

CROSSWALK BETWEEN NATIONAL STANDARDS AND AADE DEAP

NATIONAL STANDARDS, ESSENTIAL ELEMENTS, INTERPRETIVE GUIDANCE

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance (See Glossary for more information)
<p>Standard 1. Organizational Structure The DSME program will have documentation of its organizational structure, mission statement & goals and will recognize and support quality DSME as an integral component of diabetes care</p>	<p>A) There is documentation that describes or depicts Diabetes Education as a distinct component within the organization’s structure and articulates the program’s mission and goals.</p> <p>B) Documentation and/or procedures that support quality education shall include at least the following:</p> <p>i) Job descriptions of the Program Coordinator and instructional team that are congruent with program needs, including educational needs of target population.</p> <p>ii) Diabetes education process and self-management support</p>	<p>Documentation of org chart of DSMT Program: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Documentation of program mission and goals: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Policies and procedures are available: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Job Descriptions for all positions relating to the DSMT Program: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>Policies and procedures are an integral part of any quality process and should be developed for applicable program components. (Policy = directive or statement that must be adhered to. Procedure = guidelines for implementation of policy.)</p> <p>The mission can be described as a brief description of the program’s fundamental purpose. It answers the question, “Why do we exist?” Documentation should broadly describe the program’s present capabilities, customer focus, and activities. The targeted audience is typically identified in the mission statement.</p> <p>If diabetes education experience is used as the instructor qualification criteria instead of continuing education, the amount of previous diabetes education experience needed for the instructor who is not credentialed as a diabetes education or a diabetes clinical management specialist shall be included in the instructor’s job description.</p>

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<p>Standard 2. The DSME program shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.</p>	<p>A) A policy that identifies the structure and process, for the program’s advisory group, will be maintained.</p> <p>i) This policy will address the advisory group’s role in promoting quality DSMT programming.</p>	<p>Advisory Group Policy: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Advisory Group Function: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>The advisory group for each DSMT program will vary according to program size, location and scope and complexity of services provided.</p> <p>AADE suggests the advisory group includes a primary care provider, educator, community member with diabetes, etc. The group actively reviews and makes recommendations on the DSMT annual program plan and evaluation.</p>

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<p>Standard 3. The DSME program will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.</p>	<p>A) There shall be documentation of:</p> <ul style="list-style-type: none"> i) a needs assessment for the target population. ii) the availability of resources to meet these educational needs 	<p>An identifiable process was used to assess the needs of the target population:</p> <p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>Unique needs of target population specified:</p> <p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>Allocation of resources specified:</p> <p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	<p>The development of a DSMT program must include identifying who it intends to provide services to (the target population/audience)</p> <p>The decision about who to provide services to should relate to the organization’s mission. Additional decisions and assessment about the target population are needed, and include the following:</p> <ol style="list-style-type: none"> 1) The volume of people who will be in need of service on an ongoing basis 2) The type of diabetes that most potential participants have 3) Where they live 4) Unique characteristics of large segment(s) of the target population that are relatively homogenous. <p>Allocation of resources should be based on assessment of the target population.</p>

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<p>Standard 4. A coordinator will be designated to oversee the planning, implementation and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.</p>	<p>A) A completed job application/resume of the program coordinator that identifies experience and/or education in program management and the care of individuals with chronic disease, congruent with the job description, is kept on file.</p> <p>B) The coordinator’s position description will indicate that the coordinator is responsible for oversight of the planning, implementation and evaluation of the DSMT program. (See Standard 1)</p> <p>C) Coordinators are to follow the continuing education requirements of their professions (a minimum of 15 hours continuing education is required annually)</p>	<p>Coordinator’s resume (reflects academic, continuing education, and/or experiential preparation): YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Position description describes program oversight by Coordinator: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>The breadth and depth of responsibilities of the program coordinator will vary with the program size and complexity, but, at a minimum, the coordinator must have the ability to be responsible for planning, implementation and evaluation of services. The job description of coordinator should be congruent with the size and complexity of the program. (See Standard 1)</p>

