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National Health Center Training & Technical Assistance Partners
Clinical Workforce Development
A project of Community Health Center, Inc. and the MOSES/WEITZMAN Health System

Strengthening Diabetes Self-Monitoring Education and Support

Thursday October 30th, 2025

3:00-4:00pm Eastern / 12:00-1:00pm Pacific

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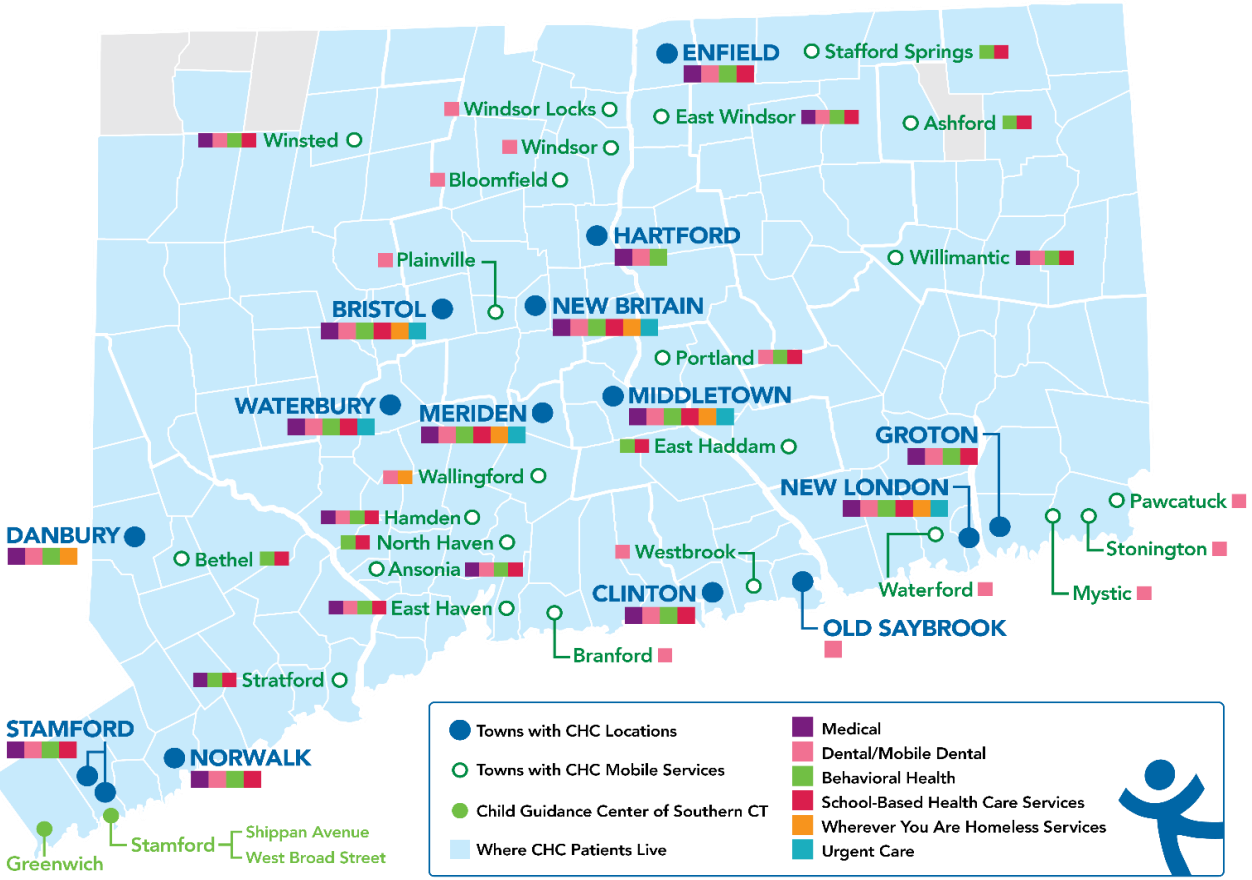
Locations & Service Sites



THREE FOUNDATIONAL PILLARS

1	2	3
Clinical Excellence	Research and Development	Training the Next Generation

Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2022	2023	2024
Patients Seen	102,275	104,917	107,225

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Speaker

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Learning Objectives

1. Understand the importance of patient self-monitoring and self-education in improving A1c levels.
2. Identify effective self-monitoring strategies and best practices for patient education on diabetes management.
3. Develop an action plan to implement diabetes self-monitoring education and support in your health center.

Why is Self-Management so Important?

- Patients spend the majority of their time on their own and at home
- Encourages patient to participate in their own care
- Works to build:
  - General health literacy/numeracy
  - Self-confidence
- Improves overall health outcomes by addressing individualized needs
- Can change the trajectory of whole families/communities (the rising tide raises all boats)

Standing Orders and Delegated Order Sets

- **Standing orders:** authorized by a licensed independent health care provider and authorizes the RN to address, assess, and treat specific conditions across specific populations of patients, with recognition that patients who present with exceptions to the norm are referred back to a health care provider.
- **Delegated order sets:** established by a patient's PCP for a specific patient to be carried out by the RN in visits between the patient and the RN based on assessment criteria.

Standing Orders

- Chronic Illnesses Care Management
  - Select evidence/ensure it matches organizational clinical expectations
  - Outline expected data collection
  - Outline optional data collection/care delivery based on assessment completed (think “menu”)
  - Create a grid of all examples
  - Who it applies to (i.e. age and symptom(s))
  - Any exclusions?
  - Don’t forget data entry issues
  - i.e. order sets, templates, order link with diagnosis/ symptom, CPT codes
  - What to do if something else comes up?
  - References

Diabetes Standing Orders: Content

- Creates the background context: Who? Why? What? How?
- States that this is a Standing Order from the Chief Medical Officer (typically)
- Identifies the process by which the organization selects and implements guidelines
- Central training and orientation tools for teams with regard to diabetes care

Diabetes Standing Orders: Procedure

- Consider team roles and top of training practice.
- This could mean separate standing orders, or defined within one policy with clear role delineation.
- If meds involved, consider how to ensure provider sign-off.
- Determine needed job tools for success and safety.

