smart Set, Notewriter or Smart Phrases.

- DM Control: foot exam, testing, diet, activity
- DM Symptoms
- DM Risk Factors/lifestyle/smoking
- DM Comorbidities
- DM Labs
- DM Meds
- Patient instructions/goals



# TOOL: SIMPLE INSULIN DOSE ADJUSTMENTS COMPETENCY VALIDATION

## THEDACARE PHYSICIANS

### THEDACARE COMPETENCY VALIDATION

Employee Name: \_\_\_\_\_

Title: Simple Insulin Dose Adjustments  
Date: 8/5/13

Dept: Nutrition and Diabetes Education  
Owner:

- Clinicians should demonstrate competent level prior to practicing independently.
- If unable to demonstrate competence, clinician will be re-trained and re-evaluated on competency prior to practicing independently.
- Needs to have passed the Diabetes Medications–Non-Insulin Competency.

#### OBJECTIVE STATEMENT: following this competency, the participant should be able to:

1. Describe action periods of rapid, fast, intermediate, long acting and premixed insulins.
2. Determine appropriate long acting or premixed insulin dose adjustments per the Insulin Management of Patients in Outpatient Diabetes Program Policy and Procedure.
3. Identify a blood glucose pattern where a patient on long acting insulin would require a change in insulin regimen and describe why.
4. Identify a blood glucose pattern where a patient on a premixed insulin regiment would require a change in insulin regimen and describe why.
5. Document insulin adjustment in a telephone encounter including documentation of blood sugars, dose adjustment, and means of communication or with whom message was left.
6. Adjust insulin orders in EPIC to reflect insulin change documentation in telephone encounter.
7. Recognize the brand and generic names of insulin.
8. Identify at least two other classes of medications that could increase the risk of hypoglycemia when taken concurrently with insulin.
9. Describe definition of hypoglycemia, four symptoms of hypoglycemia and four ways to treat low blood sugar.
10. Describe two situations where RD/RN CDE would advise patient to call MD office with blood glucose levels.
11. Describe when to give insulin in relation to meal and type of insulin.
12. Describe acceptable locations to inject insulin.
13. Describe appropriate storage of insulin.

#### KNOWLEDGE OR TECHNICAL RESOURCES:

- Insulin Management of Patients in the Outpatient Diabetes Program (Heartbeat>Webs>Nutrition and Diabetes>Team Site>Dept Resources>Outpatient>Nursing Privileges).
- Prevention, Detection, and Treatment of Diabetes in Adults 5<sup>th</sup> Edition, International Diabetes Center, 2009, 3-26-34.
- Life with Diabetes, 4<sup>th</sup> Edition, American Diabetes Association, 2009, pages 165-209.
- Drug Monographs for Lantus, Levemir, Novolin 70/30, Humulin 70/30, Novolog Mix 70/30, Humalog Mix 75/25 insulins.
- A Core Curriculum for Diabetes Education Ed: Diabetes Management Therapies, 4<sup>th</sup> Edition, American Association of Diabetes Educators, pages 91-150, 231-253.
- The Art and Science of Diabetes Self-Management Education, 2006, pages 337-370.

#### VALIDATION OF COMPETENCY:

##### A. Knowledge (Cognitive) Criteria

1. Match the appropriate action time to the appropriate insulin. (Draw lines between corresponding insulin and action time.)

<u>Insulin</u>	<u>Action Times</u>		
Rapid-Acting	Onset 1-2 hours	Peak Flat	Duration 24 hours
Short-Acting	Onset 5-15 minutes	Peak Dual	Duration 14-18 hours
Long-Acting	Onset ½-1 hour	Peak 2-4 hours	Duration 6-10 hours
Premixed Human Insulins	Onset ½-1 hour	Peak Dual	Duration 14-18 hours
Premixed Analog Insulins	Onset 5-15 minutes	Peak 1-2 hours	Duration 4-6 hours

**TOOL: SIMPLE INSULIN DOSE ADJUSTMENTS COMPETENCY VALIDATION (CONTINUED)****THEDACARE PHYSICIANS**

2. 75 year old female was started on Lantus insulin 10 units at bedtime three days ago. She has Type 2 diabetes, takes Metformin 1000mg BID, Glipizide was discontinued with initiation of insulin therapy. Patient walks 30 minutes daily after breakfast. Patient is following a carb counting meal plan of 45 grams per meal and 15 grams at bedtime. Reported blood sugars are:

<u>FBS</u>	<u>Supper</u>
180	195
201	239
182	183

What blood glucose pattern do you see?

