

2022 NATIONAL STANDARDS FOR DSMES INTERPRETIVE GUIDANCE

NATIONAL STANDARD 1	INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p>Support for DSMES Services</p> <p><i>The DSMES team will seek leadership support for implementation and sustainability of DSMES services. The sponsor organization will recognize and support quality DSMES services as an integral component of diabetes care.</i></p> <p><i>Sponsor organizations will provide guidance and support for DSMES services to facilitate alignment with organizational resources and the needs of the community being served.</i></p>	<p>LETTER OF SUPPORT</p> <p>Support must come from administrative level to which the DSMES services report, sponsoring organization owner or referring physician/qualified healthcare professional stating support for and commitment to the DSMES services and people with diabetes in your target population.</p> <p>Examples of administrators from your sponsoring organization who could provide your letter of support may be the CEO, President, Director, Clinical Manager, Quality Manager or Director, Owner, Supervisor, etc.</p> <p>Choosing who will write the letter of support depends on the specific organization and circumstances. Choose the person at the highest level of authority who can support long term sustainability of your DSMES services.</p> <p>Date of Letter of Support: Letter of support must be dated within 6 months of initial and renewal DSMES applications. If change in leadership or signatory occurs, new letter should be obtained and kept on record.</p>	<p>1. Letter of support from sponsor organization dated within 6 months of initial and/or renewal application.</p> <p style="text-align: center;"><u>OR</u></p> <p>In cases where DSMES services are delivered and/or sponsored by a solo healthcare professional, the letter will come from a referring physician/qualified healthcare professional who will champion and refer to DSMES services.</p>

NATIONAL STANDARD 2	EXCERPT AND INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p>Population and Service Assessment</p> <p><i>The DSMES service will evaluate their chosen target population to determine, develop, and enhance the resources, design, and delivery methods that align with the target populations' needs and preferences.</i></p>	<p>EVALUATION OF TARGET POPULATION</p> <p>To best plan, design, deliver, evaluate, and improve quality of services, the DSMES team must identify and understand their target populations' demographics and social determinants of health (SDOH).</p> <p>Demographic characteristics may include race, ethnic/cultural background, sex, age, geographic location, technology access, levels of formal education, literacy level, health literacy, and numeracy. The populations' perception of risk associated with diabetes, SDOH, related complications, and co-occurring conditions are also key characteristics to consider. This information is available from a variety of sources, including but not limited to community needs assessments by local or state health departments, health system/organizations specific to the populations, and DSMES data.</p> <p>IDENTIFY BARRIERS TO DSMES IN YOUR TARGET POPULATION</p> <p>It is essential to promote access to DSMES services by identifying and addressing population barriers and health inequities. Barriers may include socioeconomic factors, cultural factors, misaligned schedules, health insurance shortfalls, perceived lack of need, or limited encouragement from healthcare professionals to engage in DSMES. SDOH related to the target population should guide service design and delivery.</p>	<p>2. Description of the diabetes related demographics and additional considerations including SDOH and other barriers that impact the target population.</p>

NATIONAL STANDARD 3	EXCERPT AND INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p style="text-align: center;">DSMES Team</p> <p><i>All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement. At least one team member will be identified as the DSMES quality coordinator and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes.</i></p>	<p>QUALITY COORDINATOR: The quality coordinator needs to ensure the DSMES services are person-centered and understand the process of identifying, analyzing, and communicating quality data. The quality coordinator may partner with other team members to support quality improvement.</p> <p>Although the quality coordinator does not require additional degrees or certifications in informatics, developing an understanding of these skills—as well as marketing, healthcare administration, and business management—will be helpful as the healthcare environment continues to evolve. The quality coordinator role may vary depending on the setting of the DSMES services and may or may not be part of the instructional team.</p> <p><u>TEAM MEMBERS INVOLVED IN DIRECT DELIVERY OF DSMES:</u></p> <p>ONE CREDENTIALLED PROFESSIONAL REQUIRED ON TEAM: The DSMES team may include one or a variety of healthcare professionals. The evidence recommends that inclusion of dietitians, nurses, pharmacists, or all other disciplines with special certifications that demonstrate mastery of diabetes knowledge and training, such as Board Certified in Advanced Diabetes Management (BC-ADM) and Certified Diabetes Care and Education Specialists (CDCES), can support all DSMES services, including clinical assessment.</p>	<p>3. Description of the Quality Coordinator’s role and responsibilities within and outside the DSMES team.</p> <p>TEAM MEMBERS INVOLVED IN DIRECT DELIVERY OF DSMES:</p> <p>4. Attestation that at least one of the DSMES team members is an RN, RDN or pharmacist with training and experience pertinent to DSMES OR holds certification as a CDCES or BC-ADM</p> <p>5. Credentialed DSMES team members provide current licensure, registration and/or certification. (RDN, RN, Pharmacist, CDCES, BC-ADM, etc)</p> <p>6. 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.</p>

DIABETES COMMUNITY CARE COORDINATORS AND OTHERS INVOLVED IN DSMES DELIVERY

Professionals with additional training in DSMES effectively contribute to the DSMES team. Diabetes Community Care Coordinators and other team members must obtain continuing education specific to the role they serve within the team and provide evidence of completion of training in initial application and when added to team; New staff must complete 15 hours of CE prior to engaging in direct delivery of DSMES.