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Diabetes Standing Orders: RN Procedure & Roles

- ❑ Foot checks? (assessment vs. data collection)
- ❑ Chronic medication refills, or medication information/support (GLP-1, Insulin, etc.)
- ❑ Blood pressure follow-up (particularly if able to bill RN visits)
- ✓ Self-management education and goal-setting
- ❑ Basal Insulin Titration
- ❑ Continuous Glucose Monitoring (CGM)
- ❑ General Health Literacy

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Job Tools: Planned Care Dashboard

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)
DM Foot Exam	Patients with diabetes	Resets every calendar year	• Lync the Nurse to perform a foot exam [MA] • Perform a monofilament [Prov] [Nurse] • Or Refer to Podiatry [Prov]
***DM HbA1c (turns orange when it has been ordered >30 days ago)	Patients with diabetes age 18 or older	Varies based on last result: 1) Last A1c >=7.1% visit every 3 months 2) Last A1c <=7.0% every 6 months	• Order a lab called "Hemoglobin A1c" or "Hemoglobin A1c In House" or "Hemoglobin A1c with calculation" [MA] • Quest results: automatically attached and checked as received • In House results: will appear in "L" bubble (Labs) and need to be checked "Received" as well as to have a number in the value tab and a collection date noted [MA] • Click "Reviewed" [Prov]
***DM HbA1c Needs In Person	Patients with diabetes age 18 or older who have a telehealth visit today and are due for an A1c	Patients with a telehealth visit today who have not had an A1c as follows: 1) Last A1c >=7.1% visit every 3 months 2) Last A1c <=7.0% every 6 months	• Enter "A1c order needed" in Chief Complaint [MA] **OR** • Have patient schedule an in person visit with RN for A1c to be completed at that visit in the next week [MA] [Prov]
DM Retinopathy	Patients with diabetes	Every two years	• Order DI = Retinal Screening, Retinal Screening Outside [MA] • Create an appointment for DM Retinal with Nurse [MA] • Create a recall for DM Retinal with Nurse [MA] • If patient declines order "DM Retinal Screening Declined" [Prov] or MA with provider permission 1. Completed exam results are **"Attached"** to the DI order and checked as "Received" 2. DI- Retinal Screening must be "Reviewed" by Provider

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Job Tools: Diabetes Dashboard

Last Visit Targets				Averages									
Systolic BP	Diastolic BP	A1C	A1C in Last Year	Avg Systolic	Avg Diastolic	Avg A1C	Next Appt	Last BMI	Last Microalbumin date	Appt Place Of Last Encounter With Any PCP	Last Encounter W/PCP	Last Diagnosis	Last Retinal Screening
123	78	10.20	Y	136	86	9.66		26.66	07/19/2022	In Person	9/23/2022 10:00:00 AM	9/2/2022	6/30/2022
146	87	10.20	Y	152	91	9.78		34.34	08/08/2022	In Person	9/19/2022 8:20:00 AM	8/8/2022	12/4/2021
113	75	9.90	Y	110	73	9.68		26.68	08/16/2021	In Person	7/22/2022 4:40:00 PM	4/26/2022	2/27/2019
124	70	9.80	Y	124	67	9.47		26.81	05/09/2022	In Person	9/8/2022 9:00:00 AM	9/8/2022	2/12/2020
104	71	9.70	Y	118	79	8.37		33.89	04/01/2022	In Person	4/1/2022 11:00:00 AM	2/22/2021	3/1/2021
124	70	9.70	Y	124	67	9.47		26.81	05/09/2022	In Person	9/8/2022 9:00:00 AM	9/8/2022	2/12/2020
120	79	9.60	Y	126	81	9.57		23.29	08/17/2021	In Person	6/30/2022 10:00:00 AM	6/30/2022	10/21/2021
99	63	9.50	Y	99	63	9.85		39.52	08/16/2021	In Person	8/16/2021 9:00:00 AM	8/30/2021	8/31/2019
122	83	9.50	Y	130	88	9.10		30.96	08/10/2022	In Person	11/25/2020 12:10:00 PM	8/15/2022	4/16/2018
136	73	9.50	Y	139	78	9.30		31.38	12/29/2021	In Person	5/21/2021 3:20:00 PM	9/27/2019	2/24/2018
150	83	9.50	Y	139	85	9.00		39.09	04/18/2022	In Person	10/4/2021 1:00:00 PM	11/13/2020	1/23/2022
104	72	9.30	Y	124	73	9.77		29.02	07/05/2022	In Person	7/5/2022 10:40:00 AM	8/2/2018	5/8/2017
122	83	9.30	Y	130	88	9.10		30.96	08/10/2022	In Person	11/25/2020 12:10:00 PM	8/15/2022	4/16/2018
153	78	9.30	Y	133	73	9.20		27.62	05/24/2021	In Person	9/15/2022 2:20:00 PM	12/20/2019	4/17/2018
153	96	9.30	Y	153	96	9.30		58.62	12/13/2017	In Person	11/4/2021 9:40:00 AM	10/16/2020	
136	73	9.10	Y	139	78	9.30		31.38	12/29/2021	In Person	5/21/2021 3:20:00 PM	9/27/2019	2/24/2018
137	67	9.00	Y	137	67	9.00		31.25	08/03/2021	In Person	2/8/2022 10:00:00 AM	10/20/2020	1/16/2019
138	71	8.90	Y	126	78	9.00		29.65	03/24/2021	In Person	8/15/2022 2:40:00 PM	9/13/2022	8/31/2019
138	77	8.90	Y	137	77	10.22		37.25	02/07/2022	In Person	9/26/2022 10:52:00 AM	10/26/2021	5/25/2022
124	78	8.80	Y	127	77	8.22	10/10/2022 1:40:00 PM	29.33	07/05/2022	In Person	9/30/2022 1:00:00 PM	6/13/2022	3/15/2022
173	79	8.80	Y	159	80	9.30		30.37	08/02/2021	In Person	6/6/2022 3:40:00 PM	11/17/2020	4/12/2018
117	78	8.70	Y	121	69	9.73		36.34	06/19/2021	In Person	7/18/2022 8:20:00 AM	5/23/2022	3/27/2018
116	70	8.70	Y	122	69	7.08		36.72	06/21/2022	In Person	9/19/2022 10:00:00 AM	7/11/2022	8/9/2022
140	63	8.70	Y	124	71	8.78		27.40	02/12/2021	Phone	1/4/2022 1:20:00 PM	6/2/2021	5/26/2021
113	76	8.60	Y	117	73	8.20		27.91	11/15/2021	In Person	7/19/2022 10:20:00 AM	7/26/2022	12/3/2019
136	78	8.60	Y	133	79	8.97		23.53	10/26/2021	In Person	8/27/2022 8:40:00 AM	8/1/2022	12/4/2021
107	69	8.50	Y	112	67	8.30		30.54	05/20/2021	In Person	3/18/2022 3:20:00 PM	5/13/2022	5/13/2022
138	76	8.50	Y	121	72	8.20		25.32	08/10/2021	In Person	9/9/2022 3:00:00 PM	2/1/2021	4/18/2022
107	64	8.50	Y	132	82	8.15		27.31	06/29/2022	In Person	9/23/2022 4:20:00 PM	8/4/2022	
135	81	8.50	Y	152	88	8.63	10/7/2022 11:00:00 AM	38.37	09/14/2022	In Person	9/13/2022 9:00:00 AM	1/26/2021	3/21/2018

