

Standing Orders

Activity Session on Diabetes Management

Thursday, March 26th, 2026

2:00-3:00pm Eastern / 11:00am-12:00pm Pacific

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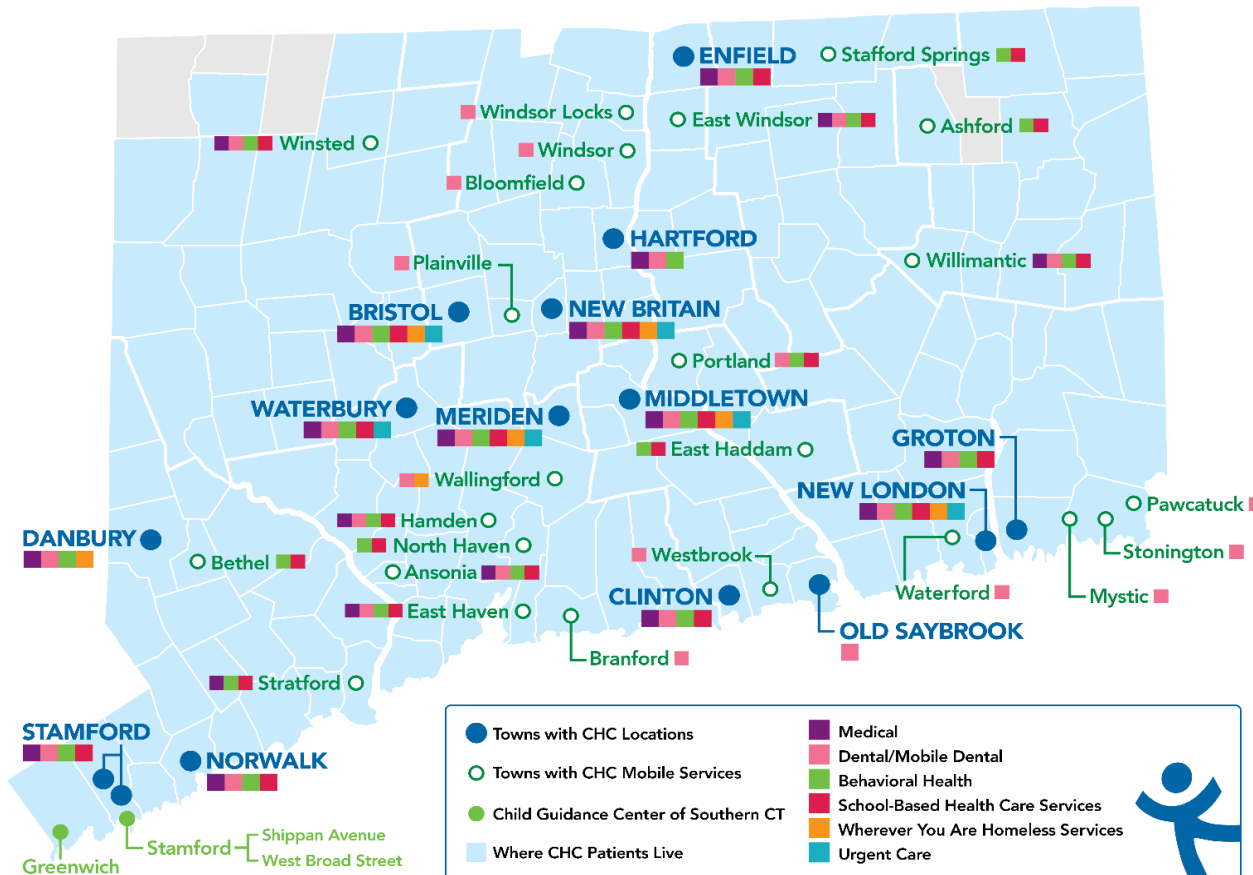
The Weitzman Institute

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Locations & Service Sites



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



National Training and Technical Assistance Partners (NTTAP) Clinical Workforce Development

Provides **free** training and technical assistance to federally funded health centers and look-alikes across the nation through webinars, activity sessions, communities of practice, trainings, publications, and more!

