

**A Sustainable Model of Diabetes Self-Management
Education/Training Involves a Multi-Level Team That Can Include
Community Health Workers**

American Association of Diabetes Educators
April 2010

The information provided in this paper is intended as guidance only and is not intended to be prescriptive. Please consider the specific needs of your program, your target audience, and the availability of healthcare professionals available in your community when creating a multi-level team.

Executive Summary

The evidence shows that diabetes education and self-management have a positive impact on the disease. Physicians and other health care professionals refer patients to diabetes educators for diabetes education that will augment the medical care they provide. DSME/T is cost-effective and improves health outcomes as patients maintain better control of their A1C levels, change their behavior, and adopt healthier lifestyles. Achieving optimal outcomes involves education that is predicated upon a construct that includes seven self-care behaviors, healthy eating, being active, monitoring, taking medication, problem solving, healthy coping and reducing risk (AADE7™).

An estimated 24 million people in the United States have diabetes. The ability of diabetes educators to meet demand is being severely tested as the number of people with diabetes reaches epidemic proportions. Historically, DSME/T services have been provided by diabetes educators who hold professional licenses (e.g., registered nurses, registered dietitians, and registered pharmacists). Diabetes educators can effectively reach more people with diabetes by expanding their education team to include community health workers (CHW) and medical assistants (e.g., Level 1 and Level 2 providers).

The Multi-Level Diabetes Education Team

With a multi-level education team, educators who are credentialed and/or have advanced skills (e.g., Level 4 or 5) can delegate some of the work to those educators who bring important competencies to the team (e.g., Level 1 or 2), but do not possess advanced clinical or DSME/T skills. Demonstration projects have shown that with a quality design structure, the outcomes of having a multi-level education team in place are: 1) increased access to excellent, focused care for people with diabetes; 2) positive net revenue to allow diabetes education programs to sustain best practices; and 3) support for educators to receive fair compensation based on their professional level.

Table 1. The Multi-Level Diabetes Education Team

<p>Level 1 <i>Non-clinical instruction</i></p>
<p>Level 2 <i>Non-clinical instruction appropriate to the individual's diabetes knowledge</i></p>
<p>Level 3 <i>Clinical instruction</i></p>
<p>Level 4 and Level 5 <i>Clinical instruction and supervisory role</i></p>

Rationale for the Multi-Level Team and Inclusion of CHWs

The ideal diabetes education team comprises more than one educator and offers a patient-focused approach to diabetes self-management. This concept is not new and is supported by the literature.

National health agencies have turned their attention to the inclusion of community health workers on the education team.

An emerging body of literature appears to support the unique role of community health workers in strengthening existing community networks for care, providing community members with social support and education, and facilitating access to care and communities with a stimulus for action. CDC's Division of Diabetes Translation (DDT) has considered the experience of projects using the talents of community health workers, and articulates the recommendations of the National Hispanic/Latino Diabetes Initiative for Action Report.

Standard 5 of the National Standards National standards for diabetes self-management education defines the Diabetes Education Team as follows, “diabetes self-management education 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 these needs are outside the instructors’ scope of practice and expertise.”

Incorporating Community Health Workers into the Team

Community health workers (Level 1 providers) are non-diabetes educators uniquely positioned to collaborate with diabetes educators and other providers to improve the quality of diabetes education, care, and prevention in communities. CHWs dedicated to diabetes prevention and care are likely to have completed specialized training. They can serve as bridges between their ethnic, cultural, or geographic communities and health care providers, and they engage their community to prevent diabetes and its complications through education, lifestyle change, self-management, and social support. CHWs also play a vital role in data gathering and data entry.

Continuing education for the team’s instructional staff is specified as being diabetes-specific, diabetes-related, and behavior change-focused, with an emphasis on self-management education strategies (e.g., the AADE7™). **CHWs have non-technical and non-clinical instructional responsibilities;** they receive ongoing informal training and formal training as appropriate. Mechanisms for meeting needs that are outside of the diabetes educator’s professional scope of practice include: 1) referral to other practitioners; and 2) partnering with a professional with additional expertise (e.g., exercise physiologist, behavioral specialist).

This white paper provides a context as well as tools for including the CHW into the DSME/T team. Readers will find sections on:

- Sample Concepts: How CHWs Can Work with Other Team Levels
- Real-World Examples of Incorporating Community Health Workers into the Team
- Taking Inventory Before Starting a Sustainable Team
- Developing and Implementing a Sustainable Team for Accreditation by AADE
- Sample Job Descriptions for the Community Health Worker
- Avenues for Recruiting the Community Health Worker
- Tips on Managing the Community Health Worker
- Payment Approaches for the Community Health Worker

Key Take-Away Messages

- Success (i.e., best patient care; DSME/T program sustainability) comes from involving an extended diabetes education team (e.g., multiple levels of providers). Higher level educators lead this effort.
- The DSME/T process involves assessment, goal setting, planning, implementation, evaluation, and follow-up. It is further defined by theoretical frameworks such as patient empowerment, health belief systems, and the chronic care model.
- Importantly, minority and vulnerable populations are more seriously affected by the diabetes/pre-diabetes epidemic and are often underserved. A multi-level team can best address the needs of these populations.
- Because the person with diabetes is responsible for 99% of his/her own care, he or she should be equipped with the knowledge and skills needed for effective diabetes self-management.
- The role played by each level of provider on the diabetes education team, currently defined by the AADE Guidelines for the Practice of Diabetes Education and Training (DSMT/E) and the accompanying Competencies for Diabetes Educators document, however the role may vary based on the program structure and type of practice, patient needs, background of each member of the diabetes education team, competencies, and reimbursement realities.
- Accredited and recognized programs may include multiple levels of diabetes educators. These programs meet the National Standards and have demonstrated quality.
- Level 4 and 5 educators will gain stature and respectability as they assume a full leadership role for the multi-level diabetes education team.
- Multiple members of the diabetes care team are important to the success of the patient's ability to self-manage and control his/her diabetes and related conditions.
- Communication across the diabetes education team and among other members of the overall care team is crucial to achieving optimal patient outcomes.

Summary

A team approach is essential to ensure that all patients with diabetes have access to diabetes self-management education, training, and support. DSME/T should focus primarily on supporting behaviors that promote effective self-management as described in the AADE7™ Self-Care Behaviors. DSME/T should follow a comprehensive 5-step process that includes: assessment, goal setting, planning, implementation, and evaluation. Diabetes education is highly effective and sustainable when it is delivered by individuals who are prepared, competent, and function within the practice level articulated in the Guidelines for the Practice of Diabetes Education and Training (DSME/T).