If you remember nothing else about imparting knowledge, remember this:

If you have a lot to say…

Don't

But The Patient Needs to Know!

Which is better?

- That the patient be told four important facts/details of his/her disease or condition and not remember one of them by the next day

or

- That the patient learn and remember one important fact/detail of his/her disease or condition per day

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Collaborative Care: Promoting Self-Management

	Traditional	Collaborative
Interactions	Based on the caregiver's agenda	Based on a shared agenda
Behavior change	Comes from knowledge	Comes from self-efficacy plus knowledge
Goal	Compliance	Self-efficacy
Decisions	Made by the caregiver	Made by the patient and caregiver in partnership

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Stages of Change

Stage	What the patient is thinking
Pre-contemplation	Patient is not thinking about changing the behavior.
Contemplation	Patient is thinking about changing the behavior but has not taken any action steps.
Preparation	Patient is committed to changing the behavior and may have made an attempt in the recent past.
Action	Patient is in the process of making overt lifestyle change.
Maintenance	Patient has established the new habit. Focus is on maintaining behavior change.
Relapse	Patient returns to problem behavior. May have cycled back into a previous stage

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Five Communication Strategies

Setting the Stage

1. Set a shared agenda
2. Ask-tell-ask (Teach Back)
3. Assess readiness to change

Taking Action

4. Set self-management goals
5. Close the loop

Keep it simple

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Chronic Diseases: Take One Step at a Time

- When talking about a chronic disease or condition, remember that the patient will have it for the rest of their life.
- There will be many opportunities to discuss the disease and ways to manage it. Take time to ensure the patient understands it and fully participates in its management.

Self Management Support

Self-management support is defined as the systematic provision of education and supportive interventions by health care systems **to increase patients' skills and confidence in managing their health problems**, including regular assessment of progress and problems, goal setting, and problem-solving support.

Institute of Medicine, 2003

Important Goals for Patients with Chronic Conditions

- Managing the illness (such as learning to take medications and monitor the condition)
- Carry on normal roles and activities of daily living
- Manage the emotional impact of the illness.

****The goal of self-management support is to assist and sustain the patient's ability to engage in self-management behaviors that fit within their own life patterns, and prepare them to make effective health decisions day to day.*

Much of the content above has been adapted from Lorig et al, Living a Healthy Life with Chronic Conditions. Bull Publishing Company, 2000.

How Do I Begin?

1. Make sure the patient understands the basics of the disease or condition (assess their health literacy/numeracy).
2. Let the patient know that
   a) they are the one who has most control over what happens outside the clinic office.
   b) there are many behaviors they can implement to help manage their condition.
3. Ask the patient if they would like to set a goal to help the disease.
   If no, **STOP** and try again next visit.
4. If yes, ask the patient if they have any in mind that they would like to try.
5. If yes, but the patient doesn't know where to begin, it may be ok to provide a prompt to assist with their first few goals.

Providing Guidance

- **Stated Goal**: “I want to change the way I eat.”
- **Guide this into an observational action:**
  - What are eating habits you want to change?
  - Exactly what could you change about that habit?
  - How sure are you that you can do this?

Providing Guidance

- **Stated goal:** "I want to stop smoking."
- **Guide this into an observational action:**
  - Would you like to attend a group?
  - Would you like to see me to work on this over the course of weeks?
  - What are triggers for your smoking that you might start with?
  - Are there certain cigarette times you are sure you could cut out?
  - Are you interested in medication to assist?

Providing Guidance

- **Stated goal:** "I want to lose weight."
- **Guide this into an observational action:**
  - Is there one behavior you could start on that would help lose weight?
  - Weight is related to eating and exercise. Where would you like to start?
  - Would you like to see one of our dieticians?

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Turning Observations into SMGs or SMART GOALS with a Specific Action Plan

SMG/Plan Should:

- Be something the patient wants to do
- Be reasonable
- Have a confidence level of 7

SMG/Plan Should Include:

- What?
- When?
- How Often?
- How Long/How Much?

Red Flags

- A person must be at least a 7 on a scale of 1-10, with 10 the most confident.
- Try to avoid “everyday.” Most people can’t do anything everyday.

Example

- **What will you do?** *Exercise on the elliptical.*
- **Where will you do it?** *At the gym.*
- **When you do it?** *Three times per week. M-W-F.*
- **For how long will you do it?** *15 minutes to start.*
- **What is your confidence level that you can do this on a scale of 1-10, with 10 being the highest?** *My confidence level is a 5.*
- **What would help you get to a higher level of confidence?** *Going with my sister. She will remind me and bug me until I do it.*

Example

- The healthy change I want to make is: *Start a walking program.*
- My goal for the next month is: *To walk three times per week.*
- The steps I will take to achieve my goal are (what, when, where, how much, how often): *I will walk around my neighborhood for 15 minutes, directly after I get home from work on Monday, Wednesday, and Friday.*
- The things that could make it difficult to achieve my goal include: *My sister may need to talk on the phone after work, and it might be too late to go after we talk.*
- My plan for overcoming these difficulties includes: *I can ask my sister if she absolutely needs to talk that day. If I have to miss a regular walking time, I can make up that day by driving to the park on the weekend and walk for 15 minutes in the morning, then resume my regular plan the following week.*
- Support/resources I will need to achieve my goal include: *I need to buy a new pair of sneakers and extra-cushioned socks so that my feet don't get blisters. I would feel more comfortable walking if I had a dog with me. I can ask my neighbors if I can 'borrow' Sparky, their dog.*
- My confidence level (scale of 1-10, 10 being completely confident that you can achieve the entire plan.): *8.*