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<p>Standard 5. DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.</p>	<p>A) Resumes and proof of licenses, registration and/or certification shall be maintained to verify that program staff is comprised of instructor(s) who have obtained and maintained the required credentials.</p> <p>B) If Community Health Workers (CHW) are part of the DSMT program team, there is documentation of successful completion of a standardized training program for CHWs and additional and on-going training related to diabetes self-management.</p> <p style="padding-left: 40px;">i) Training includes scope of practice relative to role in DSMT</p> <p>C) If CHWs are part of the DSMT program's team, there shall be documentation that they are directly supervised by, the named diabetes educator(s) in the program.</p> <p>D) Proof of continuing education will be maintained to provide evidence that each instructor maintain their qualifications according to the specific criteria below and consistent with their job description:</p> <p style="padding-left: 40px;">i) Instructors:</p> <p style="padding-left: 80px;">a) 15 hours of continuing education annually for all instructors.</p> <p style="padding-left: 80px;">b) These hours must be from a nationally recognized accrediting body.</p>	<p>Instructor's current credentials:</p> <p style="padding-left: 40px;">YES <input type="checkbox"/></p> <p style="padding-left: 40px;">NO <input type="checkbox"/></p> <p>Instructor's current resume:</p> <p style="padding-left: 40px;">YES <input type="checkbox"/></p> <p style="padding-left: 40px;">NO <input type="checkbox"/></p> <p>15 hours annual continuing education for all individuals:</p> <p style="padding-left: 40px;">YES <input type="checkbox"/></p> <p style="padding-left: 40px;">NO <input type="checkbox"/></p> <p>At least one of the instructors is an RN, RD or pharmacist:</p> <p style="padding-left: 40px;">YES <input type="checkbox"/></p> <p style="padding-left: 40px;">NO <input type="checkbox"/></p> <p>CHW training, continuing education and name of supervisor, if applicable:</p> <p style="padding-left: 40px;">YES <input type="checkbox"/></p> <p style="padding-left: 40px;">NO <input type="checkbox"/></p>	<p>There is evidence that DSMT is most effective when delivered by a multidisciplinary team that is comprised of members with varying types and levels of expertise (both professional and CHWs) who collaboratively plan and implement a comprehensive plan of care. The concept of "team approach" should be implemented through collaboration and linkages with other health care providers of various disciplines, outside of the program, particularly where a participants needs cannot be met by the program staff.</p> <p>Continuing education for instructional staff is specified as being diabetes-specific, diabetes-related, and behavior change self-management education strategies (e.g., AADE7 self-care behaviors)</p> <p>CHWs will have non-technical and non-clinical instructional responsibilities; they will receive on-going informal training and formal training as appropriate.</p> <p>Mechanisms for meeting needs outside of scope of practice include:</p> <ol style="list-style-type: none"> 1. Referral to other practitioner 2. Partnering with a professional with additional expertise (e.g., exercise physiologist or behavioral specialist)

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Standard 5, cont.	<p>E) For programs, particularly those that have solo instructors, there shall be a policy that identifies a mechanism for ensuring participant needs are met if needs are outside of instructor’s scope of practice and expertise.</p> <p>F) There shall be documentation that:</p> <ul style="list-style-type: none"> i. describes a process for ensuring that appropriate care coordination among the diabetes care team occurs. ii. Of team coordination/interaction. 	<p>Mechanisms for ensuring participants’ needs are met.</p> <p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p> <p>Team coordination and interaction is documented:</p> <p>YES <input type="checkbox"/></p> <p>NO <input type="checkbox"/></p>	<p>Quality care is more likely when the multidisciplinary team meets on an as needed basis; this should be documented. The documentation can rely on a checklist or some other vehicle. The purpose is to make certain that care and changes in care are known by all team members.</p>