A Sustainable Model of Diabetes Self-Management Education/Training (DSME/T) Involves a Multi-Level Team That Can Include Community Health Workers

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Introduction

This white paper is designed to help diabetes educators understand how to adapt the traditional model of diabetes self-management education and training (DSME/T) to meet the ever-increasing needs of people with diabetes while also ensuring the future viability of their own program by expanding the educational team.

The evidence shows that diabetes education and self-management have a positive impact on the disease.¹ Physician practices in which patients with diabetes receive self management education have better quality indicators and care management than those that do not.² Physicians and other health care professionals refer patients to diabetes educators for diabetes education that will augment the medical care they provide. DSME/T is cost-effective and improves health outcomes as patients maintain better control of their A1C levels, change their behavior, and adopt healthier lifestyles. Achieving optimal outcomes involves education that is predicated upon a construct that includes seven self-care behaviors, healthy eating, being active, monitoring, taking medication, problem solving, healthy coping and reducing risk (AADE7™).³ Simply stated, education is an essential and important adjunct to medical care and management.

An estimated 24 million people in the United States have diabetes.⁴ Historically, DSME/T services have been provided by diabetes educators who hold professional licenses (e.g., registered nurses, registered dietitians, and registered pharmacists). The ability of diabetes educators to meet demand is being severely tested as the number of people with diabetes reaches epidemic proportions.⁴ Hence, many of these educators are finding they can effectively reach more people with diabetes by expanding their education team to include community health workers and medical assistants (e.g., Level 1 and Level 2 providers). (Table 1) When done with the appropriate planning, oversight, and vision, this approach leads to a sustainable model of DSME/T. The importance of sustainability is heightened due to the anticipated impact of HC reform.

The purpose of this document is to define and clarify the appropriate planning, oversight, and vision of this expanded team approach as a sustainable model of DSME/T.

Definitions

Following are definitions and explanations of two terms used throughout this document:

- **Community Health Workers (CHWs)**—Also known as community health advocates, lay health advisors, lay health educators, community health representatives, tribal diabetes educators, peer health promoters, community health outreach workers, and promotores de salud, CHWs are frontline public health workers who are trusted members of and/or have a deep understanding of the community served. This trusting relationship enables the CHW to serve as a link between health/social services and the community, facilitating access to services and helping to improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy. They also assist people with low literacy and numeracy. The Centers for Medicare & Medicaid Services (CMS) states that “the community health worker would be providing *Non-clinical instruction*. Such services include the provision of general information, behavioral support, non-technical informal counseling, and links with the health care system. The

community health worker would not be providing clinical information as part of an instructional team.”⁵

- **Sustainable model of DSME/T**—This term is defined as a model of DSME/T in which the best quality is embraced and the highest standards of evidence-based care are provided, while simultaneously attaining revenue that exceeds the expenses of the program. Reimbursement of DSME/T depends on the payer policies, most of which have been historically exceedingly slow to change. Diabetes educators must therefore adopt strategies that allow the limited amount of DSME/T reimbursement to meet patient and program needs. The American Association of Diabetes Educators (AADE) believes this can be achieved when a multi-level diabetes education team is in place.

The Multi-Level Diabetes Education Team*

Regardless of the level of educator, the referring provider (e.g., endocrinologist, internist, family medicine, general practitioner, nurse practitioner) is a key member of any diabetes care team. Optimal patient outcomes are likely to result from ongoing communication and collaboration across the diabetes care team that includes a multi-level diabetes education team.

With a multi-level education team (**Table 1**), educators who are credentialed and/or have advanced skills (e.g., Level 4 or 5) can delegate some of the work to those educators who bring important competencies to the team (e.g., Level 1 or 2), but do not possess advanced clinical or DSME/T skills. Demonstration projects have shown that with a quality design structure, the outcomes of having a multi-level education team in place are: 1) increased access to excellent, focused care for people with diabetes; 2) positive net revenue to allow diabetes education programs to sustain best practices; and 3) support for educators to receive fair compensation based on their professional level.

Table 1. The Multi-Level Diabetes Education Team

<p>Diabetes Education Team</p> <p>Level 1 <i>Non-clinical instruction</i></p> <p>Level 2 <i>Non-clinical instruction appropriate to the individual's diabetes knowledge</i></p> <p>Level 3 <i>Clinical instruction</i></p> <p>Level 4 and Level 5 <i>Clinical instruction and supervisory role</i></p>

* Please note that this document is intended as a generic document. AADE recognizes that precise roles vary from state to state, specialty to specialty, and practice setting to practice setting.

Rationale for the Multi-Level Team and Inclusion of CHWs

The ideal diabetes education team comprises more than one educator and offers a patient-focused approach to diabetes self-management. This concept is not new. Kortas and Quinn stated:

"... because many of the complications of diabetes may be prevented or lessened by strict glycemic control, it is of the utmost importance that the individual with diabetes understand the roles of diet, exercise, and insulin/oral hypoglycemics in the management of his or her diabetes. This is an area in which diabetic education plays an important role. The properly educated individual with diabetes can learn to increase or decrease insulin, to change diet, or to modify exercise regimens based on results of home blood glucose-monitoring to achieve normoglycemia ... includes a multidisciplinary team approach to educating the diabetic patient ... involves using the skills of physicians, pharmacists, nurses, dieticians, and other health care professionals, as well as teaching tools such as diabetes patient assessment forms, diabetes education, and teaching documentation records."⁶

More recently, national health agencies have turned their attention to the inclusion of community health workers on the education team. As stated on the Centers of Disease Control and Prevention (CDC) Web site:

"Many health programs are turning to community health workers (CHWs) and promotores de salud for their unique ability to serve as "bridges" between community members and health care services. Recognition of the roles, skills, and contributions of CHWs; support for programs, including stable funding, technical assistance, and evaluation; and continuing education are needed to respectfully and effectively integrate these workers into the health care delivery system."⁷

An emerging body of literature appears to support the unique role of these community workers and advocates in strengthening existing community networks for care, providing community members with social support and education, and facilitating access to care and communities with a stimulus for action.⁸⁻¹⁵ CDC's Division of Diabetes Translation (DDT) has considered the experience of projects using the talents of community health workers and the history of this interest, beginning in 1995, with recommendations of the National Hispanic/Latino Diabetes Initiative for Action Report.^{7,16}

National Standards: Defining the Diabetes Education Team

The three diabetes education accrediting bodies recognized by the CMS—AADE, the American Diabetes Association (ADA), and the Indian Health Service (IHS)—have adopted the National Standards for Self-Management Education (referred to as National Standards).¹⁷

Standard 5 states that diabetes self-management education 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 these needs are outside the instructors' scope of practice and expertise.