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Speakers



Mary Blankson, DNP, APRN, FNP-C, FAAN
Chief Nursing Officer
Moses/Weitzman Health System



Natalie Bycenski, MSN, RN
Senior Nurse Manager
Moses/Weitzman Health System

Objectives

- Understand standing orderings and delegated orders
- Discuss examples of standing and delegated orders for diabetes care and management
- Explain the role of technology and systems to support implementation of standing orders
- Describe potential challenges
- Review team culture to support standing orders

Activity

Community Health Center, Inc. NTTAP
 Standing Orders for Diabetes Care Activity Session
 Wednesday November 2nd, 2022

Diabetes Care Practice Assessment

Which roles align with the list of tasks and processes?

1. Add tasks you would like to include
2. Edit tasks to clarify expectations specific to your practice
3. Edit the roles to represent your core and extended team members
4. Note **current role** and function in one colored pen
5. Note using second colored pen **best role** for optimization based on education, license and training

Complete as a team or individually for the purpose of identifying opportunities for:

- reducing duplication of tasks
- optimizing roles : everyone working to their highest level of training, licensure, education
- defining roles and job descriptions

Examples of Routine Diabetes Related Care

	Front Desk	Diabetes Educator	LPN/ LVN	CMA/ MA	RN	Triage RN	Care Coordinator	Care Manager	SW Case Manager	NP PA	MD	BH Specialist	Clinic Admin	Other (please specify)
Responsible for diabetes related care														
Completes foot checks														
Completes retinal screenings														
Schedules patient for routine diabetes follow-up														
Coordinates with specialty providers to obtain progress notes, external labs, and other important diabetes related information														
Evaluates health literacy related to diabetes and makes a plan to increase health literacy														

Sources Adapted for NCA TBC Collaborative Assessment Tool: E. Wager Team Based Care Model, T. Bodenheimer Share the Care, Cambridge Health Alliance Care Team Guide, LEAP project, TDI Medical Home Clinical Microsystem Assessment Tool

Standing Orders and Delegated Order Sets

- **Standing orders:** authorized by a licensed independent health care provider and authorizes the Registered Nurse (RN) to address, assess, and treat specific conditions across specific patient populations, with recognition that patients who present with exceptions to the norm are referred 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 CMO (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 medication involved, consider how to ensure provider sign-off
- Determine needed job tools needed for success and safety



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

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	<ul style="list-style-type: none"> 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 $\geq 7.1\%$ visit every 3 months 2) Last A1c $\leq 7.0\%$ every 6 months	<ul style="list-style-type: none"> 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 $\geq 7.1\%$ visit every 3 months 2) Last A1c $\leq 7.0\%$ every 6 months	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> 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

Job Tools: Diabetes Dashboard

Last Visit Targets				Averages			Next Appt	Last BMI	Last Microalbumin date	Appt Place Of Last Encounter With Any PCP	Last Encounter WPCP	Last Diagnosis	Last Retinal Screening
Systolic BP	Diastolic BP	A1C	A1C in Last Year	Avg Systolic	Avg Diastolic	Avg A1C							
123	78	9.20	Y	120	80	9.00		26.66	07/19/2022	In Person	9/23/2022 10:09:00 AM	9/2/2022	6/30/2022
148	87	10.20	Y	152	91	9.70		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 4:40:09 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
129	79	9.80	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 12:10:08 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 3:20:05 PM	9/27/2019	2/24/2018
190	83	9.50	Y	139	85	9.00		39.09	04/18/2022	In Person	10/4/2021 1:00:05 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 12:10:08 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 2:20:05 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 3:20:05 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
130	71	8.90	Y	126	70	9.00		29.66	03/24/2021	In Person	8/15/2022 2:40:05 PM	9/13/2022	8/31/2019
138	77	8.90	Y	137	77	10.22		37.26	02/07/2022	In Person	9/28/2022 10:52:00 AM	10/28/2021	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 1:00:05 PM	6/13/2022	3/15/2022
173	79	8.80	Y	159	86	9.30		30.37	08/02/2021	In Person	6/6/2022 3:40:05 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	8.70		27.40	02/12/2021	Phone	1/4/2022 1:20:08 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	6/27/2022 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 3:20:05 PM	5/13/2022	5/13/2022
130	76	8.50	Y	121	72	8.20		25.32	08/10/2021	In Person	9/9/2022 3:00:05 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 4:20:05 PM	8/4/2022	
135	81	8.50	Y	152	86	8.53	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 have a lot to say...Don't

