DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

Crosswalk for AADE's Diabetes Education Accreditation Program

National Standards for Diabetes Self-Management Education and Support (Essential Elements and Interpretive Guidance)

National Standard	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 1 **Internal Structure:** The provider(s) of DSME will document an organizational structure, mission statement, and goals. For those providers working within a larger organization, that organization will recognize and support quality DSME as an integral component of diabetes care.	A) There is documentation that describes or depicts Diabetes Education as a distinct component within the organization's structure and articulates the program's mission and goals. Documentation of an organizational structure, mission statement, and goals can lead to efficient and effective provision of DSME and DSMS. B) Documentation of an organizational structure that delineates channels of communication and represents institutional commitment to the educational entity is critical for success.	1. Clearly Documented organizational structure of DSME Program illustrating the clear channels of communication to the program from sponsorship YES ☐ NO ☐ 2. Documentation of program mission YES ☐ NO ☐ 3. Documentation of program goals YES ☐ NO ☐ 4. Letter of support from your sponsoring organization YES ☐ NO ☐	***Standard one relates to your programs formalized internal structure.*** The Organizational Chart is a graphic or narrative depiction of formal relationships within the Organization that identifies areas of responsibility, accountability relationships and channels of communication. The mission statement is a brief description of the program's fundamental purpose. It answers the question, "Why do we exist?" This statement broadly describes the program's present capabilities, customer focus, and activities. The audience is identified in the mission statement. The Goals identify the intended activities needed to accomplish the mission. AADE will review the programs mission statement, goals and letter of support from your sponsoring organization. If your program is small and you are the sponsoring organization please write a statement of support for the DSME program demonstrating the program's commitment to the people with diabetes in your community.

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Standard 2 **External Input:** The provider(s) of DSME will seek ongoing input from external stakeholders and experts to promote program quality.	A) For both individual and group providers of DSME and DSMS, external input is vital to maintain an up-to-date, effective program. Broad participation of community stakeholders, including people with diabetes, health professionals, and community interest groups, will increase the program's knowledge of the local population, and allow the provider to better serve the community. The DSME and DSMS provider(s) must have a documented plan for seeking outside input and acting on it. B) The goal of external input and discussion in the program planning process is to foster ideas that will enhance the quality of the DSME and/or DSMS being provided, while building bridges to key stakeholders. C) The result is effective, dynamic DSME that is patient-centered, more responsive to consumer-identified needs and the needs of the community, more culturally relevant, and more appealing to consumers	5. Program has a documented plan for seeking outside input YES ☐ NO ☐ 6. The program's outreach to community stakeholders and the input from these stakeholders must be documented and available for review, annually and periodically as requested YES ☐ NO ☐	***Standard two relates to the programs seeking input from key stakeholders and experts in their community***. Input can be completed by phone, survey, email or face to face. However, interactions with stakeholders and subsequent follow-up needs to be documented along with the details of the interaction and the content of the discussions including; participating Stakeholders, Program changes, Access issues, CQI action plans, DSMS. Stakeholder Feedback; a program must have an annual report reflecting this input available for review Suggested stakeholders include but are not limited to: people with diabetes, health professionals, and community interest groups A suggested timeline for new programs include: reaching out to stakeholders within the first six months of accreditation, and at the end of the first year This initial 6 month outreach will allow for input early on and will help shape and formalize new programs.

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Standard 3 **Access:** The provider(s) of DSME will determine whom to serve, how best to deliver diabetes education to that population, and what resources can provide ongoing support for that population.	A) Understanding the community, service area, or regional demographics is crucial to ensuring that as many people as possible are being reached, including those who do not frequently attend clinical appointments B) Different individuals, their families, and communities need different types of education and support. The provider of DSME needs to work to ensure that the necessary education alternatives are available. C) It is essential to determine factors that prevent people with diabetes from receiving self-management education. The assessment process includes the identification of these barriers to access These barriers may include the socio-economic or cultural factors mentioned above, as well as, for example, health insurance shortfalls and the failure of other health providers to encourage their patients to pursue diabetes education.	7. Documentation identifying your population is required and is reviewed at least annually YES ☐ NO ☐ 8. Documented allocation of resources to meet population specific needs. (E.g. room, materials, curriculum staff, support etc…) YES ☐ NO ☐ 9. Identification of and actions taken to overcome access related problems as well as communication about these efforts to stakeholders YES ☐ NO ☐	***Standard three relates to the program's knowledge and understanding of the population they serve and could potentially serve in their community.*** Provider must identify and understand their programs population demographic characteristics, such as ethnic/cultural background, gender, and age, as well as their levels of formal education, literacy, and numeracy. Understanding their population also entails identifying resources outside of the provider's practice that can assist in the ongoing support of the participant. Allocation of resources must be reviewed, and documented items which are based on assessment of the population's specific needs including but not limited to: room, materials, curriculum, staffing, support, how classes are structured and when they are offered.