[†] The underlying assumption is that a physician is always involved and refers people with diabetes for DSME/T.

For diabetes education programs accredited through AADE's Diabetes Education Accreditation Program (DEAP), AADE interprets Standard 5 as follows:

- A. Resumes and proof of licenses, registration and/or certification shall be maintained to verify that program staff is composed of instructor(s) who have obtained and maintained the required credentials.
- B. If community health workers are part of the DSME/T program team, there shall be documentation of successful completion of a standardized training program for CHWs and additional and ongoing training related to diabetes self-management.
 - a. Training includes scope of practice relative to one's role in DSME/T. If CHWs are part of the DSME/T program's team, there shall be documentation that they are directly supervised by the named diabetes educator(s) in the program.
- C. Proof of continuing education will be maintained to provide evidence that each instructor maintains his/her qualifications according to the specific criteria below and consistent with his/her job description:
 - a. 15 hours of continuing education annually for all instructors.
 - b. These hours must be attained from a nationally recognized accrediting body.
- D. For programs, particularly those that have solo instructors, there shall be a policy that identifies a mechanism for ensuring that participant needs are met if needs are outside the instructor's scope of practice and expertise.
- E. There shall be documentation that describes a process for ensuring that appropriate care coordination among the diabetes care team occurs and of team coordination/interaction.

Overview and Requirements of the Team's Five Levels

DSME/T is posited to be most effective when delivered by a multidisciplinary team comprising members with varying types and levels of expertise who work together to develop and implement a comprehensive plan of care.¹⁸ The "team approach" concept is realized through collaboration and linkages with other health care providers of various disciplines outside of the program, particularly when a participant's needs cannot be met by the program staff.¹⁸ In addition to involving practitioners in diabetes management, diabetes education, and clinical care, the sustainable team may include community health workers.

Community health workers (Level 1 providers) are non-diabetes educators who are non-health care professionals uniquely positioned to collaborate with diabetes educators and other providers to improve the quality of diabetes education, care, and prevention in communities. CHWs dedicated to diabetes prevention and care are likely to have completed specialized training. They can serve as bridges between their ethnic, cultural, or geographic communities and health care providers, and they engage their community to prevent diabetes and its complications through education, lifestyle change, self-management, and social support. CHWs also play a vital role in data gathering and data entry.

The main distinction between Level 1 and Level 2 providers lies in the amount and type of required professional education. Level 2 encompasses health care professionals who are non-diabetes educators but by virtue of their experience in the system bring additional insights. This level includes professional health care providers who have little expertise in diabetes education or management, but provide or support health care services to individuals with diabetes. Level 2 includes but is not limited to: medical assistants (MAs), licensed practical nurses (LPNs), registered nurses (RNs), nutritionists (RDs), dietetic technicians registered (DTRs), registered pharmacists (RPhs), and others. As with Level 1 providers, the key focus of Level 2 providers entails practical problem solving, advocacy, and assistance with obtaining

access to care, services, medications, and so forth. MAs work primarily in physician offices or primary care clinics. Performance of activities at this level assumes that the individual is a health care professional working under the direction of a qualified diabetes health care professional and has the training and expertise in areas relative to the medical and direct/support services.

Level 3 includes individuals who meet the AADE definition of “diabetes educator” but are not credentialed as a certified diabetes educator (CDE) or board certified in advanced diabetes management (BC-ADM). Diabetes educators are health care professionals who have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education and who have experience in the care of people with diabetes. Level 3 includes but is not limited to: registered nurses (RNs), registered dietitians (RDs), registered pharmacists/PharmDs, licensed mental health professionals, and exercise physiologists. Regardless of discipline, the diabetes educator must be prepared to assist persons with diabetes in attaining the knowledge and skills to effectively manage their diabetes.

Diabetes educators must possess a body of knowledge that spans across disciplines to provide comprehensive DSME/T. For example, RDs who are also diabetes educators may provide instruction for insulin injection, insulin dosing, and medication adverse effects, in addition to nutrition counseling. Moreover, RDs can also provide medical nutrition therapy (MNT) as a separate service; use of both DSME/T and MNT may be more efficacious for some patients than for those who receive just one of these interventions. Other examples of practitioners who apply cross-discipline knowledge include exercise physiologists, who while functioning in the diabetes educator role may help patients develop a plan for healthy coping as well as an exercise plan, and pharmacists, who may provide counseling and instruction about foot care in addition to instruction on proper use of medications.

Level 4 consists of certified diabetes educators (CDEs). In addition to fulfilling the requirements of a diabetes educator, CDEs meet the academic, professional, and experiential requirements set forth by the National Certification Board for Diabetes Educators (NCBDE).

Level 5 diabetes education practice is characterized by autonomous assessment, problem identification, planning, implementation, and evaluation of diabetes care. Practitioners with the BC-ADM credential and other providers at this level incorporate skills and strategies of DSME/T into more comprehensive clinical management of people with diabetes. Level 5 providers function either with protocols or have prescriptive authority.

Diabetes education programs may also include other professionals as strategic business partners, such as a clinical psychologist, podiatrist, physician, optometrist, nurse practitioner, physician assistant, clinical nurse specialist, or pharmacist. Ongoing communication with the referring physician, which is essential for optimal outcomes, is typically conducted by Level 3 through 5 educators, but there are occasions when the Level 1 or 2 providers may appropriately inform other members of the multidisciplinary team about areas of concern.

A more detailed description of the five levels of providers on the diabetes education team appears in Appendix A. A full discussion can be found in the 2009 AADE Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T), which define these levels and describe some of their roles and responsibilities.¹⁹ The levels are differentiated by educational preparation, credentialing, professional practice regulations, and the clinical practice environment.

Competencies of the Sustainable Team Members

In this document, “competency” refers to the ability, skill, and/or knowledge to undertake the role for the level to which the provider is best suited. Diabetes education-related competencies reflect the knowledge and skill needed by providers at various levels across the continuum of care. Both academic and practical knowledge is essential to developing a competency—work experience helps health care workers of all levels gain competency.