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<p>Standard 6. A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME program. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided:</p> <ul style="list-style-type: none"> ○ Describing the Diabetes disease process & treatment options. ○ Incorporating nutritional management into lifestyle. ○ Incorporating Physical activity into lifestyle. ○ Using medication(s) safely and for maximum therapeutic effectiveness. 	<p>A) A written curriculum that meets the patients’ needs will be maintained and updated as needed to reflect current evidence and practice guidelines.</p> <p>B) The curriculum:</p> <ul style="list-style-type: none"> i) Uses principles and concepts of the AADE7 self-care behavior framework (self-care behaviors): <ul style="list-style-type: none"> a) Healthy Eating. b) Being Active. c) Monitoring. d) Taking medications. e) Healthy coping. f) Problem solving. g) Reducing risks. ii) Includes content about the diabetes disease process/pathophysiology. iii) Is tailored for the target population. iv) Uses primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods. 	<p>A written curriculum tailored to meet the needs of the target population: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Adopts principles of AADE7 and includes disease content: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Curriculum is kept updated, reflecting current evidence, practice guidelines and is culturally appropriate: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Curriculum maximizes use of interactive training methods: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>Medicare requires DSMT programs to have a written curriculum that includes specified content areas relating to the patient’s understanding of self-management skills, knowledge and behavior change. The educational plan and comprehensive curriculum are based on the AADE7 and typically include a needs assessment, teaching techniques and tools, collaborative goal setting with implementation and criteria for assessing behavior change and goal achievement, and appropriate documentation.</p> <p>The curriculum and accompanying training materials are most effective if they are at the appropriate level of literacy and numeracy of the population being served and based upon evidenced-based principles of education and healthcare. Additionally, a curriculum that takes into account cultural beliefs, attitudes and practices held by a majority of the population targeted will help ensure successful DSMT.</p>

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<p>Standard 6, cont</p> <ul style="list-style-type: none"> ○ Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making. ○ Preventing, detecting, and treating acute complications. ○ Preventing, detecting and treating chronic complications. ○ Developing personal strategies to address psychosocial issues and concerns. 			<p>Using principles and concepts of the AADE7 self-care behavior framework for curriculum development or adaptation of standardized DSMT curriculums will provide continuity throughout the DSMT process (assessment through evaluation) and will center the focus of DSMT on behavior change, the primary purpose of diabetes education. Uses primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods.</p> <p>Criteria for evaluating immediate outcomes (learning and barrier resolution) and, as applicable, intermediate outcomes (behavior change goal achievement), using the AADE7 self-care behavior framework, (continuum of outcome measures) should be part of the written curriculum.</p>

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<p>Standard 7. An individual assessment and education plan will be developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.</p>	<p>A) There will be documentation to identify that pertinent assessment data was obtained in a collaborative, ongoing manner between the participant and instructor.</p> <p>B) The AADE7 self-care behavior framework will serve as the foundation for the assessment and include the following elements:</p> <ul style="list-style-type: none"> i) Relevant medical history ii) Present health status, health service or resource utilization iii) Risk factors iv) Diabetes knowledge and skills v) Cultural influences vi) Health beliefs and attitudes vii) Health behaviors and goals viii) Support systems ix) Barriers to learning x) Socioeconomic factors 	<p>Collaborative participant assessment: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Education Process Policy: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Plan of care based on assessment and meets the individual's needs: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Integration of AADE7: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Intervention per plan provided and outcomes evaluated: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Collaborative development of education goal, objectives and plan: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>The Diabetes Educational Process is comprised of an individualized assessment, goal setting, development of an educational plan, implementation of the educational plan and evaluation of the effectiveness of the DSMT interventions. The process is collaborative between/among the participant and instructor/s. An integral part of the process includes documentation in the education/medical/clinical record which promotes continuity of care.</p> <p>Also see Standard 6.</p> <p>Communication back to the referring physician and other members of the diabetes care team is essential to high quality patient care and optimal health outcomes.</p>

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Standard 7, cont.	<p>C) There will be a written policy that describes the diabetes education process (assessment, planning, intervention and evaluation) and there will be documentation of the following for each patient:</p> <ul style="list-style-type: none"> i) Educational plan ii) Educational interventions provided <ul style="list-style-type: none"> a) If interventions not provided according to the plan, there shall be documentation about plan revision. iii) Achievement of learning objectives <p>D) Staff providing service will be identifiable in a way that can be authenticated.</p> <p>E) There shall be documentation to identify that an educational goal/s, and learning objectives and the plan for educational content and method/s were collaboratively developed between the participant and instructor(s).</p>		