Based on the policy and procedure, what insulin dose change would you recommend and why?

Blood sugars at next report five days later are:

<u>FBS</u>	<u>Supper</u>
173	199
180	169
172	165
182	177
176	172

What blood glucose pattern do you see?

Based on the policy and procedure, what insulin dose change would you recommend and why?

Blood sugars at next report three days later are:

<u>FBS</u>	<u>Supper</u>
143	162
152	157
156	154

What blood glucose pattern do you see?

Based on the policy and procedure, what insulin dose change would you recommend and why?



Blood sugars at next report four days later are:

<u>FBS</u>	<u>Supper</u>
132	125
128	130
125	122
127	118

What blood glucose pattern do you see?

Based on the policy and procedure, what insulin dose change would you recommend and why?

3. 48 year old male with Type 2 diabetes has been taking Lantus insulin 50 units daily. He also takes Metformin 1000mg BID. He eats about 60-75 grams of carb/meal. He does no exercise but is active working as a farmer. He started Byetta 5mg one week ago. Lantus insulin was reduced at that time from 60 to 50 units daily. Blood sugar test results are as follows:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
76	100	64	110
82	92	85	104
69	110	78	113
88	74	65	92
75	83	98	98
109	97	102	103
71	78	69	99

What blood glucose pattern do you see?

Based on the policy and procedures, what insulin dose change would you recommend and why?

4. 57 year old male with Type 2 diabetes is taking Levemir insulin 40 units BID. He also takes Metformin 1000mg BID. A1C was 8.4. Recent test results are:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
136	162	154	194
150	158	161	187
144	170	180	213
180	188	174	200
128	156	163	181
139	167	177	198
141	171	180	250

What blood glucose pattern do you see?



**TOOL: SIMPLE INSULIN DOSE ADJUSTMENTS COMPETENCY VALIDATION (CONTINUED)****THEDACARE PHYSICIANS**

What insulin dose change is needed and why?

5. 72 year old female with Type 2 diabetes eats 45 grams of carb/meal and 15 grams at bedtime. Rides a stationary bike after breakfast for 30 minutes daily. Babysits grandchildren in afternoon. Medicines are: Metformin 1000mg BID daily and Humalog mix 75/25 insulin 30 units at breakfast and 22 units at dinner. Recent blood glucose tests results:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
122	101	86	140
130	110	77	125
108	78	146	111
101	68	102	133
114	72	76	104
121	111	65	98
99	70	138	116

What blood glucose pattern do you see?

Based on the policy and procedures, what insulin dose change would you recommend and why?

6. 62 year old male with Type 2 diabetes. He lost his insurance and cannot afford his Lantus and Humalog insulins. He was changed to Novolin (Relion) 70/30 insulin 24 units at breakfast and 12 units at supper. He continues on Metformin 1000mg BID. Blood glucose test results are:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
78	101	105	201
65	98	138	186
72	125	122	168
85	136	103	194
75	122	114	155

Based on the policy procedure, what would you recommend and why?

7. 52 year old male with Type 2 diabetes had an A1C of 9.4. He was started on Lantus insulin and doses have been titrated up gradually from 24 units to 36 units daily in the morning. He also is taking Metformin 1000mg BID. He eats 3 meals daily. Carb amounts are 60 grams for breakfast and lunch and 75-90 grams for dinner. He has been advised to decrease carbs at dinner to 60 grams; he is unwilling to do so. He is also unwilling to add exercise in the later part of the day. Recent blood glucose test results:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
113		132	186
130	86	101	178
82		99	235
125	82	86	165
88		110	160
80	90		

What blood glucose pattern do you see?

Based on the policy and procedure, what would you recommend and why?

8. 48 year old female with Type 2 diabetes is taking Humalog Mix 75/25 insulin 15 units at breakfast and 10 units at supper. She is on no other diabetes medication. She eats about 45 grams of carbohydrates at breakfast, skips lunch most days because she forgets to eat/isn't hungry and eats 45-60 grams of carbohydrates at dinner and 0-15 grams of carbohydrates at bedtime. Blood sugars are as follows:

<u>FBS</u>	<u>Lunch</u>	<u>Supper</u>	<u>Bedtime</u>
128		68	143
133		80	132
132		76	127
105	110 (ate this day)	92	101

What blood glucose pattern do you see?