The following domains provide an initial framework for non-clinicians and clinicians to understand the skill set they should possess and what would be needed to move upward in the field of diabetes education and management:²⁰

- **Domain 1: Pathophysiology, Epidemiology, and Clinical Guidelines of Diabetes** - Addresses the competencies needed for individuals to demonstrate familiarity with pathophysiology, epidemiology, and clinical guidelines consistent with diabetes care provider level.
- **Domain 2: Culturally-Competent Supportive Care Across the Lifespan** - Addresses the competencies needed to provide diabetes support and care in a culturally-competent manner across the lifespan.
- **Domain 3: Teaching and Learning** - Addresses the competencies needed to apply principles of teaching and learning and/or behavior change to facilitate self-management skills of individuals with diabetes.
- **Domain 4: Self-Management Education** - Addresses the competencies needed to work with an interdisciplinary diabetes care team to tailor interventions to individual patient self-management education needs.
- **Domain 5: Program and Business Management** - Addresses the competencies needed to apply principles of program and/or business management to create a climate that supports successful self-management of diabetes.

Sample Concepts: How CHWs Can Work with Other Team Levels

The four hypothetical sample concepts or scenarios presented here reflect concepts on how Level 1 providers can work with Level 3 through 5 providers. These samples serve as illustrations only; the authors recognize that in the real world, situations vary and many other scenarios are plausible. In all of the following scenarios, oversight by a Level 4 or 5 educator, communication back to the referring physician about the patient’s self-management progress and clinical changes is essential to the care and well-being of the patient’s on-going self-management support.

- **Shared Teaching Concept** – CHWs and Level 3 through 5 diabetes educators work together in the same room. This enables them to see many more patients at any one time, because the CHW assists in what the Level 3, 4, or 5 educator does, essentially serving as an “education extender.”

For example, the diabetes educator provides the educational instruction (e.g., how to use a meter to test blood glucose) and content. The CHW moves from table to table to reinforce what was taught and help correct misinterpretations. He/she calls upon the educator to correct

misconceptions or patient confusion. The CHW also helps patients locate affordable local resources for glucose test strips.

- **Top Down Concept** -- The Level 4 or 5 diabetes educator serves as the supervisor. The Level 3 through 5 diabetes educator provides all the clinical teaching, and the CHW provides all the non-clinical instruction. The higher level educator has the overall responsibility for the self-management education of the patient. The Level 3, 4, or 5 educator and CHW work in the same room; it may be desirable, but it is not necessary, to do so at the same time. For example, the “supervisor” could read the patient’s chart while the CHW provides training on community resources available to support people with diabetes.

In this scenario, the CHW would translate, help patients find sources of affordable pharmaceuticals, identify safe walking paths in the community, and help patients by reminding them what they were taught by the educator and providing them opportunities to restate and practice what they have been taught. CHWs can also assist people with low-literacy who attend the classes by reading materials to them.

- **Multiple Classes at One Time Concept** – The Level 3 through 5 diabetes educator floats between classrooms, supervising up to three non-clinical classes led by CHWs during the same timeframe in the same building. The educator serves as the overall supervisor; the CHW is involved in non-clinical classes.

For example, while the diabetes educator splits his/her supervisory time across the classrooms, the CHWs may be teaching culturally relevant healthy eating to three different ethnic groups. Another example: One CHW is leading an exercise class for older adults, while another is teaching about how to locate community resources for pharmaceutical products and support, and the third CHW is demonstrating how to complete a food log.

- **Supportive Role Only Concept** – The Level 3 through 5 diabetes educator provides all the education (i.e., all the clinical and non-clinical instruction). The CHW primarily provides translation and support, assisting the higher level educator upon request.

For example, the diabetes educator asks the CHW to demonstrate a fast or slow walk in the lesson on being active. As a bridge to community resources for low-income individuals, the CHW shows them lists of community services and where to apply for financial support.

Real-World Examples of Incorporating CHWs into the Team

The preceding section presented sample concepts within the context of the organizational flow of a diabetes education program. As with these scenarios, the following examples offer ways to think about incorporating CHWs into the team—one difference, however, is that these examples come from real-world situations. They focus on specific activities in DSME/T that involve CHWs and relate to behavior change. These three examples were submitted to AADE by practicing diabetes educators and illustrate the differences and idiosyncrasies that exist in the provision of DSME/T.

Example 1: Teaching the Being Active Behavior

The Level 3 educator teaches the patients that physical activity is necessary for diabetes self-care because it can help keep blood glucose levels close to normal. Because everyone's physical abilities are different, each patient will need guidance from his/her physician or other providers. The diabetes educator helps patients identify the best ways to fit physical activity into daily life and medication schedules.

The CHW suggests culturally relevant exercise and helps patients find locations for exercise facilities near their home/work. The CHW also provides maps of hiking and bike paths in the community. In addition, the CHW helps with data collection and data entry.

Example 2: Teaching the Problem-Solving Behavior

The Level 4 diabetes educator (CDE) teaches patients to understand how diabetes affects the body, and then helps them identify problems and learn how to solve them. The CHW is not involved in the actual teaching, serving best as a bridge to the culture and community. For example, the Level 4 educator may say the following when teaching patients:

Every person is unique. It's important that you recognize the early warning signs and symptoms that occur when your blood glucose begins to drop too low. Two people may have the same low blood glucose level, but experience very different symptoms. You may find that your hypoglycemic symptoms vary from episode to episode. Your symptoms may begin at different glucose levels on different occasions. Some common signs and symptoms of hypoglycemia can include shaking/trembling, nervous feeling, sweaty, and clammy skin. As soon as you suspect hypoglycemia, check your blood glucose level. Do not delay! If your blood glucose is below target, promptly eat or drink 15 grams of fast-acting carbohydrate. Wait 15 minutes, and then re-check your glucose."

The CHW reinforces this education by translating the information into culturally appropriate messages that are of the appropriate literacy and numeracy levels for the person with diabetes and the family. The CHW supports the class participants by providing linkages to community resources so that the individual with diabetes understands ahead of time where to turn for help when he/she has low blood glucose. The CHW also suggests culturally appropriate problem solving. The CHW also enters data for the program, such as data entry into the AADE7 system.

