**TABLE OF CONTENTS: CURRENT ACCREDITATION CYCLE:**

|  |  |
| --- | --- |
|  | **PAGE #** |
| **PROGRAM OVERVIEW**  Current DEAP Accreditation Certificate/s  Overview of DSMES program services and locations |  |
| **STANDARD 1:**  Letter of support from sponsor organization dated within 6 months of initial and/or renewal application |  |
| **STANDARD 2:**  Description of the diabetes related demographics and additional considerations including SDOH and other barriers that impact the target population |  |
| **STANDARD 3:**  Description of the Quality Coordinator’s role and responsibilities within and outside the DSMES team  Credentialed DSMES team members provide current licensure, registration and/or certification. (RDN, RN, Pharmacist, CDCES, BC-ADM, etc.)  Evidence of at least 15 hours of diabetes-related continuing education each year for all DSMES team members **-OR-** evidence of current/unexpired CDCES or BC-ADM certificate  *Evidence that Diabetes Community Care Coordinator has the training and/or experience related to their specific role on the team. (If applicable and involved in direct delivery of DSMES)* |  |
| **STANDARD 4:**  Evidence that Quality Coordinator and team has access to - and is familiar with - a published and up to date curriculum applicable to their target population.  Evidence that DSMES team reviews overall DSMES services offered to ensure content is current with practice and meeting the needs and preferences of the target population and reflects current evidence, practice guidelines and cultural appropriateness at least annually. |  |
| **STANDARD 5:**  Description of how the assessment process is administered and informs a collaborative person-centered plan for the DSMES intervention. Include how the participant is involved throughout the DSMES plan and overall intervention.  Provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record-See DEAP Chart Audit Tool |  |
| **STANDARD 6:**  A Plan for collecting outcome data for evaluation and improvement of overall DSMES services and reporting to ADCES as part of Annual Status Report.  Every year: One CQI project will be reported to DEAP as part of Annual Status Report  Two Outcome Measures will be chosen by DSMES team and reported in aggregate as part of Annual Status Report   1. Clinical or Behavioral Outcome Measure: 2. Clinical or Behavioral or Process Outcome Measure: |  |

**DSMES PROGRAM OVERVIEW**

|  |  |
| --- | --- |
| DOCUMENTATION REQUIREMENT: | **PAGE #** |
| Copy of Current DEAP Accreditation Certificate |  |
| Overview of DSMES Program and Services: *Not required, but a nice touch for an audit!*  [add an example of your marketing materials, brief success story or showcase a recent accomplishment of your DSMES services] |  |

**STANDARD 1: SUPPORT FOR DSMES SERVICES**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Letter of support from sponsor organization dated within 6 months of initial and/or renewal application |  |

**STANDARD 2: POPULATION AND SERVICE ASSESSMENT**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Description of the diabetes related demographics and additional considerations including SDOH and other barriers that impact the target population |  |

**STANDARD 3: DSMES TEAM**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Description of the Quality Coordinator’s role and responsibilities within and outside the DSMES team |  |
| Credentialed DSMES team members provide current licensure, registration and/or certification. (RDN, RN, Pharmacist, CDCES, BC-ADM, etc.) |  |
| Evidence of at least 15 hours of diabetes-related continuing education each year for all DSMES team members OR evidence of current/unexpired CDCES or BC-ADM credential |  |
| Evidence that Diabetes Community Care Coordinator has the training and/or experience related to their specific role on the team. (If applicable and involved in direct delivery of DSMES) |  |

**STANDARD 4: DELIVERY AND DESIGN OF DSMES SERVICES**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Evidence that Quality Coordinator and team has access to - and is familiar with - a published and up to date curriculum applicable to their target population. Attestation that QC and all team members have reviewed for content and application to current organizational practices. |  |
| Evidence that DSMES team reviews overall DSMES services offered to ensure content is current with practice and meeting the needs and preferences of the target population and reflects current evidence, practice guidelines and cultural appropriateness at least annually. |  |