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<p>Standard 8. Process A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and instructor(s). The patient’s outcomes and goals, and the plan for on-going self-management support will be communicated to the referring provider.</p>	<p>A) There will be a written policy and documentation that identifies that a personalized follow-up plan to ensure on-going self-management support (DSMS) was developed in collaboration with the participant.</p> <p>B) There shall be documentation that identifies that the patient’s outcomes and goals, and the plan for DSMS are communicated to the referring physician (or qualified non-physician practitioner).</p>	<p>Communication of educational services to physician/ qualified non-physician practitioner: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Policy for personalized process and on-going self-management support strategies: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>Achieving and maintaining behavior change goals that are necessary for successful diabetes self-management usually requires ongoing support upon completion of a diabetes education program or course. Diabetes self-management support (DSMS) can be provided by a variety of different people including health care professionals, community health workers, peer support and family; using a variety of different methods (telephone, web and e-mail, meetings, etc.). It is important to have an individualized plan for ensuring the provision of DSMS for most DSMT participants to help people continue to keep focused on diabetes.</p> <p>Communication back to the referring physician and other members of the diabetes care team is essential to high quality patient care and optimal health outcomes.</p>

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<p>Standard 9. The DSME program will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.</p>	<p>A) The evaluation policy shall use the AADE7 self-care behavior framework (or equivalent), core outcomes measures, behavioral and clinical outcomes for each patient individually and in aggregate. Outcomes will be compared to quality indicators to assess the effectiveness of the patients' care plan and the education intervention.</p> <p>i) Individualized and aggregate outcomes data includes at a minimum, attainment of participant-defined behavior change goal(s) (intermediate outcomes) and at least one post-intermediate or long term health outcome measure.</p> <p>ii) There shall be evidence that there was a critical analysis that determined the choice for the post-intermediate (clinical improvement) or long term (health status improvement) outcome measure that will be or was tracked.</p>	<p>Individual and aggregate achievement of behavior change goal(s): YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Policy required that outcomes data include appropriate measures: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Reason for choice of outcome measures: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Effectiveness of intervention is based on data: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>Individual patient outcome measures are used to guide the intervention and improve care for that participant. Aggregate population outcome measures (program outcome measures) are used to guide programmatic services and CQI activities for the DSMT and the population it serves.</p> <p>AADE electronic data collection tools could be used for data collection and analysis; other data collection tools are also applicable.</p> <p>Communication to the instructional team and members of the diabetes care team is essential to high quality patient care and optimal health outcomes.</p>

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<p>Standard 10. Outcomes The DSME program will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.</p>	<p>A) There is documentation that:</p> <ul style="list-style-type: none"> i) Identifies opportunities for improvement, as indicated by data tracked, were identified ii) Is a process for improvement implemented if feasible (or an explanation for why it was not) iii) Is a continuous quality improvement (CQI) improvement activity shall be undertaken annually 	<p>Systematic process for implementing a CQI process/plan: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>Program improvement, if applicable, is based on data deficiencies that have been analyzed: YES <input type="checkbox"/> NO <input type="checkbox"/></p> <p>CQI results shared with the Advisory Group annually: YES <input type="checkbox"/> NO <input type="checkbox"/></p>	<p>Program operation elements, e.g., wait times and program attrition are options for CQI projects. Data tracked and used for CQI purposes could also include other program quality indicators (data related to program operations/structure, process issues) such as wait time for educational services, reimbursement issues, number of referrals, etc.</p> <p>AADE suggests that the CQI plan be in place that is consistent with the organization's mission and strategic plans, and evaluates the DSMT education process and program outcomes. We also suggest that the components in the CQI plan should be in the CQI results. The CQI plan and reports should be shared with the advisory group.</p> <p>AADE electronic data collection tools could be used for CQI; other data collection tools are also applicable.</p>