



Compilation of Comments Received during the Public Comment Period

In February, a draft of the AADE Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T) was posted to AADE's website with a call for comments. We received written comments from eleven reviewers. The comments along with AADE's reactions are listed below for your consideration.

Reviewer 1

-In reading these over I think that AADE may want to expand the potential lay role. As you know in November 2008 CMS approved the reimbursement of peer educations offering the Stanford Self-Management Program. Of course the devil is in the details but these are being worked out by AOA, CDC, and CMS as I write. I think that it is important that AADE thus recognizes in their practice guidelines the ability of peers to teach programs—of course, I also think that this needs to have some constraints. Also the Peers for Progress programs, Merck programs and now Johnson and Johnson are all looking at peer led diabetes education.

-I do not see this in any way as a threat to AADE anymore than community health workers have been a threat to APHA. Rather, I see this movement as a way to expand the reach of diabetes education and to expand the role of CDEs and other professional diabetes educators. By embracing this role now you put AADE at the forefront of thinking.

AADE REACTION: WE THANK THE REVIEWER FOR THESE COMMENTS. AS ARTICULATED IN THE NEWLY UPDATED POSITION STATEMENT ON COMMUNITY HEALTH WORKERS, (AVAILABLE AT: [HTTP://WWW.DIABETES EDUCATOR.ORG/ABOUT/POSITION/POSITION STATEMENTS.HTML](http://www.diabeteseducator.org/about/position/position_statements.html)) ALSO KNOWN AS LAY HEALTH WORKERS), COMMUNITY HEALTH WORKERS (CHW) CAN MAKE IMPORTANT CONTRIBUTIONS TO DIABETES SELF-MANAGEMENT EDUCATION/TRAINING (DSME/T). BY SERVING AS A BRIDGE FROM THE DIABETES CARE TEAM TO THE PATIENT, CHWs HELP TO ENSURE THAT DIABETES EDUCATION IS CULTURALLY RELEVANT AND MEANINGFUL WITHIN THE PATIENTS' COMMUNITY. THE GUIDELINES DELINEATE A ROLE FOR CHWs THAT INCLUDES SUPERVISION BY DIABETES EDUCATORS. IN ADDITION, AADE'S DIABETES EDUCATION ACCREDITATION PROGRAM INCLUDES A NON-INSTRUCTIONAL ROLE FOR CHWs IN ACCORDANCE WITH THE REQUIREMENTS SET FORTH BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS).

Reviewer 2

-I think that this version is excellent. My compliments to AADE and the writing team!

AADE REACTION: THANK YOU FOR YOUR INTEREST AND RESPONSE.

Reviewer 3

References to medical nutrition therapy (MNT) should be omitted in the paper and nutrition education should be the basis for meeting the healthy eating self-care behavior.

While AADE's reference to MNT, in the section that describes the healthy eating self-care behavior, highlights the RD's role in diabetes services and as a key member of the DSMT team, it blends components of the two separate healthcare services and programs—MNT and DSMT/E. MNT is a separate service under Medicare, defined by the government and with its own set of regulations that must be followed for provision of these services. This section must be edited to focus on nutrition education as the basis for meeting the healthy eating self-care behavior.

AADE REACTION: WE AGREE THAT A CLEAR DISTINCTION SHOULD BE MADE BETWEEN MNT AND NUTRITION EDUCATION. A FOOTNOTE HAS BEEN ADDED TO CLARIFY THIS DISTINCTION.

ADietA recently released a Diabetes White paper to help clarify roles and responsibilities of providers involved in diabetes programs such as the federal government's Medicare benefits for medical nutrition therapy (MNT) and diabetes self-management training (DSMT). One of our goals with releasing the paper was to help professionals recognize and respect the unique components that distinguish the education and training curriculum included in Medicare DSMT programs, with the services offered through MNT provided by RDs and nutritionists. Information included in ADA's White Paper may serve as a resource for clarifying this point in your document. ADA's White Paper indicates "... a registered dietitian is recommended to be the team member who provides the nutrition education component of the DSMT curriculum; however, when an RD is not available to teach the group session, the non-RD program instructor may perform tasks described in Figure 1." (A copy of the ADA White Paper, including Table 1 is enclosed for your reference.)