Problem-Solving Techniques

- **Patients need both support and skills to change behavior!**
  - **Identify the problem:** Help the patient get to the root of the issue. For example, is it that they have problems maintaining a diet when they eat out, or their family doesn't understand their wishes to eat a healthier diet?
  - **List ideas to solve the problem:** Help the patient come up with many ideas, some they have tried before to some that may seem ridiculous, and to come up with a list of ideas that might work.
  - **Choose one method to try:** Out of all the options listed, help the patient choose one, or a combination of ideas that they think will work for them.
  - **Try it for 2 weeks**: Encourage patients to give each idea a good trial period to see if it will work.

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Best Practices:

- ✓Reframe the Goal
- ✓If the person gets stuck offer tips “Would you like some suggestions about how to …”
- ✓Investigate the behavior with the patient
- ✓Keep a list of resources handy
- ✓Ask about a buddy or support person
- ✓Suggest setting a reward
- ✓Get social support – online or in person
- ✓Consider a written or online tracking system

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Follow-Up

- **Evaluate the results:** After the patient's given the idea a fair trial, assess the outcome.
- **Try another idea if the first one doesn't work:** Have the patient return to their list of ideas and try another.
- **Locate other resources:** Resources can be friends, family, members of their health care team, or a community link such as the public library or a health fair.
- **Accept that the problem may not be solvable right now:** Remind the patient that if the solutions they came up with this time haven't worked, that it doesn't mean that other solutions won't be effective at another time, or that different problems can't be solved using this solution. Encourage them to keep trying; do your best to foster hope and persistence.

SMG & MI Structured Data Entry

- **Ready to set a new goal?**
  - If yes, how confident are you that you will achieve your goal?
  - What do you do if the patient is not confident that they can achieve their goal?
- **Following up on a goal?**
  - If yes, what is your progress toward your goal?
  - What do you do if progress is not happening?
- **Was motivational interviewing done?**

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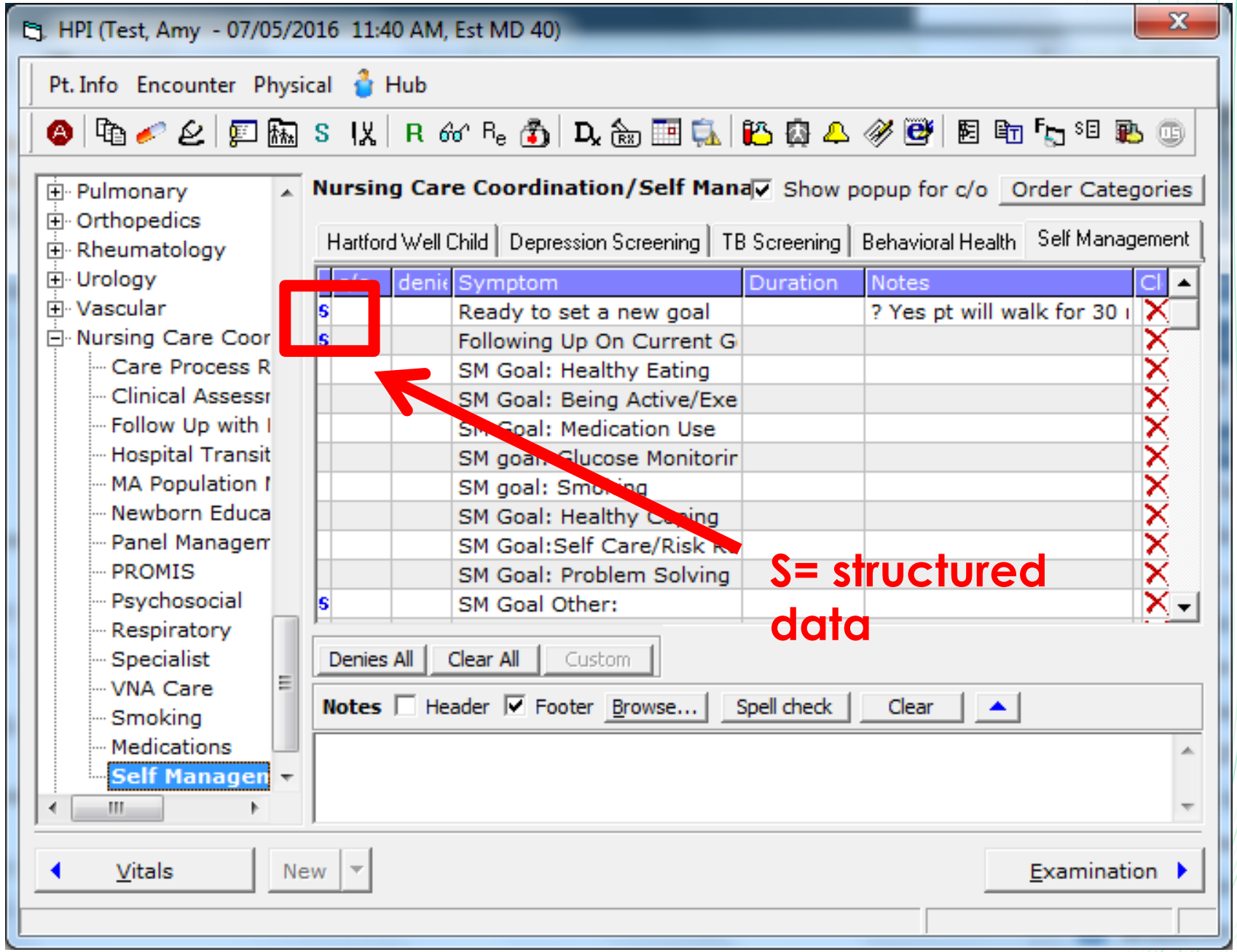