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Standard 4 **Program Coordination:** A coordinator will be designated to oversee the DSME program. The coordinator will have oversight responsibility for planning, implementation, and evaluation of education services.	A) Coordination is essential to ensure that quality diabetes self-management education and support is delivered through an organized, systematic process. B) The coordinator's role may be viewed as that of coordinating the program (or education process) and/or as supporting the coordination of the many aspects of self-management in the continuum of diabetes and related conditions when feasible. C) This oversight includes designing an education program or service that helps the participant access needed resources and assists him or her in navigating the health care system. D) Coordinators are to follow the continuing education requirements of their professions (a minimum of 15 hours continuing education is required annually)	10. Coordinator's resume (reflecting experience managing a chronic disease, facilitating behavior change, and experience with program and/or clinical management): YES ☐ NO ☐ 11. Job description describing program oversight (must include planning, implementation and evaluation of the DSMT program): YES ☐ NO ☐ 12. Documentation that the Program Coordinator received a minimum of 15 hours of CE credits per year (program management, education, chronic disease care, behavior change) OR credential maintenance (CDE or BC-ADM) YES ☐ NO ☐	***Standard four focuses on the leadership of the program through the program coordinator.*** The breadth and depth of responsibilities of the program coordinator will vary with the program size and complexity, but, at a minimum, the coordinator must have the ability to be responsible for planning, implementation and evaluation of services. The program coordinator must have skills and experience of working with managing a chronic disease, facilitating behavior change, in addition to experience with program and/or clinical management. The program coordinator must complete 15 hours of continuing education on an annual basis as it relates to diabetes care as well as their profession i.e. program management, education, chronic disease care, behavior change. {If the program Coordinator is a CDE or BC-ADM they do not need the 15 hours in the year prior to accreditation but must attest to receiving these hours on an annual basis, moving forward after accreditation.}

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Standard 5 **Instructional Staff:** One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be an RN, RD or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes with supervision and support.	A) Resumes and proof of licenses, registration and/or certification shall be maintained to verify that program staff is comprised of instructor(s) who have obtained and maintained the required credentials. B) If Community Health Workers (CHW) are a part of the DSMT program team, there is documentation of successful completion of a standardized training program for CHWs and additional and on-going training related to diabetes self-management. a. Training includes scope of practice relative to role in DSMT C) If CHWs are part of the DSMT program's team, there shall be documentation that they are directly supervised by, the named diabetes educator(s) in the program. D) Professionals serving as instructors must document appropriate continuing education or comparable activities to ensure their continuing competence to serve in their instructional, training and oversight roles: a. Instructors: 15 hours of continuing education annually for all instructors. If Instructor is a CDE they must maintain the CE requirement of their certification if the instructor is a BC-ADM they must maintain the requirements to maintain certification these hours must be from a nationally recognized accrediting body.	13. Document that at least one of the instructors is an RN, RD or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM YES ☐ NO ☐ 14. Current credential for instructor(s) (including licensure and/or registration proof) YES ☐ NO ☐ 15. Instructor's resume is current and reflects their diabetes education experience YES ☐ NO ☐ 16. 15 hours of CE credits per year for all instructors annually YES ☐ NO ☐	***Standard five focuses on meeting the needs of the population the program serves through qualified instructional staff and outside referrals as needed***. Expert consensus supports the need for specialized diabetes and educational training beyond academic preparation for the primary instructors on the diabetes team A number of studies have endorsed a multi-disciplinary team approach to diabetes care, education, and support, reflecting the evolving health care environment, Continuing education for instructional staff needs to be diabetes-specific, diabetes-related, and/or behavior change self- management education strategies-specific (e.g., AADE7 self-care behaviors) Lay health, community workers and peer counselors or educators may contribute to the provision of DSME instruction and provide DSMS if there is documentation of their having received training in diabetes self-management, the teaching of self-management skills, group facilitation, and emotional support. The annually reviewed and updated documentation of appropriate training needs to be signed by the program