AADE REACTION: THANK YOU.

While AADE has included the Centers for Medicare & Medicaid Services' reference to the complementary nature of MNT and DSMT programs (page 15) "In the provision of both DSME/T and MNT, benefits may be more medically effective for some beneficiaries than for those that received just one of the interventions," the paper should go farther to distinguish the two services. The emphasis of nutrition education, not MNT, should serve as the basis for the healthy eating self-care behavior in the DSMT/E program.

AADE REACTION: WE AGREE AND BELIEVE THE FINAL VERSION OF THE GUIDELINES CLEARLY INDICATES THIS FOCUS.

Healthy Eating Self-Care Behavior and medical nutrition therapy, continued

Footnotes and references linked to medical nutrition therapy should be corrected.

Editing the document to remove the reference to MNT as the healthy eating component of DSME/T also requires adjustment to statements and references cited in this section. In addition, we request clarification regarding reference 52a- ADA's Web page. It is not clear what document(s) is cited.

The references to the evidence that supports the benefits of healthy eating for people with diabetes is misleading and should be corrected in the document.

AADE REACTION: THANK YOU. WE HAVE REVIEWED THE DOCUMENT TO CLARIFY THE CITATIONS AND ENSURE CONSISTENCY.

The section of the guideline that addresses “good evidence” of interventions for ‘healthy eating’ is misleading. The reference cited in this sentence links back to MNT, not nutrition education as a component of DSME/T programs. In particular, the sentence, “There is now good evidence to show the benefits of healthy eating for people with diabetes... [52]” should be clarified. The cited reference is the American Diabetes Association’s Nutrition Recommendations and Interventions for Diabetes, which describes MNT. While MNT can address ‘healthy eating,’ based on ADA’s comments recommending that MNT be separated from DSME/T program components, this section needs revision to clarify the nutrition education component of DSME/T for ‘healthy eating’. As noted in AADE’s document “Diabetes and Healthy Eating: A Systematic Review of the Literature” the review did not find “good evidence” with regards to healthy eating interventions, rather exercise was the only intervention where “there was a tendency for successful interventions.” I’ve attached a commentary from Marion Franz where she makes this point regarding the systematic review document and confusion with regards to terms referenced in the Systematic Review.

AADE REACTION: THANK YOU. WE ARE REVIEWING THE CITATIONS TO ENSURE THEIR ACCURACY.

Roles and responsibilities of those who deliver diabetes education and care and Table 3: “General Scope of Diabetes Educational/Clinical Care Activities”

The levels of care for healthcare professionals need further refinement.

ADietA believes the levels of care inaccurately describe healthcare professionals involved in diabetes care. There is considerable overlap in activities listed in Table 3, and in other cases there is omission of information. For example, with respect to activities RDs perform for diabetes care, many of the assessment, goal setting and planning activities that are listed in level 4 could also be listed in level 3.

AADE REACTION: THE WRITING TEAM CAREFULLY CONSIDERED THE MULTIDISCIPLINARY NATURE OF THE DIABETES EDUCATION SPECIALTY IN DEVELOPING THE SECTION BEING ADDRESSED. THE WRITING TEAM THEREFORE BELIEVES THAT THE ORIGINAL WORDING IS CLEAR AND APPROPRIATE.

We feel the level titles are misleading and imply that certain healthcare professionals are not diabetes educators, and the level titles and descriptors disregard the healthcare professionals’ certification and/or credentials that allow these practitioners to practice in their respective profession. It is still not clear in Table 3, and the text in the document, how AADE is defining “non-diabetes educator” and “diabetes educator” and “non-credentialed diabetes educator” versus “credentialed diabetes educator.” Is this solely on the CDE, and/or BC-ADM credentials?

AADE REACTION: WE HAVE MODIFIED TABLE 3 TO HELP CLARIFY THE DISTINCTIONS.

