DEAP
DIABETES EDUCATION ACCREDITATION PROGRAM
AADE American Association of Diabetes Educators

2017 National Standards for Diabetes Self-Management Education and Support

INTERPRETIVE GUIDANCE

National Standard	Essential Highlights	Interpretive Guidance	Checklist
Standard 1: Internal Structure *The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization — large, small, or independently operated.*	Documentation of a defined structure, mission, and goals supports effective provision of DSMES. Mission defines the core purpose of the organization and assists in developing professional practice and services. Business literature, case studies, and reports of successful organizations emphasize the importance of clearly shared missions, goals, and defined relationships. Providers of DSMES working within a larger organization will have the organization document recognition of and support of quality DSMES as an integral component to their mission. For smaller or independent providers of DSMES, they will identify and document their own appropriate mission, goals, and structure to fit the function in the community they serve.	***Standard one relates to your service's formalized internal structure.*** **ORGANIZATION CHART** – illustrating where the DSMES services fit into the greater organization and clear channels of communication to the service from sponsorship, including all DSMES team members. 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 service's present capabilities, customer focus, and activities. The **GOALS** identify the intended activities needed to accomplish the mission. **LETTER OF SUPPORT** – program must submit with application. Support must come from administrative level to which the program reports. If your program is small and you are the sponsoring organization or owner please write a statement of support for the DSMES service demonstrating the program's commitment to the people with diabetes in your community. Examples of administrators from your sponsoring organization who could provide your letter of support are CEO, President, Director, Clinical Manager, Quality Manager or Director, Owner, Supervisor, etc.	1. Clearly Documented organizational structure YES ☐ NO ☐ 2. Documentation of mission statement and program goals YES ☐ NO ☐ 3. Letter of support from sponsoring organization/owner YES ☐ NO ☐

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Standard 2: Stakeholder Input *The provider(s) of DSMES services will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.*	The purpose of seeking stakeholder input in the ongoing planning process is to gather information and foster ideas that will improve the utilization, quality, measurable outcomes, and sustainability of the DSMES services. A planned, documented strategy to engage and elicit input from stakeholders will shape how DSMES is developed, utilized, monitored, and evaluated. If the provider of DSMES is experiencing a lack of referrals or low utilization, the stakeholders can assist with the solution. The goal is to provide effective and dynamic DSMES services that are person-centered, culturally relevant, and responsive to the referring practitioner and participant-identified needs, ultimately engaging participants in lifelong learning.	***Standard two relates to the service seeking input from key stakeholders and experts in their community***. **Method** A formal advisory board or committee is not required, but the DSMES provider must engage key stakeholders to elicit input on DSMES services and outcomes. Input can be completed by phone, survey, email or face-to-face. **Stakeholders** Stakeholders should be representative of the community where the services are provided and can be identified from DSMES participants, referring practitioners, and community based groups that support DSMES (e.g, health clubs and health care professionals [both within and outside of the organization] who provide input to promote value, quality, access, and increased utilization. **Timing** Programs will attest to the completion of stakeholder input on their annual status report and will be required to submit evidence of this documentation during onsite/desk audits by AADE and/or Medicare.	4. Evidence of a documented process for seeking outside input and includes a list of identified stakeholders YES ☐ NO ☐ 5. The program's outreach to community stakeholders and the input from these stakeholders must be documented annually and available for review as requested YES ☐ NO ☐

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Standard 3: Evaluation of population served *The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services.*	Currently the majority of people with and at risk for diabetes do not receive DSMES. Providers of DSMES, after clarifying the specific populations they are able to serve, must understand their community and regional demographics. Individuals, their families, and communities require education and support options and tools that align with their needs. Understanding the population's demographic characteristics, including ethnic/cultural background, sex, age, levels of formal education, literacy, and numeracy as well as perception of diabetes risk and associated complications is necessary. It is essential to identify the barriers that prevent access to DSMES during the assessment process. Individual' barriers may include socioeconomic or cultural factors, participant schedules, health insurance shortfalls, perceived lack of need, and limited encouragement from other health care practitioners to engage in DSMES. Creative solutions incorporating technology to increase reach and engagement must be examined. Telehealth, electronic health records, mobile applications, and cognitive computing will proactively identify and track participants while offering endless opportunities for individualized and contextualized DSMES.	***Standard 3 relates to the service's knowledge and understanding of the population they serve and could potentially serve in their community.*** **Demographic Data** In order to design services that align with the characteristics and needs of the community served, the provider of DSMES services must document and review available demographic data for their area and update as needed. **Resources** Determine factors that prevent people with diabetes from attending DSMES. Services such as learning session frequency and length should be designed based on the population's needs and accessibility. Considerations must be made for space, equipment, materials, curriculum, staff, interpreter services, accommodations for low vision, hearing impaired, disabled, low literacy, etc. **Noteworthy Practice** Quality coordinator should utilize stakeholders to provide input to solve access problems and gaps in services.	6. Documentation of community demographics for the area where DSMES services are provided YES ☐ NO ☐ 7. Documented allocation of resources to meet population specific needs YES ☐ NO ☐ 8. Documentation of actions taken to overcome access-related problems YES ☐ NO ☐