Example 3: Endocrine Clinic with a Multi-Level Team

The endocrine clinic in this example uses a variety of individuals (Levels 2-5) to educate patients about self-managing diabetes and achieving their monitoring behavior goals. Although a CHW is not part of the team, this illustrates the roles that Level 2 educators can play as part of the team in a specialty practice.

A CHW could be added to further expand the team by serving as a linkage to community resources. The general roles of the multi-level team are presented in **Table 2**.

Table 2. Example: Multi-Level Roles in an Endocrine Clinic

Staff	Role
MA/Lab tech (Level 2)	Download meters; treat hypoglycemia; perform lab tests
LPN (Level 2)	Obtain height/weight measurements; conduct meter training
RN (Level 3)	Conduct assessments; provide 1:1 education
CDE or BC-ADM (Level 4 or 5)	Undertake insulin adjustments per protocol-delegation; teach diabetes self-management class on monitoring and problem solving
ARNP (Level 3)	Prescribe medication (according to protocols); order laboratory tests; make referrals; coordinate diabetes education/clinic/research

NOTE: It is assumed that a physician is involved in overall care of the patient.

MA = medical assistant; LPN = licensed practical nurse; RN = registered nurse; CDE = certified diabetes educator; BC-ADM = board certified advanced diabetes management; ARNP = advanced registered nurse practitioner

Example 4: Indian Health Service Team

After the clinician and/or Level 3 – 5 diabetes educator teaches people from American Indian communities in the clinic setting, CHWs commonly get involved to:

- reinforce proper preventive food care in the home
- review many of the self-care steps that have been taught by the Level 3 - 5 educator
- observe the patient’s technique
- run through a return demonstration in the comfort of the person’s home

Taking Inventory before Starting a Sustainable Team

The first step in developing and implementing a sustainable diabetes education team is to assess various factors—skills, resources, and needs—that will impact such a team and the delivery of DSME/T. This step requires addressing the following questions:

- How can you best help your patients?
- What are the specific needs (cultural, language, age-related) of the population you serve?
- At what level are you?
- At what levels are other members of your current team?
- When you refer your patients to other providers, what level of expertise is needed?
- How does your team match up with the 2009 AADE Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T)?

Developing and Implementing a Sustainable Team for Accreditation by AADE

Diabetes educators of all levels should have an understanding of the AADE7™ Self-Care Behavior framework. The AADE7™ provides an evidence-based schema for assessment, intervention, and outcome evaluation of the diabetes patient, program, and population. In addition, the interventions provided by diabetes educators can be organized according to the framework.

According to the AADE Diabetes Education Accreditation Program (DEAP), diabetes education provided by the team focuses on the seven self-care behaviors that are essential for improved health status and greater quality of life.²¹ As noted above, the AADE7™ are healthy eating, being active, monitoring, taking medication, problem solving, healthy coping, and reducing risks. When blended with education and behavior change theory, the AADE7™ provides standardized nomenclature for assessment, problem solving, barrier identification and resolution, goal setting, documentation, measurement, evaluation, and quality improvement.

Continuing education for the team's instructional staff is specified as being diabetes-specific, diabetes-related, and behavior change-focused, with an emphasis on self-management education strategies (e.g., the AADE7™). **CHWs have non-technical and non-clinical instructional responsibilities;** they receive ongoing informal training and formal training as appropriate. Mechanisms for meeting needs that are outside of the diabetes educator's professional scope of practice include: 1) referral to other practitioners; and 2) partnering with a professional with additional expertise (e.g., exercise physiologist, behavioral specialist).

High-quality care is more likely when the multidisciplinary team has access to all patient-related data and communicates well, either through written or verbal exchanges or face to face meetings that are well 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.

Sample Job Descriptions for the Community Health Worker

Following are two examples of job descriptions for a community health worker who is part of the sustainable diabetes education team:

Example 1: Community Health Worker Job Description

Reports to:

DSME/T Program Coordinator

Position Overview:

Coordinates and manages community outreach activities to provide diabetes and prediabetes education through established community forums.

Duties and Responsibilities:

- Develops educational goals for each community education initiative
- Provides non-clinical education instruction at community sites that uses interactive training methods
- Participates in the selection and/or development of educational materials
- Participates in the continuous quality improvement (CQI) process
- Participates in marketing activities

- Identifies areas of strength and areas for improvement and helps to develop a plan for growth

Experience/Education:

A basic, non-clinical degree or certification in a health science field, with emphasis on nutrition

Experience in Community Outreach and Education Activities:

Attended a comprehensive DSME/T course

Example 2: Community Health Worker Job Description

Position Overview:

Community Health Worker is bilingual (English/Spanish); Community Health Worker is responsible for supporting community diabetes education and follow-up.

Duties:

- Works with the diabetes educator to conduct diabetes management and prevention classes
- Supports the diabetes educator in presenting the risk factors of diabetes throughout the community
- Understands effective time and task management
- Is sensitive to client needs
- Displays professionalism at all times
- Stays updated on diabetes information
- Coordinates and oversees support groups
- With supervision of the diabetes educator, communicates and provides reinforcement and culturally appropriate information to individual clients and group about diabetes management, detection, and prevention
- Reviews the accuracy and confidentiality of client records and results
- Supports the diabetes educator's efforts to administer, collect, and enter data on diabetes programs (e.g., attendance in group activities) into data collection systems
- Supports the diabetes educator's efforts to administer, collect, and report on diabetes programs and activities
- Maintains sign-in records
- Collects data required for tracking purposes
- Organizes support activities such as cooking classes, community diabetes expo, camps, and any other relevant activities with guidance from the diabetes educator
- Acts as a diabetes advocate in the community
- Participates in relevant meetings and collaborations
- Recruits clients for programs
- Follows up on progress of clients
- Promotes programs and services
- When appropriate, speaks to the community and local media about ways to combat and control diabetes, doing so in culturally relevant terms
- Performs other duties as assigned

Avenues for Recruiting the Community Health Worker

In large health centers, CHWs can be recruited from existing health promoters and can be cross-trained for diabetes education. CHWs may also be recruited from diabetes education classes (for peers and

caregivers) or from local community groups that are related to health and wellness. Another avenue for recruitment may be specific programs that train CHWs, including the Diabetes Empowerment Education Program (DEEP) and the Stanford Model. In addition, CHWs may be recruited from those who enroll in AADE's "Fundamentals of Diabetes Care" course.