ADietA believes RDs demonstrate their knowledge and experience in diabetes through a variety of venues such as individual or formal study programs, job experience, continuing education, mentoring, advanced practice, and additional certifications. In some cases, such as a rural setting, an RD generalist may perform diabetes nutrition education to individuals with diabetes. It appears these RDs would fall into level 2 and level 3 since the RD would provide activities described in both levels. Due to staffing issues, among other items that impact access to healthcare professionals, it seems unlikely that a healthcare professional e.g. RD, as designated in the AADE level 2 would perform the activities in level 2, and then at a later occurrence, another healthcare professional, e.g. RD diabetes educator, would provide activities defined in level 3.

AADE REACTION: HEALTHCARE PROFESSIONALS MAY PRACTICE AT MORE THAN ONE LEVEL, PROVIDED THEY HAVE THE EDUCATION, SKILLS, AND CREDENTIALS TO DO SO.

Roles and responsibilities of those who deliver diabetes education and care and Table 3: “General Scope of Diabetes Educational/Clinical Care Activities,” continued

Additionally, the title and description of individuals in level one is misleading. Level one is titled “Non-Health Care Professional” and the document describes this group as “community health care providers.” However, the terms “professional” and “provider” usually identify practitioners with sufficient expertise and training to perform healthcare services without direct supervision. Generally, providers are recognized by healthcare groups and the government to meet certain requirements to independently provide certain services.

AADE REACTION: WHERE APPROPRIATE WE HAVE CLARIFIED THE USE OF TERMS. THE REFERENCE TO NON-HEALTH CARE PROFESSIONALS IS IN ACCORDANCE WITH AADE POSITIONS ON CHWs (SEE COMMENTS IN RESPONSE TO REVIEWER 1 ABOVE).

In reviewing the practitioners listed in the various levels, we wondered about the ability of certain individuals, such as medical assistants, to perform activities in level 2 without supervision or oversight by other healthcare professionals. Another factor is the role of state licensure and/or scope of practice issues related to the activities performed by individuals cited in various levels in Table 3.

AADE REACTION: WORDING ABOUT THE RELEVANCE OF EACH PRACTITIONER’S SCOPE OF PRACTICE AND STATE LICENSURE IS INCLUDED IN THE GUIDELINES.

Lastly, one omission that we noticed was the reference to dietetic technicians, registered (DTRs). Although DTRs are not employed in all healthcare settings, RDs and DTRs frequently work together as teams to provide nutrition services, including nutrition education to individuals with diabetes. The level of autonomy between the RD and DTR is determined by regulation; that is, state dietitian/ nutritionist licensure statutes and rules, as well as facility accrediting bodies and facility policies and procedures. DTRs could be listed as an additional practitioner within the guideline paper, yet based on the current activities defined in Table 3, it is unclear which level to include DTRs.

AADE REACTION: CONSIDERABLE DISCUSSION AND THINKING WERE INVOLVED IN DEFINING THE FIVE LEVELS. MEDICAL PROFESSIONALS MAY, IN FACT, PRACTICE AT MORE THAN ONE LEVEL. FOR EXAMPLE, AN RD MAY FIT INTO LEVEL 3 OR BECOME A CERTIFIED DIABETES EDUCATOR AND PRACTICE AT LEVEL 4. AN RN WITH A BC-ADM WOULD PERFORM AT A LEVEL 5, WHILE THIS PERSON’S COUNTERPART WORKS HEAVILY IN RADIOLOGY, BUT HAS VERY LITTLE PROFESSIONAL INVOLVEMENT IN ADDRESSING DIABETES, COULD FUNCTION AT A LEVEL 2.

Scientific Evidence Supporting the Guideline Recommendations:

The document should clarify and offer a more transparent description of the evidence linked to the graded recommendations.

While the paper describes the writing groups’ procedures to review literature to support the guideline recommendations, a few items are not clear regarding the research reviewed for the respective guidelines. It is not clear if the search terms were identical for research reviewed for each guideline recommendation. We were also not able to determine the actual research studies that were reviewed and that served as the basis for grading each recommendation.

AADE REACTION: THE WRITING TEAM HAS WORKED WITH THE AADE RESEARCH COMMITTEE TO REVISE THE SECTION ON GRADING THE EVIDENCE TO PROVIDE ADDITIONAL EXPLANATION AND CLARITY. ASIDE FROM APPLYING SPECIFICALLY TO EACH OF THE AADE7 SELF-CARE BEHAVIORS, THE SEARCH TERMS WERE IDENTICAL.