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Standard 4: Quality Coordinator Overseeing DSMES Services *A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement.*	For DSMES to be sustainable, quality must be a priority. Most importantly, the quality coordinator is charged with collecting and evaluating data to identify gaps in DSMES, providing feedback on the performance of the DSMES services to team members, referring practitioners, and the organization's administrator. The quality coordinator utilizes data mining to inform payers and members of the health care team of the clinical outcomes of DSMES. Although the quality coordinator does not require additional degrees or certifications in informatics, developing an understanding of these skills-as well as marketing, health care administration, and business management-will be helpful as the health care environment evolves.	***Standard 4 focuses on the leadership of the services through the quality coordinator.*** **Qualifications** Quality coordinators must be aggregators of data and be able to communicate outcomes to key stakeholders. Resume and/or CV must reflect experience with chronic disease management, facilitating behavior change, and experience with managing clinical services and lists current position as providing oversight of DSMES services. In order to provide adequate oversight, the quality coordinator may need to expand their skills in business-related areas such as program management, education, chronic disease care, behavior change. **Oversight of DSMES Services** The quality coordinator is responsible for implementation of the standards, ensuring services are evidence-based, making sure service design incorporates population needs, ensuring ongoing service evaluation and continuous quality improvement plan is reviewed at least annually. Examples of documentation of the coordinator's oversight include but are not limited to a resume or CV, a job description, competencies, or a performance review. **Continuing Education Documentation** Documentation of continuing education must be on an official transcript or copies of CE certificates; a listing or spreadsheet generated by the team member is not adequate. Documentation must be collected annually based upon calendar year or accreditation date, but must be consistent throughout the 4-year accreditation cycle. Initial accreditation requires credits to be obtained within the 12 months prior to applying for accreditation.	9. Evidence of coordinator's resume and/or CV YES ☐ NO ☐ 10. Evidence of documentation that the quality coordinator provides oversight of DSMES services, which includes: • Implementation of the standards • Ensuring services are evidence-based • Making sure service design incorporates population needs • Ensuring ongoing service evaluation and continuous quality improvement plan is reviewed at least annually YES ☐ NO ☐ 11. Documentation that the Quality Coordinator obtained a minimum of 15 hours of CE credits within 12 months prior to accreditation and annually throughout the accreditation 4-year cycle OR maintain current CDE or BC-ADM certification. YES ☐ NO ☐