ADCES TRAINING AND RESOURCES for DCCC

- [Diabetes Community Care Coordinators certificate](#)
- [ADCES7 Self-Care Behaviors™](#)
- [NDPP Lifestyle Coach Training](#)

DOCUMENTATION OF CONTINUING EDUCATION

For members of the DSMES team that do not have the CDCES or BC-ADM credential, documentation of continuing education (CE) related to the needs of people living with diabetes must be maintained on an annual basis.

DSMES team members must document appropriate continuing education of diabetes-related content, which can include chronic disease management, diabetes specific or related content, behavior change, marketing, and healthcare administration.

Initial accreditation requires hours to be obtained within the 12 months prior to applying for DSMES accreditation.

Accredited programs will maintain records that include CE within consistent cycle over four-year term: calendar year or accreditation year.

CE official transcript or copies of CE certificates will be required with initial application and if audited.

Diabetes Community Care Coordinators (if applicable and involved in direct delivery of DSMES):

7. Attestation that the diabetes community care coordinator/s directly report/s to credentialed professional team member.
8. Evidence that Diabetes Community Care Coordinator has the **training and/or experience** related to their specific role on the team.

NATIONAL STANDARD 4	INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p>Delivery and Design of DSMES Services</p> <p><i>DSMES services will utilize a curriculum to guide evidence-based content and delivery, to ensure consistency of teaching concepts, methods, and strategies within the team, and to serve as a resource for the team.</i></p> <p><i>DSMES teams will have knowledge of and be responsive to emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies relevant to the population they serve.</i></p>	<p>CURRICULUM</p> <p>A curriculum provides guidance for the DSMES team, with examples of effective teaching strategies, methods for evaluating learning outcomes, and includes all aspects of diabetes self-management and support.</p> <p>The chosen DSMES curriculum must include the following core content areas, and content must be prioritized to meet the individual PWD’s current needs, abilities and goals</p> <p>CORE CONTENT AREAS (Type 1 & 2, GDM, pregnancy complicated by diabetes) in the following topic areas:</p> <ul style="list-style-type: none"> • Pathophysiology of diabetes and treatment options • Healthy coping • Healthy eating • Being active • Taking medication • Monitoring • Reducing risk (treating acute and chronic complications) • Problem solving and behavior change strategies <p>DEAP PRE-APPROVED CURRICULA</p> <ul style="list-style-type: none"> • ADCES Diabetes Education and Care Curriculum • Type 2 Diabetes BASICS Curriculum Guide • ADA Life with Diabetes • Conversation Maps 	<p>9. Curriculum: 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.</p> <p>10. Delivery and Design of DSMES Services: 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.</p>

DELIVERY & DESIGN OF DSMES SERVICES

DSMES delivery should integrate topics across content areas rather than creating silos of content that limit informed and wise decision-making. The delivery of curriculum content must be dynamic, based on continuing assessment of need, preferences, and evaluation of outcomes.

The most effective and evidence-based delivery methods move beyond the mere acquisition of knowledge to support informed decision making while addressing psychosocial concerns of the PWD. The use of interactive teaching styles that include meaningful discussions to address individual questions and needs while fostering a culture of positivity within the DSMES services is recommended. The curriculum content and delivery should be creative, culturally appropriate and adapted as necessary for the individuals and groups within the target population. Furthermore, culturally-tailored services have been shown to be effective in improving diabetes care outcomes.

Applicants will provide an overview of the DSMES services that includes a description of the modes of delivery that are offered (in person, virtual, telephone, group, one on one), the types of sessions offered in each mode (Type 1, Type 2, Gestational, etc) and a brief description of how interaction, discussion and individual questions are addressed in each mode of delivery. **Existing programs** will maintain evidence that DSMES team has reviewed overall service offerings each year.