Other general comments:

Clarification on the guideline document regarding patient-focused care and diabetes prevention/pre-diabetes.

While the paper addresses diabetes as a chronic condition, it omits any references to prevention of diabetes and education for individuals with pre-diabetes. It appears the paper is not aligned with healthcare models that emphasize patient-focused care.

AADE REACTION: THIS IS AN INSIGHTFUL COMMENT. THE DOCUMENT NOW INCLUDES REFERENCES TO PREVENTION. UNFORTUNATELY, VERY LITTLE, IF ANY, REIMBURSEMENT IS AVAILABLE FOR DSME/T THAT IS PROVIDED AS A PREVENTIVE INTERVENTION.

AADE REACTION: OVERALL, WE THANK THE REVIEWER FOR PROVIDING SUCH THOUGHTFUL AND COMPREHENSIVE COMMENTS.

Reviewer 4

-As AADE members & CDEs for a hospital based ADA Recognized Program we would like to provide our comments/questions on the proposed guidelines:

* Is the proposed draft intended for health care professionals? These guidelines are written at a health literacy level that may make it difficult for "non-health care professionals" to interpret and utilize.

AADE REACTION: WE AGREE THAT LITERACY LEVEL IS AN IMPORTANT CONSIDERATION. THE GUIDELINES ARE WRITTEN FOR THOSE WHO PRACTICE DIABETES EDUCATION. WE ALSO ENVISION THAT THEY WILL BE READ BY THOSE WHO WISH TO ENTER THE SPECIALTY AND BY THOSE WHO EMPLOY DIABETES EDUCATORS.

* We understand the goal of these guidelines is to open up access to diabetes education but at what price? In our opinion, these guidelines suggest a watered down version of quality diabetes education. What is in place to ensure the education being offered at a local community center is of the same caliber as that of an ADA or AADE recognized program. For example: is diabetes care received from a Primary Care physician the same as diabetes care received from an Endocrinologist?

AADE REACTION: THE REVIEWER HAS RAISED SOME INTERESTING QUESTIONS THAT GO BEYOND THE SCOPE OF THE GUIDELINES. WE BELIEVE THAT SEVERAL DOCUMENTS UNDERLIE HIGH QUALITY DMSE/T PROGRAMS, E.G., THE SCOPE AND STANDARDS, SCOPE OF PRACTICE AND NATIONAL STANDARDS. WE AGREE THAT QUALITY OF DSME/T IS FURTHER ASSURED FOR PROGRAMS THAT SEEK TO BECOME ACCREDITED BY AADE OR RECOGNIZED BY THE INDIAN HEALTH SERVICES OR ADA.

* It is not clear as to the credentials of the non-healthcare professional and healthcare professional non-diabetes educator? We think there would need to be requirements in place to assure competency in the areas listed for general scope of diabetes education activities.

AADE REACTION: THE QUESTION GOES BEYOND THE SCOPE OF THE GUIDELINES. AADE IS DEVELOPING A COMPETENCIES DOCUMENT THAT WILL BE AVAILABLE LATER IN 2009.

* Who will provide the training and monitor competency in the non-healthcare professional and healthcare professional non-diabetes educator to ensure provision of quality diabetes care?

AADE REACTION: WE APPRECIATE THIS QUESTION BECAUSE OF ITS FOCUS ON QUALITY. THE DOCUMENT NOW REFLECTS APPROPRIATE WORDING. DEPENDING ON THE PROGRAM INSTRUCTIONAL STAFF, A QUALIFIED HEALTHCARE PROFESSIONAL (POSSIBLY A CDE) SUCH AS A RN, RD, OR PHARMACIST WOULD OVERSEE THE TRAINING AND MONITORING COMPETENCIES. IT MAY ALSO BE THE QUALIFIED COORDINATOR WHO PROVIDES TRAINING AND THEN ASSIGNS AN INSTRUCTOR TO MONITOR COMPETENCIES.

* It is not clear, but are the guidelines saying a "diabetes educator" needs to be available for the Level 1 and Level 2 providers?