Tips on Managing the Community Health Worker

The University of Illinois at Chicago (UIC) Midwest Latino Health Research Training and Policy Center states that the role of the supervisor is to:²²

- Mentor
- Serve as an advisor
- Provide trust and support
- Share his/her experiences and knowledge
- Provide encouragement for continuous improvement

Supervisory functions that could be performed by the Level 3 through 5 educator include:

- Ensuring quality control (safe, ethical practice of DSME/T that is in line with the National Standards, AADE position statements, and other official documents)
- Facilitating supervisees in maintaining their competencies and capabilities
- Helping supervisees work effectively, which includes: 1) promoting quality control and preserving client safety; 2) accepting responsibility and primarily working independently, with appropriate supervision; 3) developing own professional identity; 4) enhancing self-awareness and resilience (e.g., effective personal coping with the job); and 5) practicing critical reflection and maintaining lifelong learning skills)

When delegating activities from the care plan, the Level 3 through 5 diabetes educator has the following responsibilities:

- Maintaining a high standard of care
- Teaching and assessing competence through: 1) clinically-focused supervision; 2) evaluation of patient outcomes; and continuous quality improvement (CQI), which involves reflection on and improvement of practice using facts to drive changes

When teaching a task to a CHW, the RN, RD, RPh/PharmD, or other health care professional can achieve success by breaking down the activity into components and then assessing which components can be taught to and safely undertaken by the CHW or medical assistant.²³ Making this determination is important, because what appears simple to a higher level practitioner may involve many different elements, such as the integration of information regarding the patient's self-management of his/her condition and its impact on the patient's life. Consequently, some aspects of the care must not be delegated, but instead retained by the Level 3, 4, or 5 educator. Activities that are delegated to the Level 1 or 2 provider can be explained in the education plan.

Accountability cannot be delegated; rather, it is shared among the health care professionals, CHWs, and employers. The Level 3 through 5 educator who delegates a task from an education process or care plan to an unlicensed CHW is accountable for the delegation decision, the process of delegation, and that assurance that standards are maintained by monitoring the outcomes of the delegation. Hence, the Level 3 through 5 educator must be familiar with the CHW's capabilities and must clearly communicate the task being delegated and provide the appropriate level of supervision. Those supervised are

accountable for their actions and should only undertake tasks that have been properly delegated to them and that they are legally authorized and competent to perform. As an example, the Level 3 through 5 educator who involves an MA in the team should be familiar with the scope of practice for MA's, to avoid confusion as to what can be delegated. Employers are accountable for providing sufficient resources to enable safe and competent care.²³

Potential Payment Process for the Sustainable Team

Medicare as well as commercial payers typically reimburse the diabetes education program based on the G-codes. Diabetes educators who work independently should establish their fees based on their business plan.²⁴

Reimbursement is available for the sustainable model when DSME/T programs are accredited by AADE or recognized by the American Diabetes Association or Indian Health Service. A flow chart of the payment process is shown in **Table 3**.

Table 3. Payment Process for Accredited/Recognized DSME/T Programs

Physician or qualified non-physician practitioner refers patient to accredited or recognized DSME/T program

- Patient goes to accredited or recognized DSME/T program
- Program submits claims to payer (using NPI #)
- \$\$\$ is paid to NPI #/Program by CMS or other third party payer (G-Codes)
- \$\$\$ is distributed among the program, coordinator, instructors, and CHWs

Flow of Funds Example

Here is an example of how payment is made for DSME/T:

A community-based program serves both insured and uninsured patients. The instructional team is led by a registered dietitian who is a certified diabetes educator (RD, CDE) and is supported by one medical assistant who is a trained certified nursing assistant (CNA). The flow of funds is as follows:

20 patients attend DSME/T classes

- DSME/T program bills CMS/third-party payers using G-codes for 15 of these patients (the other 5 patients are self-pay (charity care may be available in some instances)[‡]
- CMS/other payer pays DSME/T program for classes for the 15 patients who have insurance
- 30% of the revenue goes to the DSME/T program to cover overhead; 55% goes to support the salary of the Level 4 educator (RD, CDE) for her/his role as coordinator/instructor and supervisor; 15 % of the revenue goes to support the salary of the Level 2 educator (CNA).

[‡] This is provided for illustration only. Because reimbursement is unique to each situation, professional guidance regarding billing and reimbursement issues should be sought

In this example, for illustration and simplicity, \$10 represents Medicare reimbursement for the G-codes. Please note this is NOT the actual amount, which varies from region to region and is considerably greater than \$10 for one hour of DSMT.

Let's assume: Medicare pays \$10 per patient in a group class; 15 patients X \$10 = \$150. The program retains \$45 (30%); \$82.50 (55%) supports the salary of the Level 4 educator and \$22.50 (15%) supports the salary of the Level 2 educator.

This example discusses the payment model for one class and tracks reimbursement. It does not however, discuss costs so an assumption cannot be made that this is a sustainable program. To account for costs in the example, the following could be considered.

1. what is the proposed average salary (and benefits) of RD
2. what is the proposed average salary (and benefits) of CHW
3. what is the facility charge
4. does the program reimbursement cover any of the cost of the RD as manager of the program
5. how many paying participants and group classes are needed to cover fixed costs
6. how many participants are in class if there is only one instructor, the RD (assume there are less if only one instructor) vs. how many can be seen if there is a CHW and RD (assume there are more, e.g., 20)

Seeking DSME/T Program Accreditation and Reimbursement

As previously noted, diabetes education programs that meet the requirements of AADE's Diabetes Education Accreditation Program (DEAP), the American Diabetes Association (ADA) Education Recognition Program (ERP), or the Indian Health Services ERP are eligible for Medicare reimbursement.²¹

Accreditation through AADE's DEAP serves to inform patients, prospective patients, and payers that the diabetes education practice offers high quality, comprehensive diabetes education and care. AADE's accreditation materials and tools provide guidance for meeting practice standards, such as Healthcare Effectiveness Data and Information System (HEDIS) quality measures. The DEAP Web site also offers tools that can improve patient outcomes and meet the needs of the growing diabetes population as well as assist practitioners with their performance improvement efforts.

AADE accreditation is flexible, as it enables programs to easily accredit multiple sites with one application and an all-inclusive fee. For example, if several physician offices decide to share the services of one diabetes education team, each office has the opportunity to be accredited as a diabetes education provider with a single application.