What are your recommendations and why?

9. Based on your actions in question in #3, please complete a telephone encounter including dose changes for zztest, Julie, and print of your telephone encounter and attach to this competency.
10. Based on your actions in question #7, please complete a telephone encounter for zztest, Julie, and print off your telephone encounter and attach to this competency.
11. Match the generic and brand name of the insulins. (Draw lines between the corresponding generic and brand name.) More than one line may go to the same generic.

<u>Generic Name</u>	<u>Brand Name</u>
Lispro	Humulin 70/30
Glargine	Novolin N
Regular, Human	Humalog
Glulisine	Novolin R
Insulin Lispro Protamine Suspension/Lispro	Apidra
Aspart	Levemir
Detemir	Novolog Mix 70/30
NPH, Human (Human Insulin Isophane Suspension)	Novolog
	Humulin R
Insulin Aspart Protamine Suspension/Insulin Aspart	Novolin 70/30
	Lantus
Insulin Isophane/Insulin Regular	Humulin N
	Humalog Mix 75/25

**TOOL: SIMPLE INSULIN DOSE ADJUSTMENTS COMPETENCY VALIDATION (CONTINUED)****THEDACARE PHYSICIANS**

12. Name at least two other classes of diabetes medications that could increase the risk of hypog when taken with insulin.
  
13. Hypoglycemia is defined as a blood sugar less than \_\_\_\_\_ mg/dl.
14. List four symptoms of hypoglycemia.
  
15. List four ways to treat a low blood sugar.
  
16. At what point should a patient call their MD with blood sugar levels (list two)?
  
17. List four areas where a person can inject insulin.
  
18. At what temperature range should the insulin vial/pen that is being used be stored?
  
19. Where should extra insulin vials/pens be stored?
  
20. How soon should a person eat after taking the following insulins?
 

_____ Rapid insulin	a. Within 15 minutes
_____ Short acting insulin	b. Within 30 minutes
_____ Long acting insulin	c. Does not need to be taken in relationship to food
_____ Premixed Human Insulin	
_____ Premixed Analog insulin	
_____ Intermediate acting insulin	
  
21. If using premixed insulins twice daily, when should the patient take the two doses of insulin?
  - a. Before breakfast and bedtime
  - b. Before breakfast and supper
  - c. 12 hours apart, e.g. 6 AM and 6 PM
  - d. Before their two largest meals



**B. Standard Work/Process Steps**

Step Number	Work Steps
1	Collect blood sugars and assess for patterns. (See protocol.)
2	Collect information from patient and evaluate need for change in meal plan or exercise patterns to bring blood sugars to target.
3	Evaluate need for insulin dose changes to bring blood sugars to target.
4	Instruct patient on diet, exercise and/or insulin change recommendations.
5	Document blood sugars and recommendations in telephone encounter. (See standard work.)
6	Change insulin doses in medication list in telephone encounter. (See standard work.)
7	Route telephone encounter to referring provider if dosing changes were made. (See job aide.)
8	Route telephone encounter to referring provider if adjustments are needed that are outside the accepted protocol adjustments. (See protocol.)

**C. Competency Level Definitions**

1. Beginner	Received training. Performs simulation. Performs 10 dose adjustment encounters with supervision. Completes knowledge test with 100% accuracy.
2. Competent	Performs 15 dose adjustment encounters independently without defect per policy and procedure. Completes Validation of Competency.
3. Proficient	Strong use of reasoning and judgment in problem solving with more complex patient situations. Shows greater speed and flexibility in assessment, determining dose changes and documentation. Trains others.
4. Expert	High degree of skill & knowledge with depth/breadth of experience Works through complex decision-making. Leads/mentors others.

Validated Beginner by: \_\_\_\_\_ Date: \_\_\_\_\_

Validated Competent by: \_\_\_\_\_ Date: \_\_\_\_\_

Validated Proficient by: \_\_\_\_\_ Date: \_\_\_\_\_

Validated Expert by: \_\_\_\_\_ Date: \_\_\_\_\_