AADE REACTION: YOU ARE INSIGHTFUL READERS AND NOTE WHERE THE WRITING TEAM HAS CHOSEN TO BE SILENT ON CERTAIN ISSUES. AADE BELIEVES THAT OVERSIGHT BY A DIABETES EDUCATOR IS ALWAYS PREFERRED, BUT IN REALITY THE ANSWER IS THAT "IT MAY NOT BE AVAILABLE. PROGRAMS THAT WISH TO SEEK ACCREDITATION MUST ENSURE THAT LEVEL 1 PROVIDERS ARE SUPERVISED. DIABETES EDUCATORS ARE SPECIALLY EDUCATED, HAVE SPECIAL SKILL SETS AND CAN SERVE AS EXCELLENT SUPERVISORS. ON THE OTHER HAND, THERE ARE ACCEPTED MODELS (E.G., STANFORD CHRONIC CARE MODEL) IN WHICH THE NON-HEALTH CARE PROFESSIONAL WORKS AS A CO-EQUAL WITH OTHER HEALTH CARE PROFESSIONALS.

* How is the relationship with the non-health care professional and a diabetes educator established? It would be helpful to include examples of these relationships.

AADE REACTION: THANK YOU FOR THE QUESTION, BUT WE BELIEVE THAT IT GOES BEYOND THE SCOPE OF THE GUIDELINES.

* What is the minimum number of levels needed in a setting to provide diabetes education?

AADE REACTION: THIS IS A VERY GOOD QUESTION. WHILE IT IS BEYOND THE SCOPE OF THE GUIDELINES TO ANSWER THIS QUESTION, WE INTEND TO POSE THIS AS A RESEARCH QUESTION TO OUR RESEARCH COMMITTEE IN THE NEAR FUTURE. .

AADE REACTION: WE THANK YOU FOR YOUR OVERALL INTEREST AND THOUGHTFUL COMMENTS.

Reviewer 5

-Hello, Wow. Thanks for working on such a comprehensive document. I appreciate having easy access to references that back up our plans. Also, I'm glad it's set up in the question/answer format. It helps focus the document in a language that any entry level educator could utilize to advocate for his/her practice.

AADE REACTION: THANK YOU.

-I saw the reference to diabetes educator competencies on page 6. I'm not sure I know the details about the AADE competencies, but now know to look them up.

AADE REACTION: AADE IS DEVELOPING A COMPETENCIES DOCUMENT THAT WILL BE AVAILABLE LATER IN 2009.

Thanks for doing this.

AADE REACTION: WE ARE PLEASED TO BE ABLE TO SUPPORT DIABETES EDUCATORS AND THE PRACTICE OF DSME/T IN THIS WAY.

Reviewer 6

I like the concept of the levels of diabetes educators. I do think that this needs to be defined, if we are to pursue legislative action and reimbursement for CDE providers.

-Not all diabetes educators are created equal, as far as preparation goes and clinical expertise. This does create a dilemma, as the average PCP is unaware of this.

AADE REACTION: WE BELIEVE THAT THE GUIDELINES WILL HELP DIABETES EDUCATORS TO IDENTIFY WHERE THEY FIT IN AND FURTHER THEIR DEVELOPMENT ALONG A LOGICAL PATH. OTHER DOCUMENTS ARE BEING DEVELOPED TO ADDRESS CORE COMPETENCIES FOR DIABETES EDUCATORS.

-I do think that there are many CDEs who also are not utilizing technology to its fullest potential, if at all - such as downloading meters or pumps.

AADE REACTION: THANK YOU FOR THIS OBSERVATION. THE TOPIC OF TECHNOLOGY USE IS BEYOND THE SCOPE OF THE GUIDELINES DOCUMENT; HOWEVER, THE AUTHORS NOTE THAT THE FUTURE WILL INCLUDE GREATER USE OF TECHNOLOGY.

-As we move forward as an organization, we need to challenge our peers to step up to the current day practice. We no longer can afford to do the same education that we have for the past 10-15 years, we must be outcome driven, current in practice and be creative in our approaches to DSMT. If we are to sustain DSME/T, then we need to be diabetes clinical consultants that create a diabetes education momentum that empowers our patients in their care.