Which is better?

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

or

- That the patient learns and remembers one important fact/detail of their disease or condition per day

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

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.

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.

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 goals 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?



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.

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

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?**

Diabetes Testing – ADA Standards

Self-Monitoring of Blood Glucose (SMBG)
<p>Encourage for patients receiving multiple dose insulin or insulin pump therapy:</p> <ul style="list-style-type: none"> • 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)
<p>Results may be useful for guiding treatment and/or self-management for patients using less frequent insulin injections or noninsulin therapies</p> <ul style="list-style-type: none"> • 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 (cont.)

Continuous Glucose Monitoring (CGM)
Useful for A1C lowering in select adults (aged ≥ 25 yrs) with type 1 diabetes requiring intensive insulin regimens
<ul style="list-style-type: none">• 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
<ul style="list-style-type: none">• 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.”

Diabetes Testing – CGM Example

GLUCOSE STATISTICS AND TARGETS

December 24, 2025 - January 6, 2026 **14 Days**
Time CGM Active: 97%

Ranges And Targets For	Type 1 or Type 2 Diabetes
Glucose Ranges	Targets % of Readings (Time/Day)
Target Range 70-180 mg/dL	Greater than 70% (16h 48min)
Below 70 mg/dL	Less than 4% (58min)
Below 54 mg/dL	Less than 1% (14min)
Above 180 mg/dL	Less than 25% (6h)
Above 250 mg/dL	Less than 5% (1h 12min)
Each 5% increase in time in range (70-180 mg/dL) is clinically beneficial.	