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Standard 5: DSMES Team *At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDE®) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.*	The evidence supports an inter-professional team approach to diabetes care, education, and support. Current research continues to support nurses, dietitians, and pharmacists as providers of DSMES responsible for curriculum development. Expert consensus supports the need for specialized clinical knowledge in diabetes and behavior change principles for DSMES team members. Registered nurses, registered dietitian nutritionists, pharmacists, and members of health care disciplines that hold a certification as a CDE or BC-ADM can perform all the DSMES services including clinical assessments. Diabetes paraprofessionals, e.g. medical assistants, community health workers, peer educators, etc. can instruct, reinforce self-management skills, support behavior change, facilitate group discussion, and provide psychosocial support and ongoing self-management support. Paraprofessionals must receive continuing education specific to the role they serve within the team and must directly report to the quality coordinator or one of the qualified DSMES team members. For services outside the expertise or scope of the professional or paraprofessional, there is a mechanism in place to ensure that the participant is referred to the appropriate health care professionals.	***Standard 5 focuses on the members of the DSMES team, their training and credentials.*** **Maintenance of Credential** Professional educators must maintain their current credentials. Professional 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. **Paraprofessionals** Paraprofessionals with additional training in DSMES effectively contribute to the DSMES team. Paraprofessional team members need continuing education specific to the role they serve within the team and clear documentation of that training. Examples of this training can include structured training such as the AADE Career Paths, Stanford, or DEEP, other state-specific certification training programs in diabetes. Another example can be training designed by an organization and should include competencies specific to the paraprofessional's role in DSMES. A resource for paraprofessional competencies can be found in the Competencies for Diabetes Educators and Diabetes Paraprofessionals at https://www.diabeteseducator.org/docs/default-source/practice/practice-resources/comp003.pdf?sfvrsn=2%20%20%20%20praclev2016.pdf Training obtained within the required timeframe may also fulfill the continuing education requirement for paraprofessionals. **Documentation of Continuing Education** Documentation of continuing education must be on an official transcript or copies of CE certificates; a listing or spreadsheet generated by the team member is not adequate. Documentation must be collected annually based upon calendar year or accreditation date, but must be consistent throughout the 4-year accreditation cycle. Initial accreditation	12. Documentation explaining a mechanism for ensuring participant needs are met if needs are outside of the diabetes professional or paraprofessional's scope of practice and expertise YES ☐ NO ☐ **Professional Team Members** 13. Document that at least one of the team members is an RN, RD or pharmacist with training and experience pertinent to DSMES, **OR** a member of a health care discipline that holds certification as a CDE or BC-ADM YES ☐ NO ☐ 14. Evidence of current credentials for every professional team member including valid licensure, registration and/or certification YES ☐ NO ☐ 15. Evidence of at least 15 hours of diabetes-related continuing education annually for all professional team members **OR** evidence of current CDE or BC-ADM credential. YES ☐ NO ☐ **Paraprofessional Team Members** 16. Must demonstrate previous experience or training, in diabetes, chronic disease, health and wellness, community health, community support, healthcare, and/or education

		requires credits to be obtained within the 12 months prior to applying for accreditation.	methods either through a resume or certificate. YES ☐ NO ☐ 17. Evidence of at least 15 hours of diabetes-related continuing education annually specific to the role they serve within the team YES ☐ NO ☐ 18. Documentation that the diabetes paraprofessional directly reports to the quality coordinator(if a healthcare professional) or one of the professional DSMES team members YES ☐ NO ☐

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Standard 6: Curriculum *A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.*	The curriculum is the evidence-based foundation from which the appropriate content is drawn to build an individualized education plan based on each participant's concerns and needs. The following core content areas demonstrate successful outcomes and must be reviewed to determine which are applicable to the participant: -preventing, detecting and treating chronic complications; (including immunizations and preventive eye, foot, dental, and renal examinations as indicated per the individual participant's duration of diabetes and health status), healthy coping with psychosocial issues and concerns, problem solving. The curriculum must be supplemented with appropriate resources and supporting educational materials and must be dynamic. It is crucial that the content be tailored to match individual's needs and be adapted as necessary for age, developmental stage, type of diabetes, cultural factors, health literacy and numeracy, and comorbidities.	***Standard six specifies the type of curriculum and how it will be utilized to meet the participants' needs.*** **Curriculum** Adaptation of the curriculum must also take into account learning style preferences and may involve practical problem-solving approaches. 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 most effective. An education plan based on the individual assessment will determine which elements of the curriculum are required for each participant. **Core Content Areas** (Type 1 &2, GDM, secondary, pregnancy complicated by diabetes) in the following topic areas: • Pathophysiology and treatment options • Healthy eating • Physical activity • Medication usage • Monitoring, including pattern management • Preventing, detecting and treating acute (hypo/hyper, DKA, sick days, severe weather or crisis supply management) and chronic complications (immunizations, eye, foot, dental, exams and kidney function testing as indicated) • Healthy coping • Problem solving	19. Documentation of an evidence-based curriculum that is reviewed at least annually and updated as appropriate to reflect current evidence, practice guidelines and cultural appropriateness (see Interpretive Guidance for core content areas). YES ☐ NO ☐

