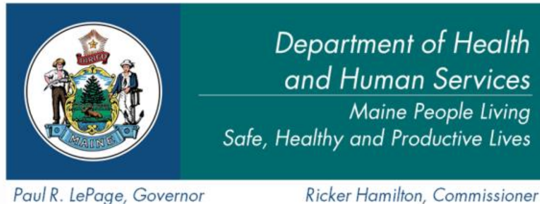

Department of Health and Human Services
Maine Center for Disease Control and Prevention
286 Water Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-8016; Fax: (207) 287-9058
TTY Users: Dial 711 (Maine Relay)

Maine CDC
Chronic Disease Prevention & Control Program
286 Water Street, 5th Floor - 11 State House Station
Augusta, Maine 04333-0011
(207) 287-5380

DIABETES SELF-MANAGEMENT TRAINING (DSMT) PROGRAM

Letter of Understanding for Calendar Year 2018

Please ensure that this LOU is completed and returned to the Maine CDC not later than January 31, 2018.

This is a *Letter of Understanding* between the Maine CDC – Chronic Disease Prevention and Control, hereinafter referred to as the "Department" and ____ , **(Sponsoring Agency/Institution)** hereinafter referred to as the "Provider", describing responsibilities of each party in presenting the DSMT Program. The DSMT Program is delivered as a part of a statewide effort supporting diabetes self-management education.

The Provider will:

1. Establish a written institutional policy committing to the creation, delivery, and maintenance of the DSMT Program at the site.
2. Deliver the DSMT Program in accordance with guidelines and criteria outlined in the DSMT Program Manual.
3. Designate a Coordinator and Instructors to coordinate and implement the DSMT Program at the site. Coordinator and Instructor responsibilities are listed in the DSMT Program Manual.
4. Obtain continuing education annually (coordinator, instructors) as outlined in the DSMT Program Manual. New instructors must attend the Department's Professional Diabetes Educator Program.
5. Designate a Physician Advisor for the DSMT Program at the site. The Advisor's responsibilities are listed in the DSMT Program Manual.
6. Offer the DSMT Program at least four (4) times annually.
7. Designate a standing Advisory/Oversight Committee for the site's DSMT Program. Composition and responsibilities of the Committee are listed in the DSMT Program Manual.
8. Allocate sufficient funds to the DSMT Program budget to cover program expenses.
9. Encourage and support the DSMT Program Coordinator and Instructors to attend continuing education workshops.
10. Document participant encounters (e.g. assessment, plan of care, clinical and behavioral outcomes) using DSMT Program data forms, computer software, or other electronic software of the site's choice.

11. Participate in site visits conducted by the Department on an as needed basis.
12. Submit to the Department a copy (electronically or hard copy) of all documentation (including but not limited to – Annual Status Reports- clinical and behavior goals outcomes tracking) related/sent to ADA or AADE at the same time documentation is due/submitted to these recognition organizations.
13. Notify the Department within 30 days of any changes related to Education Recognition Program status including notification of loss or reinstatement of Education Recognition.
14. This LOU must be submitted to the Department not later than January 31st of the calendar year.
15. To the extent that the services carried out under this Agreement involve the use, disclosure, access to, acquisition or maintenance of information that actually or reasonably could identify an individual or consumer receiving benefits or services from or through the Department ("Protected Information"), the Provider agrees to a) maintain the confidentiality and security of such Protected Information as required by applicable state and federal laws, rules, regulations and Department policy, b) contact the Department within 24 hours of a privacy or security incident that actually or potentially could be a breach of Protected Information and c) cooperate with the Department in its investigation and any required reporting and notification of individuals regarding such incident involving Protected Information. To the extent that a breach of Protected Information is caused by the Provider or one of its subcontractors or agents, the Provider agrees to pay the cost of notification, as well as any financial costs and/or penalties incurred by the Department as a result of such breach.

The Department will:

1. Coordinate and conduct the Professional Diabetes Educator Program for newly designated DSMT Program coordinators and instructors twice a year (Spring and Fall).
2. Provide a DSMT Program Manual to each participant at the Professional Diabetes Educator Program.
3. Provide ongoing educational consultation and technical assistance to each DSMT Program site as requested by site personnel.
4. Audit each site's file annually to assure adherence to quality standards.
5. Conduct on-site site visits as necessary.
6. Serve as a liaison between the site and third-party payers to assist sites in securing reimbursement for the DSMT Program.
7. Maintain bi-annually for the State of Maine Bureau of Insurance the DSMT program site registry to ensure State recognition which qualifies sites for DSMT reimbursement.
8. Inform sites of the current status and availability of all the Department's programs and activities including those provided by internal and external partners.
9. Inform sites of continuing medical education programs in the prevention, detection, treatment, and control of diabetes and diabetes-related complications.
10. Serve as a resource and referral center for questions and requests related to diabetes prevention and management.

DIABETES SELF-MANAGEMENT TRAINING (DSMT) PROGRAM

Letter of Understanding for Calendar Year 2018

1. Sponsoring Institution/Provider: ______________________________

Address of the Main/Primary Office: ______________________________

Names and Addresses of Secondary or Satellite DSMT Program Sites:

____

____

____

____

____

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____

____

2. Coordinator:

Name: ______________ Credentials ______________

Mailing Address: ______________

Phone: ______________ Fax: ______________

Email: ______________

3. Instructors (must include at least 1 RN and 1 RD):

Name: ______________________ Credentials ______________
Address: ______________________
____
Phone: ______________________ Fax: ______________
Email: ____

Name: ______________________ Credentials ______________
Address: ______________________
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Phone: ______________________ Fax: ______________
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Email: ____

Name: ______________________ Credentials ______________
Address: ______________________
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Phone: ______________________ Fax: ______________
Email: ____

4. **Physician Advisor:**

Name: ______________________________ Credentials ______________

Address: ______________________________

____

Phone: ______________________________ Fax: ______________

Email: ______________________________

This administrator affirms that the institution and the people listed above, are complying with the requirements stated in this Letter of Understanding and will continue to do so during this authorization period.

______________________________ ______________________________

(Sponsoring Institution Administrator) (Date)

______________________________ ______________________________

(Maine CDC, Senior Health Program Manager) (Date)