NATIONAL STANDARD 5	INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p>Person-Centered DSMES</p> <p><i>Person-centered DSMES is a recurring process over the life span for a PWD. Each person’s DSMES plan will be unique and based on the person’s concerns, needs, and priorities collaboratively determined as part of a DSMES assessment. The DSMES team will monitor and communicate the outcomes of the DSMES services to the diabetes care team and/or referring physician or other qualified healthcare professional.</i></p>	<p>DSMES ASSESSMENT: To implement a person-centered DSMES plan, the diabetes care and education specialist must closely work in partnership with each PWD to better understand how to (e.g., modality, content, and frequency) best suit that person. The assessment process involves collaborative communication between a healthcare professional and the PWD to identify needs and agree on the PWD’s preferred educational, coping, and behavioral interventions that will be used to develop needed problem solving, decision making, and self-management skills and strategies.</p> <p>DSMES PLAN AND TOPICS COVERED: The DSMES plan, topics covered at each session, and the outcomes of the intervention are documented in the DSMES record for each person. This documentation provides evidence of person-centered DSMES and communication among other members of the person’s healthcare team. This enhances long-term management and continuity of diabetes care, education, and support. Using technology tools and EHRs, in turn, increase access to information for all team members to work collaboratively and have access to documentation</p> <p>All DSMES interventions must be documented in a format that allows for communication across the diabetes care team and must be HIPAA compliant and protect PHI. This can be done through a shared electronic medical record or paper chart for the individual, and documentation must be completed for every participant that attends DSMES.</p>	<p>11. 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.</p> <p>12. Provide evidence of at least one DSMES intervention within the last 12 months as documented in the medical record.</p> <p>Before submission it must be completely de-identified of all PHI and include the following components:</p> <ul style="list-style-type: none"> <input type="checkbox"/> DSMES Assessment <input type="checkbox"/> DSMES Plan <input type="checkbox"/> Each DSMES Visit including date/time and topic areas covered with plan for follow up <input type="checkbox"/> Behavior Goal (ADCES7) and progress <input type="checkbox"/> Outcomes of intervention communicated to referring physician/qualified healthcare professional

	<p>DSMES PROGRESS AND OUTCOMES: It is crucial for each PWD to collaboratively develop action-oriented behavior change plans to reach their personal behavioral goals, coping strategies, and treatment (or clinical) targets. The DSMES team will explain and demonstrate psychosocial and behavior change strategies that can be used by the PWD to meet their self-determined goals and targets. The role of the DSMES team is to provide support in problem solving during this process. The ADCE7 Self-Care Behaviors™ (found in core content areas Standard 4) can be used for tracking progress in behavior goals.</p> <p>SUMMARY OF DOCUMENTATION OF DSMES INTERVENTION: <i>required for individual medical record of each participant</i></p> <ul style="list-style-type: none"> • Medicare Referral Order: Applicants billing Medicare will be asked to provide at least one example of a signed referral order meeting Medicare guidelines. • DSMES Assessment to review health status, learning level, lifestyle practices, and psychosocial adjustment and SDOH that informs DSMES Plan. May be collected through medical record review, intake forms and questionnaires, or conversation with participant. • DSMES Plan: After the initial assessment, the PWD and DSMES team member(s) develop a person-centered DSMES plan (Can use ADCE7). • Topics covered at each session (Can use ADCE7). • Self-determined behavioral goal (ADCE7) and Progress • Outcomes of the intervention shared with participant and referring physician/qualified healthcare professional 	<p><i>*Example must be from actual participant who has received DSMES services and show how and where documentation will occur in the medical record or electronic medical record. Note that electronic health information for DSMT must be maintained for a minimum of 6 years. Screenshots or images from EMR must be completely de-identified of all PHI prior to submission.</i></p>
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NATIONAL STANDARD 6	INTERPRETIVE GUIDANCE	REQUIRED DOCUMENTATION
<p>Measuring and Demonstrating Outcomes of DSMES Services</p> <p>DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services. Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services redesign and optimization</p>	<p>CQI PROJECT TO IMPROVE DSMES SERVICES</p> <p>DSMES teams must have a procedure in place to collect, combine, analyze, and demonstrate outcomes for participants seen as part of the DSMES services across all sites.</p> <p>Three fundamental questions to be answered by the CQI project:</p> <ol style="list-style-type: none"> 1. What are we trying to accomplish? 2. How will we know a change is an improvement? 3. What changes can we make that will result in an improvement? <p>Each year, quality coordinators are required to submit:</p> <ol style="list-style-type: none"> 1. Report of completed CQI project demonstrating progress, changes, or achievement from current/reporting year beginning year 2 of accreditation cycle. 2. At least one clinical or behavioral outcome (before and after DSMES) aggregated from participants seen for DSMES. 3. At least one other outcome related to DSMES team’s chosen CQI project. Data must indicate measure before and after CQI project implementation. <p>Examples of combined (aggregate) outcomes to measure and report include but are not limited to:</p>	<p>13. 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.</p> <p>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.</p> <p>14. One CQI project will be reported with related outcomes each year as part of Annual Status Report.</p> <p>15. Minimum of one other program level outcome (can be part of CQI) will be aggregated and reported to ADCES annually.</p>

Table 1. DSMES Outcome Examples

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