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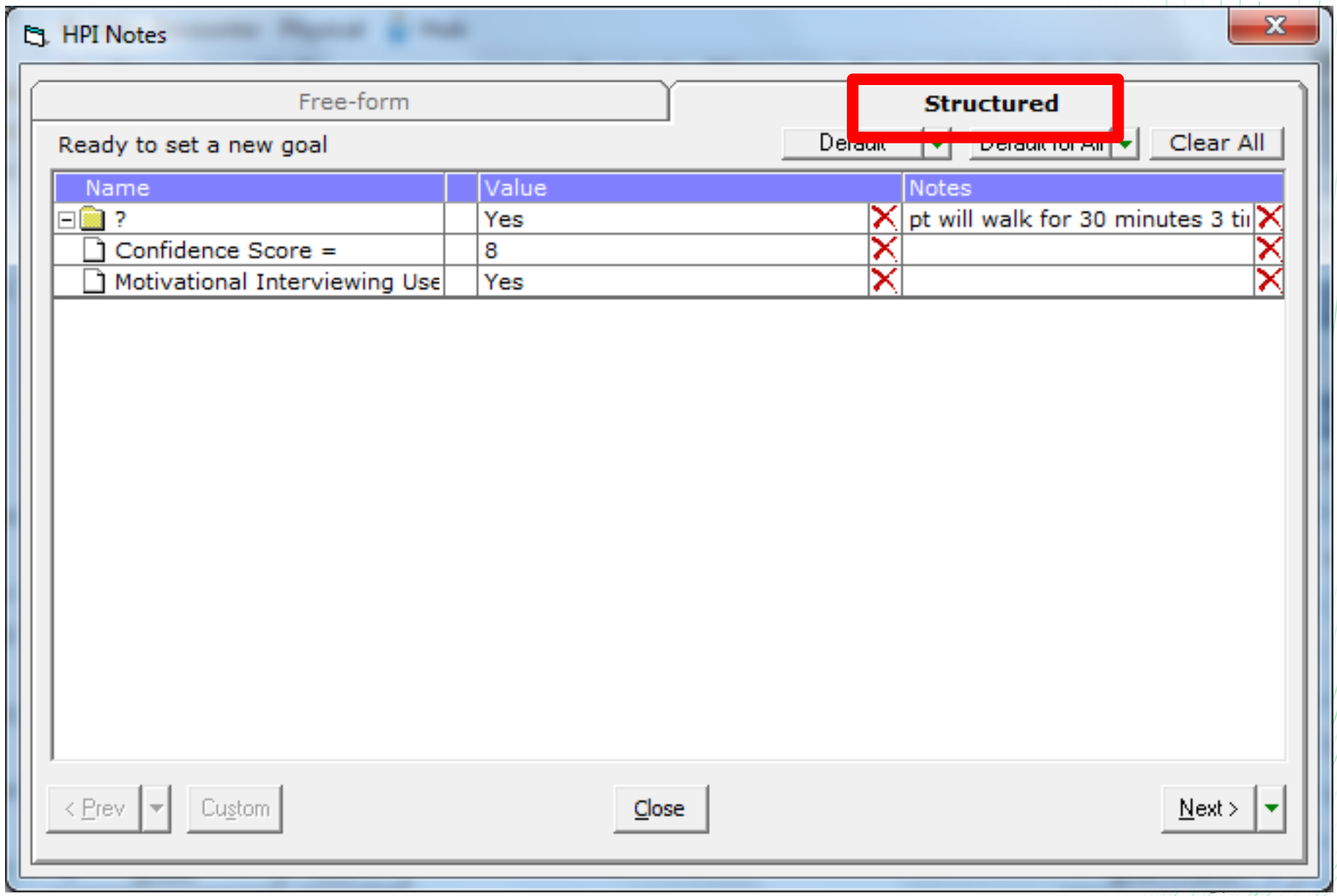

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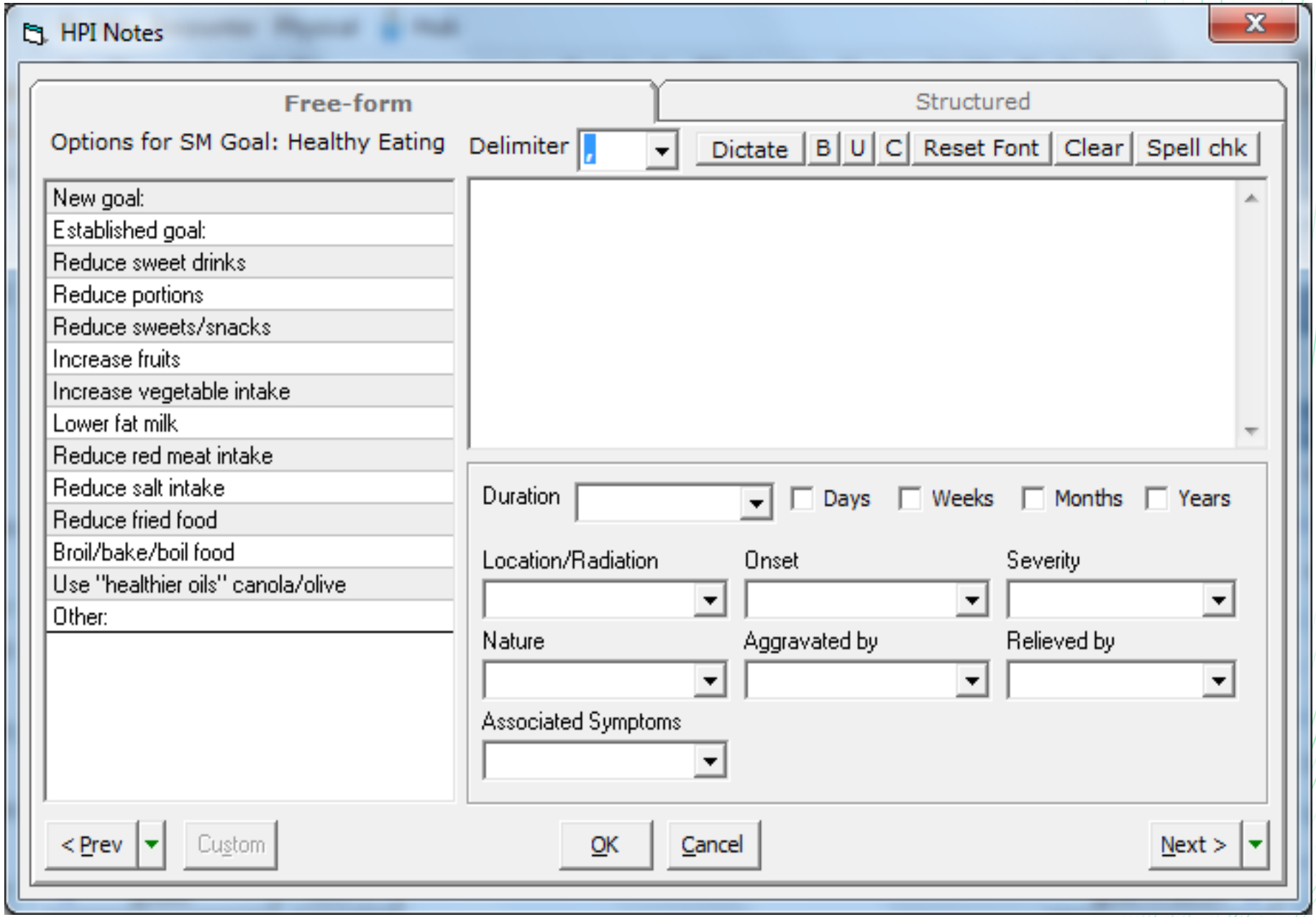