**STANDARD 5: PERSON-CENTERED DSMES**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Description of how the assessment process is administered and informs a collaborative person-centered plan for the DSMES intervention. Include how the participant is involved throughout the DSMES plan and overall intervention. |  |
| Provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record.   * DSMES Assessment * DSMES Plan * Each DSMES Visit including date/time and topic areas covered with plan for follow up * Behavior Goal (ADCES7) and progress * Outcomes of intervention communicated to referring physician/qualified healthcare professional |  |

**DEAP CHART REVIEW TOOL: STANDARD 5**

**LABEL YOUR CHART ACCORDING TO TOOL BELOW**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Standard 5: Person Centered DSMES** | Notes: |
|  |  | **Referral for DSMES** in chart: see diabeteseducator.org/referdsmes for template & guidelines for **Medicare – reviewed by DEAP auditors to support programs to ensure they are being reimbursed for DSMT appropriately.** |  |
| ASSESSMENT |  | **Assessment:**  Health Status: type of diabetes, clinical needs, health history, disabilities, physical limitations, SDOH and health inequities (e.g., safe housing, transportation, access to nutritious foods, access to healthcare, financial status, and limitations), risk factors, comorbidities, and age  Psychosocial Adjustment: emotional response to diabetes, diabetes distress, diabetes family support, peer support (e.g., in-person or via social networking sites), and other potential promotors and barriers  Learning Level: diabetes knowledge, health literacy, literacy, numeracy, readiness to learn, ability to self-manage, developmental stage, learning disabilities, cognitive/developmental disabilities (e.g., intellectual disability, moderate-severe autism, dementia), and mental health impairment (e.g., schizophrenia, suicidality)  Lifestyle Practices: self-management skills and behaviors, health service or resource utilization, cultural inﬂuences, alcohol and drug use, lived experiences, religion, and sexual orientation |  |
| DSMES PLAN |  | ***Document at least once throughout DSMES intervention:***  How (group, individual)  What (Assessment of ADCES7 Self Care Behaviors and needs – to be determined collaboratively between participant and DSMES team)  When (how many visits anticipated and how often they will come for DSMES)  Where (in person, telehealth (audio or audio-video) combination)  Why: Purpose for DSMES, diagnosis, complications, etc. |  |
| DSMES INTERVENTION |  | ***Document for each participant at every session:***  When: Date of Service and Plan for Follow Up (timing for next DSMES session)  Who: DSMES Instructor/Team and Participant/family in attendance  What: Topics Covered (ADCES7 Self Care Behaviors)  How: Participant’s progress with learning  Why: Participant’s current progress with SMART goal and action plan; then next steps (what will participant work on between now and next DSMES session) |  |
|  | **Communication back to referring provider** that includes summary of DSMES provided, participant outcomes and plan for follow up. |  |

**STANDARD 6: MEASURING AND DEMONSTRATING OUTCOMES OF DSMES SERVICES**

|  |  |
| --- | --- |
| REQUIRED DOCUMENTS: | **PAGE #** |
| Initial applicants will provide a plan for collecting outcome data for evaluation and improvement of overall DSMES services and reporting to ADCES as part of Annual Status Report. |  |
| Existing programs will provide a minimum of one program level clinical or behavioral outcome aggregated and reported to ADCES as part of **Annual** Status Report |  |
| Minimum of one other program level outcome (can be part of CQI) will be aggregated and reported to ADCES **annually** |  |
| One CQI project will be reported with related outcomes each year as part of **Annual** Status Report |  |

|  |  |
| --- | --- |
| Outcome type | Examples |
| Process outcomes | Referral process  Attendance  Education mapping  Social determinants of health  Timing of education sessions (e.g., times that meet the PWD needs) |
| Clinical outcomes | A1C  Time in hypoglycemia  Pregnancy outcomes  LDL-cholesterol levels  Body mass index and body weight  Blood pressure  Time in range (TIR) |
| Psychosocial and behavioral outcomes57 | Healthy coping  Healthy eating  Being active  Taking medication  Monitoring  Reducing risk  Problem solving |
| Patient-reported outcomes | Health-related quality of life  Diabetes-related quality of life  Diabetes distress  Self-efficacy  Functional status  Patient satisfaction |
| Patient generated health data | Blood glucose trends  CGM glucose management indicator (GMI)  Weight, activity, steps  Food/beverage intake  Sleep  Blood pressure |