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	E) For programs, particularly those that have solo instructors, there shall be a policy that identifies a mechanism for ensuring participant needs are met if needs are outside of instructor's scope of practice and expertise. F) There shall be documentation of: A process for ensuring that appropriate care coordination among the diabetes care team occurs and Team coordination and interaction.	17. There is documentation of successful completion of a standardized training program for CHWs (Training includes scope of practice relative to role in DSME): YES ☐ NO ☐ 18. Documentation that the CHWs are supervised by, the named diabetes educator(s) in the program YES ☐ NO ☐ 19. Policy that identifies a mechanism for ensuring participant needs are met if needs are outside of instructor's scope of practice and expertise YES ☐ NO ☐	coordinator. This documentation must be available for review and because this level staff may not qualify for Continuing Education. Documentation can be a certificate of completion or a competency checklist. CHW must receive training on an annual basis specific to their role. A system is in place that ensures supervision of the services the CHW provides. The nature of this supervision by a named diabetes educator or other health care professional and professional back-up to address clinical problems or questions beyond their training must be documented This supervision can be in person, by phone using a protocol for suggesting follow-up with the diabetes educator or other health care professional. Mechanisms for meeting needs outside a scope of practice includes: referrals to other practitioner and/or partnering with a professional with additional expertise (e.g., exercise physiologist or behavioral specialist) and is clearly documented.

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Standard 6 **Curriculum:** Written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSME. The needs of the individual participant will determine which parts of the curriculum will be provided to that individual.	A) The curriculum must be dynamic and reflect current evidence and practice guidelines.. B) The following core topics are commonly part of the curriculum taught in comprehensive programs that have demonstrated successful outcomes. Describing the diabetes disease process and treatment options: a. Incorporating nutritional management into lifestyle b. Incorporating physical activity into lifestyle c. Using medication(s) safely and for maximum therapeutic effectiveness d. Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making e. Preventing, detecting, and treating acute complications f. Preventing detecting, and treating chronic complications g. Developing personal strategies to address psychosocial issues and concerns. h. Developing personal strategies to promote health and behavior change.	20. Evidence of a written curriculum, tailored to meet the needs of the target population, is submitted and includes all content areas listed in the essential elements YES ☐ NO ☐ 21. The curriculum adopts principles of AADE7™ behaviors YES ☐ NO ☐ 22. The curriculum is reviewed at least annually and updated as appropriate to reflect current evidence, practice guidelines and its cultural appropriateness YES ☐ NO ☐ 23. Curriculum reflects maximum use of interactive training methods YES ☐ NO ☐	***Standard six specifies curriculum teaching strategies utilized. Programs using a purchased curriculum must describe how the curriculum has been adapted to meet the needs of the population served.*** While the content areas listed in the essential elements provide a solid outline for a diabetes education and support curriculum, it is crucial that the content be tailored to match each individual's needs. This includes adaptation as necessary for the following: Assessed need, age and type of diabetes (including prediabetes and diabetes in pregnancy), cultural factors, health literacy and numeracy, and comorbidities, learning style preferences. The content areas must also be adapted and modified to fit the program's practice setting. Creative, patient-centered, experience-based delivery methods—beyond the mere acquisition of knowledge—are effective for supporting informed decision-making and meaningful behavior change and addressing psychosocial concerns. Approaches to education that are interactive and patient-centered have been shown to be effective.