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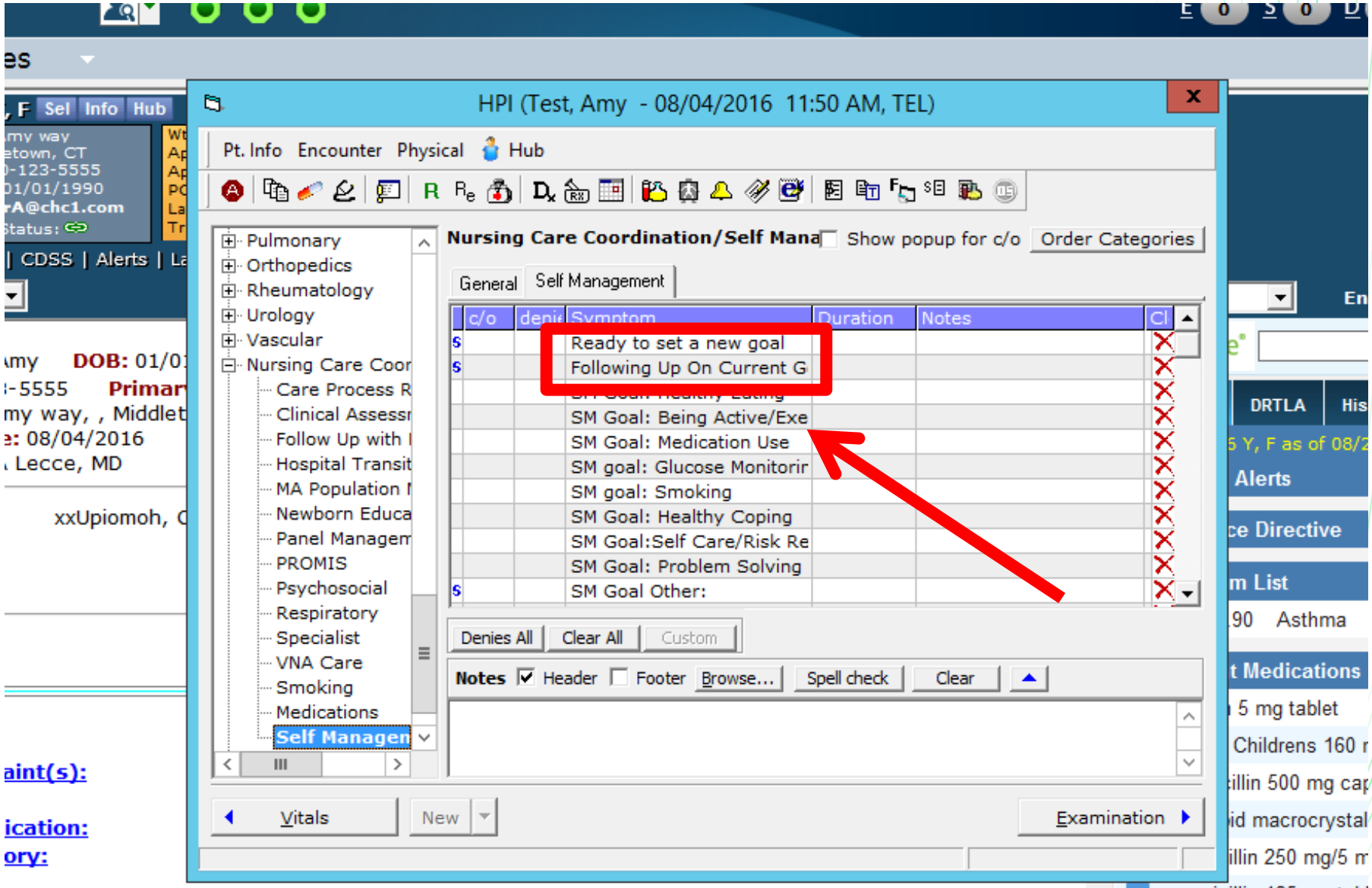