AADE-accredited programs have access to[§]:

- **An AADE diabetes self-management education curriculum that facilitates behavior change leading to improved clinical outcomes.** Diabetes education programs may purchase a written curriculum specifically tailored to their practice setting. The curriculum is based on the AADE7™ Self-Care Behaviors framework and current evidence and practice guidelines. It promotes behavior change strategies as critical to patients' success with diabetes, and it supplies criteria for evaluating patient outcomes.

§ These tools are available to all from AADE; fees may apply.

- **Tracking tools for patients' self-management goals.** The AADE7™ System tools can potentially interface with existing disease management software and electronic health record systems or can be used independently.

For more information and to view the DEAP accreditation application, visit <http://www.diabeteseducator.org/ProfessionalResources/accred/>.

AADE's Position on the Community Health Worker in DSME/T

The AADE position statement on CHWs in diabetes management and prevention articulates support of the following:⁵

- The roles of CHWs as bridges between health care systems, communities, and people diagnosed with or at risk for diabetes
- The roles of CHWs in primary prevention (e.g., lifestyle changes) and secondary prevention (e.g., smoking cessation and self-management skills)
- Opportunities for core diabetes skills and competencies training and continuing education for CHWs
- Reciprocal exchange of information and support between CHWs and the health care team to facilitate the best outcomes for people with and at risk for diabetes
- Continued research that evaluates the roles, contributions, and effectiveness of CHWs in diabetes care, prevention, diabetes education, and community engagement
- Diabetes educators and other health care professionals becoming familiar with publications addressing practical applications and research findings regarding contributions of CHWs
- Participation of CHWs in AADE and participation of diabetes educators in CHW organizations, as well as collaboration between AADE and CHW organizations

Key Take-Away Messages

- Success (i.e., best patient care; DSME/T program sustainability) comes from involving an extended diabetes education team (e.g., multiple levels of providers). Higher level educators lead this effort.
- The DSME/T process involves assessment, goal setting, planning, implementation, evaluation, and follow-up. It is further defined by theoretical frameworks such as patient empowerment, health belief systems, and the chronic care model.
- Importantly, minority and vulnerable populations are more seriously affected by the diabetes/prediabetes epidemic and are often underserved. A multi-level team can best address the needs of these populations.
- Because the person with diabetes is responsible for a large part of his/her own care, he or she should be equipped with the knowledge and skills needed for effective diabetes self-management.
- The role played by each level of provider on the diabetes education team, currently defined by the AADE Guidelines for the Practice of Diabetes Education and Training (DSMT/E) and the accompanying Competencies for Diabetes Educators document, however the role may vary based on the program structure and type of practice, patient needs, background of each member of the diabetes education team, competencies, and reimbursement realities.
- Accredited and recognized programs may include multiple levels of diabetes educators. These programs meet the National Standards and have demonstrated quality.

- Level 4 and 5 educators will gain stature and respectability as they assume a full leadership role for the multi-level diabetes education team.
- Multiple members of the diabetes care team are important to the success of the patient's ability to self-manage and control his/her diabetes and related conditions.
- Communication across the diabetes education team and among other members of the overall care team is crucial to achieving optimal patient outcomes.

Closing Remarks

A team approach is essential to ensure that all patients with diabetes have access to diabetes self-management education, training, and support. DSME/T should focus primarily on supporting behaviors that promote effective self-management as described in the AADE7™ Self-Care Behaviors. DSME/T should follow a comprehensive 5-step process that includes: assessment, goal setting, planning, implementation, and evaluation. Diabetes education is highly effective and sustainable when it is delivered by individuals who are prepared, competent, and function within the practice level articulated in the Guidelines for the Practice of Diabetes Education and Training (DSME/T).

Acknowledgements

AADE expresses thanks to the following members of the writing team: Kristina Ernst, BSN, RN, CDE; Linda Haas, PHC, RN, CDE; Tamara Hammons, PharmD, RPh, CD; Patricia Lierman, PharmD, RPh, CDE; Nadine Uplinger, MS, RD, CDE, BC-ADM; Donna Rice, MBA, BSN, RN, CDE, FADE. Dawn Sherr, RD, CDE; Vicki Weiss, RN, BSN, MSN; Leslie Kolb, BSN, RN, MBA; Karen Fitzner, PhD; and Audrey Porritt.

Appendix A: A Closer Look at the Roles for the Five Levels of Diabetes Educators

The following description of the five levels of providers on the diabetes education team is extracted from the 2009 AADE Guidelines for the Practice of Diabetes Self-Management Education and Training (DSME/T), which define these levels and describe some of their roles and responsibilities.¹⁹ The levels are differentiated by educational preparation, credentialing, professional practice regulations, and the clinical practice environment.

Level 1: Non-Health Care Professional

Level 1 comprises non-professional health care providers who have little expertise in diabetes education and/or management, but provide and/or support health care services to individuals with diabetes. This level includes but is not limited to: health promoters, health educators, and community health workers.

The key focus of Level 1 team members, particularly CHWs, entails practical problem solving, advocacy, and assistance with obtaining access to care, services, medications, etc. Performance of activities at this level should be under the direction of a qualified diabetes health care professional who has training and expertise in areas relative to the direct/support services specified below. Level 1 providers can be expected to perform the following:

- *Assessment:* Measure basic vital signs, measure height and weight, assess literacy, and follow protocols for patient intake. Assessment may include family and social support systems. Provide support, general information, and guidance regarding accessing care, available diabetes education offerings, and financial assistance.
- *Goal Setting:* May help patients by providing basic information and assisting in setting basic goals for healthy eating and physical activity.
- *Planning:* Follow the prescriber's orders and diabetes educator's guidance for planning.
- *Implementation:* Refer/support diabetes management skill training, and offer guidance on accessing care and financial resources.

Level 1 DSME/T providers may lead support groups or organize a community physical activity (e.g., walking group). They may also refer to the prescriber or diabetes educator as needed. Level 1 educators also monitor progress toward the plan and report findings to the prescriber and diabetes educator.

Level 2: Health Care Professional Non-Diabetes Educator

The Level 2 health care professional non-diabetes educator can be expected to perform the following tasks with perhaps greater insight into the overall health status of the patient than can be expected of the Level 1 provider:

- *Assessment:* Measure vital signs and anthropometrics, assess literacy, and follow protocols for patient intake. Assessment may include family and social support systems. Provide support and general information and guidance regarding accessing care (e.g., available diabetes education offerings) and financial assistance.
- *Goal Setting:* Assist patients by providing basic information, assisting in setting basic goals for healthy eating and physical activity, and identifying community resources.
- *Planning:* Follow the prescriber's orders and diabetes educator's guidance for planning.
- *Implementation:* Refer/support/assist diabetes management skill training. For example, Level 2 providers might offer guidance on accessing care, identify financial resources, and provide culturally appropriate basic health information. May lead support groups or organize a

community physical activity (e.g., walking group). May refer to the prescriber or diabetes educator as needed.