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Standard 7 **Individualization:** The diabetes self-management, education, and support needs of each participant will be assessed by one or more instructors. The participant and instructor(s) will then together develop an individualized education and support plan focused on behavior change.	A) Each Participants needs must be individualized. An assessment process must be used to identify what those needs are, and to facilitate the selection of appropriate educational and behavioral interventions and self-management support strategies, guided by evidence. B) The assessment must garner information about the individual's medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, diabetes self-management skills and behaviors, emotional response to diabetes, readiness to learn, literacy level (including health literacy and numeracy), physical limitations, family support, and financial status. C) The education and support plan that the participant and instructor(s) develop will be rooted in evidence-based approaches to effective health communication and education while taking into consideration participant barriers, abilities, and expectations. D) The assessment and education plan, intervention, and outcomes will be documented in the education/health record. Documentation of participant encounters will guide the education process, provide evidence of communication among instructional staff and other members of the participant's healthcare team, prevent duplication of services, and demonstrate adherence to guidelines. E) The instructor will employ clear health	24. The education process is defined as an interactive, collaborative process which assesses, implements and evaluates the educational intervention to meet the needs of the individual YES ☐ NO ☐ 25. De-identified patient chart must include evidence of the following elements Collaborative participant initial assessment includes minimally: • Medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, diabetes self-management skills and behaviors, emotional response to diabetes, readiness to learn, literacy level (encompassing health literacy and numeracy), physical limitations, family support, and financial status	***Standard seven focuses on ensuring that the education provided is individualized to each participant. The instructor will assess each participant in order to individualize the best educational and behavioral intervention and support strategies.*** This assessment can be done individually or in group. It may include a self-assessment completed by the individual prior to the first meeting. This process should be appropriate for the population the program serves as well as being tailored to meet the needs of any individual participant. There needs to be a complete, individualized education plan for each participant that includes interventions and desired outcomes. The education plan needs to be developed collaboratively with the participant and family or others involved with the participants care as required. This will guide the process of working with the participant and must be documented in the education records. Programs also need to document an individualized follow-up support plan. A variety of assessment modalities include: telephone follow-up and use of other information technologies (e.g., Web-based, text-messaging, or automated phone calls), and may be used to augment face-to-face follow-up, progress assessments.

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	communication principles, avoiding jargon, making information culturally relevant, using language– and literacy-appropriate education materials, and using interpreter services when indicated. Evidence-based communication strategies such as collaborative goal-setting, motivational interviewing, cognitive behavior change strategies, problem-solving, self-efficacy enhancement, and relapse prevention strategies are also effective.	YES ☐ NO ☐ • Individualized educational plan of care based on assessment and behavioral goal YES ☐ NO ☐ • Documented individualized follow-up on education and goals YES ☐ NO ☐	An action -oriented behavioral goal/objective plan, clearly documents the plan and guides follow up discussion of progress towards achieving goals, or identifies gaps.

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Standard 8 **Ongoing Support:** The participant and instructor(s) will together develop a personalized follow-up plan for ongoing self-management support. The participant's outcomes and goal and the plan for ongoing self-management support will be communicated to other members of the healthcare team.	A) Because self-management takes place in participants' daily lives and not in clinical or educational settings, patients will be assisted to formulate a plan to find community-based resources that may support their ongoing diabetes self-management. B) DSME and DSMS providers will work with participants to identify such services and, when possible, track those that have been effective with patients, while communicating with providers of community-based resources in order to better integrate them into patients' overall care and ongoing support. C) Primary responsibility for diabetes education belongs to the provider(s) of DSME, participants benefit by receiving reinforcement of content and behavioral goals from their entire health care team. D) Many patients receive DSMS through their primary care provider. Thus, communication among the team regarding the patient's educational outcomes, goals and DSMS plan is essential to ensure that people with diabetes receive support that meets their needs and is reinforced and consistent among the healthcare team members.	De-identified Chart must also include the following: • On-going Self-Management Support options reviewed with the Participant YES ☐ NO ☐ • Communication to the health care team includes participant's plan for ongoing support YES ☐ NO ☐	***Standard eight focuses on the importance of ongoing support above and beyond the initial DSME.*** While DSME is necessary and effective, it does not in itself guarantee a lifetime of effective diabetes self-care. Initial improvements in participants' metabolic and other outcomes have been found to diminish after approximately 6 months. DSMS (Diabetes Self-Management Support) is defined as: Activities that assist the person with prediabetes or diabetes in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis beyond or outside of formal self-management training. The type of support provided can be behavioral, educational, psychosocial, or clinical. Programs need to identify community opportunities/resources that may benefit their participants and support their commitment to their chosen behavioral modifications. The options available need to be offered patient preferences documented. Community programs need to be reviewed periodically to insure that participants are provided with current information. The community programs can also provide external input to meet elements in Standard two.