AADE REACTION: THANK YOU FOR THIS COMMENT. WHILE SOMEWHAT BEYOND THE SCOPE OF THE GUIDELINES, WE CONCUR THAT THE PRACTICE OF DSME/T NEEDS TO BE MORE OUTCOME DRIVEN.

Reviewer 7

-I need to know more about diabetes educators in Spanish.

AADE REACTION: WHILE LINGUISTICS IS BEYOND THE SCOPE OF THE GUIDELINES DEVELOPMENT EFFORT, WE DO WISH TO POINT OUT THAT MANY DOCUMENTS ARE AVAILABLE IN SPANISH FROM AADE AND OTHERS. WE URGE YOU TO CONSIDER JOINING THE AADE HISPANIC/LATINO AMERICAN SPECIALTY PRACTICE GROUP.

Reviewer 8

-Samples of standing orders for out patient clinic who has access to fax insulin adjustments to doctor's offices for their signature.

-Give an example of standing orders to be used.

AADE REACTION: WE THANK THE REVIEWER, BUT ADMIT TO BEING PERPLEXED BY THESE REQUESTS. THEY APPEAR TO BE BEYOND THE SCOPE OF THE GUIDELINES.

Reviewer 9

Thank you for the opportunity to comment. The Guidelines seem clear and well defined. It appears to outline for each individual where their responsibility and role in diabetes education should focus. It does seem that some individuals may continue to work beyond the focus outlined due to the lack of qualified educators in their referral network or service area. I'm not sure this is an issue this document can address, but perhaps it will offer these individuals an opportunity for additional professional education and/or training to achieve the level necessary to meet the needs of the patients they serve. I would hope that the statements concerning individual professional regulations and state license practice acts are strong enough so individuals continue to practice within the limits of their professional license, as well as their professional knowledge and understanding of diabetes and DSME/T.

AADE REACTION: WE THANK THE REVIEWER FOR THESE SUPPORTIVE COMMENTS AND BELIEVE THE GUIDELINES WILL HELP DIABETES EDUCATORS TO BETTER UNDERSTAND THEIR ROLES. SOME OF THE TOPICS ADDRESSED HERE ARE BEYOND THE SCOPE OF THE GUIDELINES, BUT ARE ADDRESSED BY EACH PROFESSION'S SCOPE OF PRACTICE AS WELL AS THE NATIONAL STANDARDS. PLEASE NOTE THAT AADE IS TAKING STEPS TO INCREASE ACCESS TO DSME/T FOR PEOPLE IN UNDERSERVED AREAS. AADE ALSO OFFERS CONTINUING EDUCATION FOR DIABETES EDUCATORS.

Reviewer 10

It has been discussed, but our recommendation is that AADE should not add health coaches to the Guidelines.

AADE REACTION: WE APPRECIATE THE COMMENT. HEALTH COACHES ARE NOT INCLUDED IN THE GUIDELINES.

Reviewer 11

On behalf of the American Diabetes Association staff and volunteer members of the Executive Committee Health Care and Education track, we would like to thank you for inviting our input into the above document, and for extending the time for us to review. Several of us have reviewed this document; however, due to personal and other recent matters of importance that we have needed to attend to in the past couple of weeks, we have not fully collected our responses to this document. We feel that it would be inappropriate for us to comment officially at this time, particularly because we are unsure that we have an adequate understanding of the full impact that the document carries.

Thanks to you for your patience in waiting for our response.

AADE REACTION: WE APPRECIATE THE INTEREST EXPRESSED BY THE ADA IN THE GUIDELINES. THANK YOU.

Reviewer 12

The American Association of Clinical Endocrinologists urges AADE to recognize the role of physicians in the delivery of diabetes education.

AADE REACTION: WE APPRECIATE THE INTEREST EXPRESSED BY AACE IN THE GUIDELINES AND RECOGNIZE THAT PHYSICIANS PLAY AN IMPORTANT ROLE IN COORDINATING THE CARE OF PATIENTS WITH DIABETES AND REFERRING THEM TO DSME/T. THANK YOU.