- *Monitoring/Evaluation:* Monitor progress toward the plan and report findings to the prescriber and diabetes educator.

Level 3: Non-Credentialed Diabetes Educator^{*}**

Both credentialed and non-credentialed diabetes educators are chiefly concerned with and actively engaged in the process of DSME/T, as follows:

- *Assessment:* Conduct a thorough, individualized self-management assessment of the person with or at risk for diabetes.
- *Goal Setting:* Guide the patient in setting and prioritizing individualized behavioral goals based on assessment and preference. This process also includes developing success metrics for the specific behavior(s) to be addressed.
- *Planning:* Collaboratively develop basic plans for persons with diabetes to acquire necessary diabetes self-management skills based on the needs identified in the assessment.
- *Implementation:* Provide diabetes self-care skill training. Offer guidance on accessing care and financial issues (reimbursement) and refer to prescriber or CDE or BC-ADM as needed.
- *Monitoring/Evaluation:* Re-assess understanding of and progress toward the patient's goals and plan, and refer to the prescriber or CDE as needed.

Level 4: Credentialed Diabetes Educator

Level 4 providers can be expected to perform the following:

- *Assessment:* Use the assessment performed by Level 1, 2, or 3 providers. Perform assessments of physical health, medications, and psychosocial issues and identify areas for education and clinical interventions.
- *Goal Setting:* Guide the patient in setting individualized behavioral and clinical goals to address the needs identified in all areas of the assessment, develop success metrics, and use behavior change methodology to facilitate patient participation in the education process.
- *Planning:* Develop an education plan to address behavioral goals established during the goal setting process, develop a learning plan to address gaps in knowledge, collaborate with patients to plan strategies for addressing barriers identified, and refer to the prescriber as needed.
- *Implementation:* Recommend and execute plans, ensuring that the patient has the knowledge, skills, and resources necessary to follow through on the plan. Identify and address barriers that become evident throughout the process.
- *Monitoring/Evaluation:* At each visit, monitor progress of the plan and re-assess the patient's understanding of goals and plan, knowledge and skills, and clinical and behavioral goal achievement. Revise, in collaboration with the patient, the plan and goals as needed. Refer to the prescriber as needed.

Level 5: Advanced Level Diabetes Educator/Clinical Manager

These individuals possess the skills needed to perform complete and/or focused assessments, recognize and prioritize complex data, and provide therapeutic problem solving, counseling, and regimen adjustments for persons with diabetes. Level 5 roles and responsibilities include:

^{***} The term "non-credentialed diabetes educators" refers to health care professionals who are not certified diabetes educators or have not earned the BC-ADM credential. Some "non-credentialed diabetes educators" possess professional licenses and credentials. Practitioners at other levels may also use protocols, depending on their professional scope of work.

- *Assessment:* Use the assessment performed by Level 1, 2, 3, and 4 providers. Perform more complex assessments of physical health, medications, and psychosocial issues and make a diagnosis for education and clinical interventions.
- *Goal Setting:* Guide patients in setting individualized behavioral and clinical goals to address the needs identified in all areas of the assessment, develop success metrics, and use behavior change methodology to facilitate and influence patient participation in the education process.
- *Planning:* Develop an education plan to address both behavioral and clinical goals established during the goal setting process, develop a learning plan to address gaps in knowledge, and collaborate with patients to plan strategies for addressing barriers identified.
- *Implementation:* Recommend and execute plans, ensuring that the patient has the knowledge, skills, and resources necessary to follow through on the plan. Identify and address barriers that become evident throughout the process.
- *Monitoring/Evaluation:* At each visit, monitor progress of the plan and re-assess the patient's understanding of goals and plan, knowledge and skills, and clinical and behavioral goal achievement. Involve the patient in revising the plan and goals as needed. Follow protocols^{††} as prescribed, make treatment changes, and refer to other specialists as needed.

^{††} Practitioners at other levels may also use protocols, depending on their professional scope of work.

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Appendix A: Assumptions Underlying the Sustainable Model

1. The model is driven by:
 - a. AADE Guidelines for the Practice of Diabetes Education and Training (DSME/T)
 - b. AADE's Competencies for Diabetes Educators
 - c. AADE Position Statements
 - d. The Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators
 - e. National Standards
 - f. Medicare G-Code reimbursement requirements
 - g. Physician involvement
2. The breadth of the diabetes education team is defined by the needs of the target population and structure of the diabetes education program
3. DSME/T is provided by a program that is accredited by DEAP or recognized by ADA-ERP or the IHS
4. The program meets the National Standards
 - a. Coordinator, instructor, and CHW roles are defined
 - i. Level 3-5 diabetes educators (licensed health care professionals with diabetes expertise) provide oversight and clinical instruction
 - ii. Level 1-2 educators (CHWs and non-diabetes professionals) help make DSME/T culturally relevant and
 1. may provide non-clinical instruction and serve as a resource for referrals to community services
 2. may serve as a referral link to affordable community-based resources
 3. require oversight by professional diabetes educator (e.g., Levels 3-5)
 - b. All instructors are trained/educated in recognized programs with acceptable curricula and their education is ongoing
 - i. Acceptable curricula for training of :
 1. Level 3-5 educators include, but are not limited to:
 - a. AADE Core Concepts course
 - b. ABCs of Diabetes Education for Level 3; Facilitating Behavior Change for Levels 3-5
 2. CHWs include, but are not limited to:
 - a. Diabetes Empowerment Education Program (DEEP)
 - b. AADE's Fundamentals of Diabetes Care course
 - c. Stanford Model
 - ii. Acceptable curricula for:
 1. Level 3-5 educators include, but are not limited to:
 - a. AADE Diabetes Education Curriculum
 - b. Basics course
 - c. Life With Diabetes course
 - d. Diabetes Conversation Maps
 2. CHWs to train others include but are not limited to:
 - a. AADE's new CHW curriculum (in development)
 - b. DEEP materials
 - c. Stanford Model materials