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Standard 9 **Patient Progress:** The provider(s) of DSME and DSMS will monitor whether participants are achieving their personal diabetes self-management goals and other outcome(s) as a way to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.	A) Effective diabetes self-management can be a significant contributor to long-term, positive health outcomes. The provider(s) of DSME and DSMS will assess each participant's personal self-management goals and his or her progress toward those goals B) The AADE Outcome Standards for Diabetes Education specify behavior change as the key outcome and provide a useful framework for assessment and documentation. The "AADE7™" lists seven essential factors: *physical activity, healthy eating, medication taking, monitoring blood glucose, diabetes self-care related problem solving, reducing risks of acute and chronic complications, and psychosocial aspects of living with diabetes;* which serve as a useful format. C) Assessments of participant outcomes must occur at appropriate intervals. The interval depends on the nature of the outcome itself and the timeframe specified based on the participant's personal goals. For some areas, the indicators, measures, and timeframes will be based on guidelines from professional organizations or government agencies.	De-identified chart must also show evidence of: • Collaborative development of behavioral goals with interventions provided and outcomes evaluated YES ☐ NO ☐ • Documentation and assessment of at least one clinical outcome measure YES ☐ NO ☐	***Standard nine focuses on establishing individualized clinical outcomes and behavioral goals*** All goals, including behavioral goals, must be: SMART- specific, measureable, achievable, reasonable, and timely. In addition, these behavior goals must relate to the AADE7™ (Healthy Eating, Being Active, Monitoring, Taking Medication, Problem Solving, Healthy Coping and Reducing Risks). Patients do not need to work on all seven behavioral goals.at once. Most patients will select one or two initial goals. Clinical outcome measurements need to be chosen based on the population served, organizational practices and availability of the outcome data. Examples include but are not limited to: A1c, weight, B/P, BMI, waist circumference, lipids etc… The participant medical record must reflect assessment of the individual participant's achievement of goals including any review and / or adjustments made to the educational plan or goals.

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Standard 10 **Quality Improvement:** The provider(s) of DSME will measure the effectiveness of the education and support and look for ways to improve any identified gaps in services or service quality, using a systematic review of process and outcome data.	A) Diabetes education must be responsive to advances in knowledge, treatment strategies, education strategies, and psychosocial interventions, as well as consumer trends and the changing health care environment. By measuring and monitoring both process and outcome data on an ongoing basis, providers of DSME can identify areas of improvement and make adjustments in participant engagement strategies and program offerings accordingly. B) DSME provider must designate timelines and important milestones including data collection, analysis, and presentation of results.	26. Evidence of aggregate data collected and used for analysis of both behavioral and clinical outcomes is clearly identified at time of application YES ☐ NO ☐ 27. Annual report documenting the ongoing CQI activities following initial accreditation YES ☐ NO ☐	***Standard ten relates to the annual process by which programs will assess their operations, including the delivery of education and support.*** Programs must have a process/system in place in order to collect, aggregate and analyze clinical outcomes measures and behavioral goal achievement. *Evidence of this process with data will need to be submitted at time of application and annually.* Continuous Quality Improvement (CQI) insures program engagement, intentional and systematic service improvement with intention of increasing positive outcomes CQI is a cyclical, data-driven process which is proactive, not reactive. Data for the CQI plan is collected and used to makes positive changes—even when things are going well—rather than waiting for something to go wrong and then fixing it. All DSMT sites, including new entities by the six month mark, must be able to show implementation of the CQI plan. A program may be randomly selected within the first year of accreditation to submit their CQI plan. Examples include but are not limited to: wait times, program attrition, referrals, reduction in A1Cs, education process, weights, foot and eye exams, reimbursement issues, number of referrals, follow up, etc.