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Standard 7: Individualization *The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES team member(s) will develop an individualized DSMES plan.*	The DSMES services must be designed using person-centered care practices, in collaboration with the participant, focusing on the participant's priorities and values. **The most important element to appreciate is that no participant is required to complete a set DSMES structure.** When participants have achieved their goals, they can determine that their *initial* DSMES intervention is complete. However, DSMES is an ongoing, lifelong process with ongoing assessments of AADE7 Self-Care Behaviors and continual support. Evidence-based communication strategies such as collaborative goal setting, action planning, motivational interviewing, shared decision making, cognitive behavioral therapy, problem solving, self-efficacy enhancement, teach back, and relapse prevention strategies are effective. Incorporating PGHD, especially BG and or CGM data into decision-making individualizes self-management and empowers participants to fully engage in personal problem solving to change behavior and improve outcomes. A variety of assessment modalities, including online assessments via consumer portals and EHR, tablet computers that integrate with EHR, text messaging, web-based tools, automated telephone follow-up, and remote monitoring tools can be used. Documentation of participant contact with DSMES team members will guide the education process, provide evidence of communication among other members of	***Standard 7 focuses on ensuring that the education provided is individualized for each participant. <u>Professional</u> members of the team will assess each participant to collaboratively determine the best interventions and support strategies for them.*** **De-identified chart** According to HIPAA regulations, name, date of birth, address, provider, names, addresses, telephone numbers, email addresses, medical record numbers, health plan beneficiary numbers, and account numbers, need to be deleted from the record. **Individual Assessment** The assessment must incorporate the individual's: Health status • relevant medical and diabetes history • physical limitations • hospitalizations or ER visits related to diabetes Psychosocial adjustment • emotional response to diabetes/diabetes distress • social support systems • readiness to change • financial means Learning level • diabetes knowledge • health literacy and numeracy Lifestyle practices • cultural influences • health beliefs and attitudes • diabetes self-management skills and behaviors The assessment can be done individually or in a group. The participant may complete a self-assessment before the initial visit. The process should be appropriate for the population served and documented in the health record. **Education Plan** The health care professional uses the information gleaned on assessment to determine the appropriate educational and behavioral interventions, including enhancing the participant's	20. Completely de-identified patient chart must include evidence of ongoing education planning and behavioral goal setting with follow up, based on collaboratively identified participant needs YES ☐ NO ☐ 21. Evidence that assessment is performed in the following areas in order to prepare the education plan (see Interpretive guidance for areas that must be assessed) YES ☐ NO ☐

	the individual's health care team, and demonstrate adherence to guidelines.	problem-solving skills. The plan needs to be developed collaboratively with the participant and family or others involved with the participant's care as required. This will guide the process of working with the participant and must be documented in the education records.	

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Standard 8: Ongoing Support *The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will best maintain their self-management needs.*	Ongoing support is defined as resources that help the participant implement and sustain the ongoing skills, knowledge, and behavior changes needed to manage their condition. The vital point is that the participant selects the resource or activity that best suits their self-management needs. A person-centered approach is recommended to incorporate ongoing support plans in clinical care.	***Standard 8 focuses on the importance of ongoing support beyond the initial DSMES services.*** **Support** Support can include internal or external group meetings (connection to community and peer groups online or locally), ongoing medication management, continuing education, resources to support new or adjustments to existing behavior change goal setting, physical activity programs, weight loss support, smoking cessation and psychological support, among others. Peer support using social networking sites improves glucose management, especially in people with Type 2 diabetes. It may be useful to highlight the benefits and accessibility of online diabetes communities as a resource to help participants learn from others living with the condition, facing similar issues, and is available 24 hours a day, 7 days a week. **Community Resources** DSMES providers need to identify community resources that may benefit their participants and support their ongoing efforts to maintain their achievements reached during active participation in the DSMES services. The community resource ongoing support list must be reviewed periodically to keep it up to date. Examples of community resources include the local YMCA, activity-related classes at a senior center, a local support group, grocery store tours at the local grocer, local food shelf, a walking group or local walking trails, community center swimming pool, church group, dental school for discounted or free cleanings, local mental health services, etc.	22. De-identified Chart must also include documentation of ongoing self-management support options specific to the community where the DSMES services are delivered, with participant preferences noted YES ☐ NO ☐