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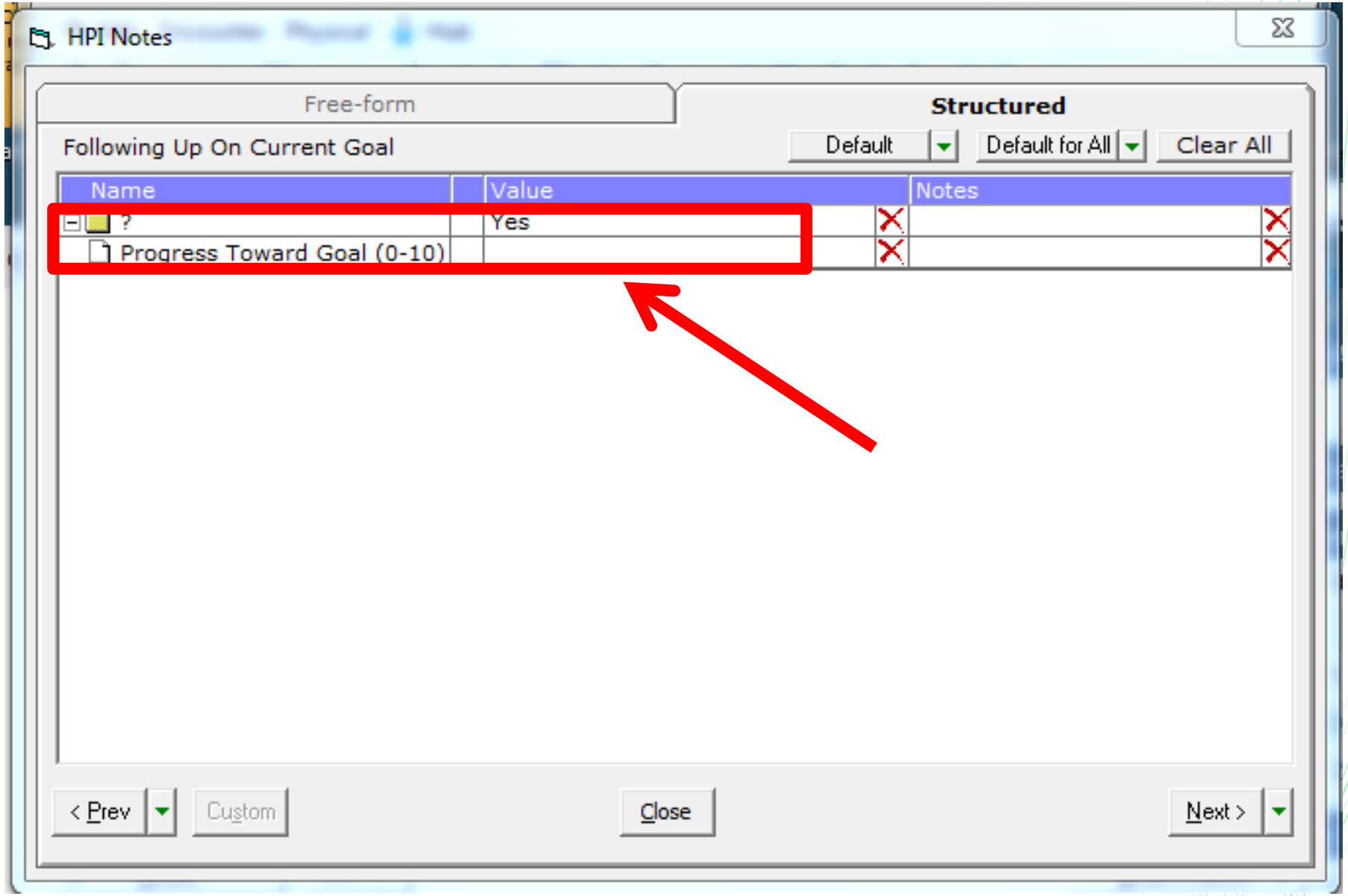

SMG & MI Structured Data Entry

Self-Monitoring of Blood Glucose (SMBG)
Encourage for patients receiving multiple dose insulin or insulin pump therapy: • Prior to meals and snacks • Occasionally postprandially • At bedtime • Prior to exercise • When low blood glucose is suspected • After treating low blood glucose until normoglycemic • Prior to critical tasks (eg, driving)
Results may be useful for guiding treatment and/or self-management for patients using less frequent insulin injections or noninsulin therapies • Provide ongoing instruction and regular evaluation of SMBG technique and results and patient's ability to use data to adjust therapy

- What about for patients on oral agents only?
- What does the insurance pay for?
- Who should use the information?
- Why is this an important tool to boost health literacy?
- What services could be billed for? (i.e. RPM time, RN visits, CDCES visits, RD visits, etc.)

Diabetes Testing – ADA Standards

Continuous Glucose Monitoring (CGM)
Useful for A1C lowering in select adults (aged ≥25 yrs) with type 1 diabetes requiring intensive insulin regimens • May be useful among children, teens, and younger adults* • Success related to adherence to ongoing use
May be a useful supplement to SMBG among patients with • Hypoglycemia unawareness and/or • Frequent hypoglycemic episodes

- "CGM is used less frequently in people with type 2 diabetes not treated with intensive insulin therapy." (read this as—Type 2 on Insulin should have CGM!)
- "Periodic CGM use may be helpful in identifying glycemic patterns and as part of an education program for people with diabetes and their care partners."

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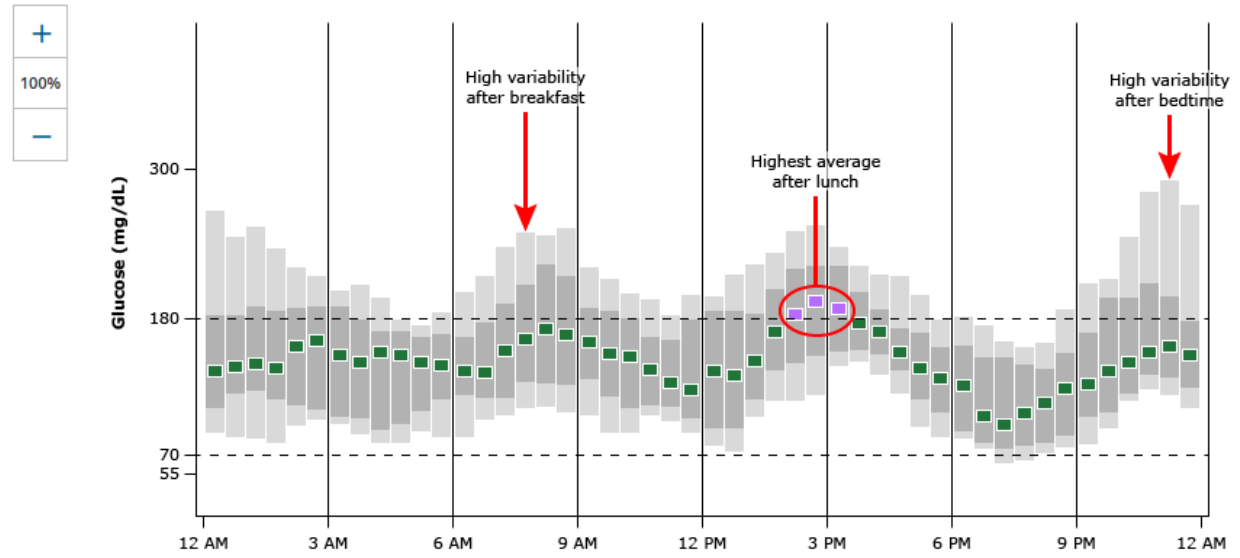
Diabetes Testing – CGM

Continuous glucose monitoring display (4-week view)



Courtesy of Irl B Hirsch, MD. Adapted from: Tidepool. Available at: https://tidepool.org/. Copyright © 2019. Reproduced under the terms of the Creative Commons Attribution Share-Alike 3.0 Unported license.