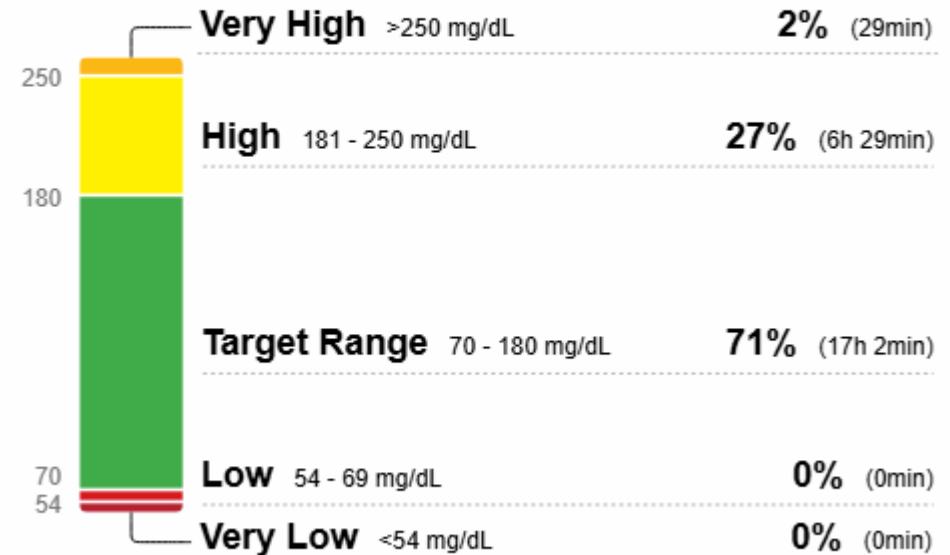
Average Glucose **163** mg/dL

Glucose Management Indicator (GMI) **7.2%**

Glucose Variability **21.7%**

Defined as percent coefficient of variation (%CV); target ≤36%

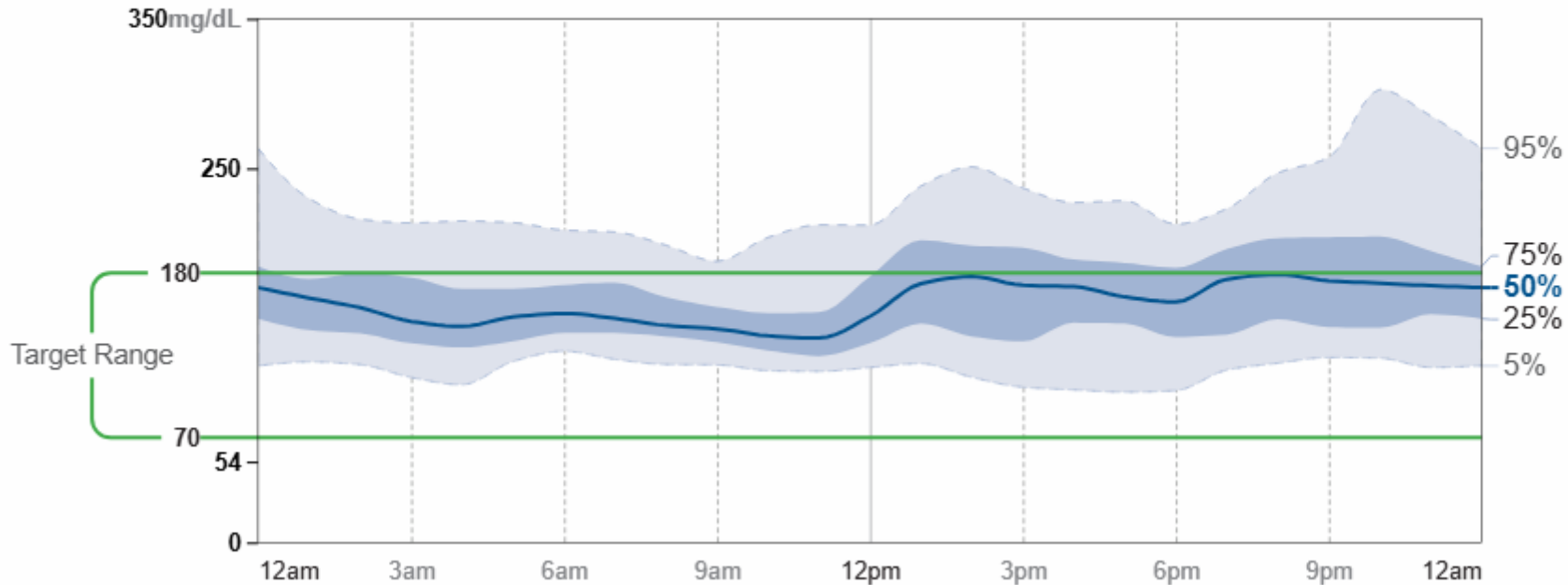
TIME IN RANGES



Diabetes Testing – CGM Example

AMBULATORY GLUCOSE PROFILE (AGP)

AGP is a summary of glucose values from the report period, with median (50%) and other percentiles shown as if occurring in a single day.



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**
 - Collaborate with team on challenges and successes



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!)

Questions?

Wrap-Up

Explore more resources!

National Learning Library: Resources for Clinical Workforce Development

National Learning Library



CHC has curated a series of resources, including webinars to support your health center through education, assistance and training.

[Learn More](#)

<https://www.weitzmaninstitute.org/ncaresources>



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National Webinars on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

Invited participation in Learning Collaboratives to advance team based care or implement a post-graduate residency training program at your health center.

Please keep watching this space for information on future sessions. To request technical assistance from our NCA, please email NCA@chc1.com for more information.

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>

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling \$550,000 with 0% financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.