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Standard 9: Participant Progress *The provider(s) of DSMES services will monitor and communicate whether participants are achieving their personal diabetes self-management goals and other outcome(s) to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.*	The provider of DSMES will rely on behavior change goal setting strategies to help participants meet their personal targets. The role of the DSMES team is to aid the goal setting process and adjust based on participant needs and circumstances. Validly measuring the achievement of SMART goals (specific, measureable, achievable, relevant, and time-bound) and action planning, including assessment of confidence and conviction is essential. To demonstrate the benefits of DSMES, it is important for DSMES providers to track relevant evidence-based DSMES outcomes such as knowledge, behavior, clinical, quality of life, cost-savings, and satisfaction outcomes. Tracking and communication of individual outcomes must occur at appropriate intervals, for example, before and after engaging in DSMES.	***Standard 9 focuses on participant progress in behavioral and clinical outcome measures, and the effectiveness of the educational interventions.*** **Goal Setting** The AADE7™ Self-Care behaviors serve as a useful framework for documenting behavior change. Participants do not need to work on all seven behaviors at once. Most will select one or two initial goals and all goals must be SMART goals (specific, measureable, achievable, relevant, and time-bound). **Other Measures** Clinical outcome measurements need to be chosen based on the population served, organizational practices, and availability of the outcome data. In order to determine the impact of DSMES services, the coordinator must compare outcomes after engagement in DSMES services with a baseline. **Communication to Provider** DSMES providers must communicate individual outcomes back to the referring provider. A summary of the education provided and the participant outcomes, both clinical and behavioral, demonstrates the benefits of DSMES.	23. De-identified chart must also show evidence of: a. At least one SMART behavioral goal with follow up and measured achievement YES ☐ NO ☐ b. Documentation of at least one clinical outcome measure to evaluate the effectiveness of the educational intervention YES ☐ NO ☐ 24. For all Medicare Providers, there must be communication back to the referring provider including the education provided, and the participant outcomes YES ☐ NO ☐

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Standard 10: Quality Improvement *The DSMES service quality coordinator will measure the impact and effectiveness of the DSMES service and identify areas for improvement by conducting a systematic evaluation of process and outcome data.*	Formal quality improvement strategies can lead to improved diabetes outcomes. By measuring and monitoring both process and outcome data on an ongoing basis, providers of DSMES can identify areas of improvement and adjust participant engagement strategies and service offerings accordingly. Evaluation can contribute to the sustainability of the service. Once areas of improvement are identified, the DSMES quality coordinator determines timelines and important milestones, including data collection, analysis, and presentation of results. Process measures are often targeted to those processes that affect the most important outcomes. A variety of methods can be used for quality improvement initiatives, such as the Plan Do Study Act model, Six Sigma, Lean, Re-AIM, and workflow mapping.	***Standard 10 relates to the process by which programs assess their operations, including the delivery of education and support.*** **Collecting and Reporting Data** DSMES providers must have a procedure in place to collect, aggregate, analyze, and report clinical and process outcomes and behavioral goal achievement. Evidence of this procedure will need to be submitted at the time of application. Examples of outcomes to measure include but are not limited to: *Process outcomes:* wait times, program attrition, referrals, education process, reimbursement issues, follow up *Clinical outcomes:* A1c's, % of body weight lost, foot and eye exams, ER visits, newborn weight, C-section delivery rate, hospitalization days, ER visits *Behavioral outcomes:* participant satisfaction, behavioral goal achievement, reduction in diabetes distress Three fundamental questions should be answered by the CQI project: 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? **Timing** CQI is a cyclical, data-driven process, which is proactive, not reactive. Data for the CQI plans is collected and used to make positive changes-even when things are going well, rather than waiting for something to go wrong and then fixing it. All DSMES sites, including new entities, must be able to show implementation of the CQI plan by the six-month mark. A program may be randomly selected within their first year of accreditation to submit their CQI plan. Annually, DSMES providers will need to submit a report of their CQI project from the previous 12 months through their anniversary date, and their CQI plan for the next 12 months.	25. Evidence of a procedure for collecting aggregate data to use for analysis of clinical, behavioral and process outcomes YES ☐ NO ☐ 26. Documentation of a CQI project measuring the effectiveness and impact of the DSMES services that identifies areas of improvement through the evaluation of process and outcome data and is reviewed and reported annually YES ☐ NO ☐