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Potential Points of Friction

- ❑ Physical plant space for longer teaching sessions vs. use of the virtual environment
- ❑ Gatekeeping vs Top of license/training practice
- ❑ Duplicative work/duplication of efforts
- ❑ Feedback seen as punitive instead of routine
- ❑ Staff Buy-in/Confidence
- ❑ Provider Buy-in/Confidence
- ❑ Patients unfamiliar with goal-setting/not interested
- ❑ Others?

Provider Role in Team Based Care

- **Model Behavior**
  - Embody “shared care”
  - Support accountability
  - Communicate value of team member contribution
- **Communicate**
  - Talk about the practice transformation work
  - Connect the work to improved patient care
- **Follow-Up and Support**
  - Check in with team members (MA, Nurses, others)
  - Address gaps and concerns in implementation
- **Collaborate**
  - Collaborative with team on challenges and successes

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Managing Culture

- Create an environment of team-based care that is based on the value of every role (not just as a downstream catchall to support providers)
- Focus on measurement in everything that you do
- Normalize feedback and data as an invitation to partner and troubleshoot
- Invite patients to help you test new workflows
- Embrace failure as just another data point on the way to a best practice
- Celebrate success (often!)

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Questions?

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Wrap-Up

Comprehensive and Team-Based Care Community of Practice (CoP)

- This eight session series will support health centers and look-alikes with developing highly trained clinical primary care teams to move towards team-based comprehensive care and improving at least one UDS measure. The CoP will provide participants with quality improvement concepts and skills to systematically achieve a specific aim, and identify areas for process improvement and role optimization.
- Outcomes of the CoP:
  - Identified a clinical team to work on a quality improvement project
  - Improved UDS measures, such as hypertension, cancer screenings, etc.
  - Implemented pre-visit planning and morning huddles
  - Integrated behavioral health with warm welcomes/handoffs
  - Conducted self-assessments of their current team-based care model to identify areas for process improvement and role optimization
- For more information/questions, please reach out to Meaghan Angers (angersm@mwhs1.com)

Activity Session – A Team-Based Approach: Leveraging Standing Orders for Immunizations and Infection Control

- Presented by Mary Blankson, Chief Nursing Officer, and Natalie Bycenski, Senior Nurse Manager, at Community Health Center, Inc. (CHCI), this 60-minute activity session will explore how to implement effective standing orders for immunizations, drawing from national best practices and CHCI's organizational guidelines. Expert faculty will highlight the key roles of Registered Nurses (RNs) and Medical Assistants (MAs) in streamlining clinical processes, training, and credentialing.
- **When**: Thursday, November 6th, 2025
- **Time:** 3:00 - 4:00pm Eastern / 12:00 - 1:00pm Pacific
- https://education.weitzmaninstitute.org/content/activity-session-%E2%80%93-team-based-approach-leveraging-standing-orders-immunizations-and

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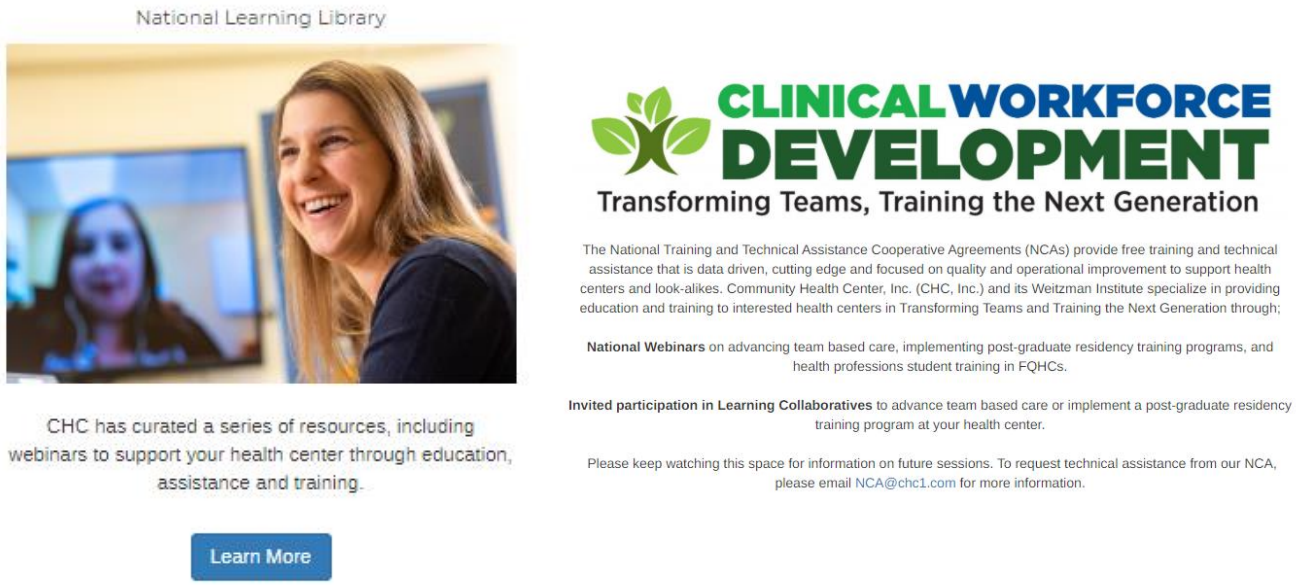
Explore more resources!

National Learning Library:
Resources for Clinical Workforce Development



https://www.weitzmaninstitute.org/ncaresources

Health Center Resource Clearinghouse

https://www.healthcenterinfo.org/

Contact Information

For information on future webinars, activity sessions, and communities of practice: please reach out to nca@chc1.com or visit https://www.chc1.com/nca

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