Standard 7

National Standard	Essential Highlights	Interpretive Guidance	Checklist
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 the individual's health care team, and demonstrate adherence to guidelines.	***Standard 7 focuses on ensuring that the education provided is individualized for each participant. Professional 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 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.	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 ☐

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.

AADE Interpretive Guidance:

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.

The 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.

A complete, individualized education plan is required for each participant that includes interventions and desired outcomes. The education plan is 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 record.

Documentation must also include topics covered in individual or group sessions along with goal setting and follow up on progress of those goals.

Documentation Requirements for Standard 7:

The components for this standard are:
☐ 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
☐ Evidence that assessment is performed in order to prepare the education plan (see interpretive guidance for areas that must be assessed)

Diabetes self-management skills and behaviors (AADE7 Self Care Behaviors)

- The participant and team member collaboratively develop an individualized DSMES Education Plan based on the assessment focusing on the participant's priorities and values.
- No Participant is required to complete a set DSMES structure.
- The plan outlines the content areas to be covered and number of sessions planned to attend.

Frequently asked questions about the de-identified participant chart are as follows:

What is a "de-identified" chart?

Any information in the medical record that may be linked to an individual must be removed before submitting your de-identified chart with your application materials. The privacy standards that are part of the Health Insurance Portability and Accountability Act (HIPPA) require protection of "individually identifiable" health information. Removing any unique identifying number, characteristics, or codes from the participant chart you submit protects you from any HIPPA violation. Examples of the type of information that must be removed are:

- Name
- Geographic subdivision smaller than a state (street address, city, precinct, zip code)
- Telephone or fax numbers
- E-mails
- Social Security number
- Medical record number
- Health plan beneficiary number
- Account number
- Date of Birth
- Never submit any patient over the age of 89

Why it is necessary to submit a patient chart and what parts do I need to include?
Reviewing documentation about the care that was actually provided is a significant part of the accreditation review process and it is used for most accreditation and/or certification processes.

How do I "de-identify" the patient's information?
Using black permanent marker is usually sufficient to effectively hide any data that identifies the patient/participant. Some people have found that using a combination of blue and black markers does a better job of concealing. You could also use "White-Out" or a strip of correction tape.

PLEASE HAVE 1-2 OTHER PEOPLE IN YOUR ORGANIZATION DOUBLE CHECK THAT THE CHART IS COMPLETELY DE-IDENTIFIED PRIOR TO SUBMISSION TO AADE.

How do I submit the patient record if I use an electronic health record?
Depending on the brand of "EHR" you are using, there may be different ways to submit your de-identified chart. Here are some tips:

- Use AADE DSMES Chart Review Form on Page 27 of this manual as a cover page for your de-identified chart.
- Print the components of the participant chart identified in the AADE Chart Review Form below.
    - Number and circle each component 1-20 to match Chart Review Form and provide any additional notes on Chart Review Form as needed.
    - Be sure to de-identify all PHI
    - Remove extraneous information to reduce number of pages submitted
    - Scan and submit via DEAP Dashboard
- Obtain a "screen shot" of the components of the record needed
    - Save the components identified above in a format that can be saved
    - Number and circle each component 1-20 to match Chart Review Form and provide any additional notes on Chart Review Form as needed.
    - De-identify the screen shot version of the electronic health record
    - Save the de-identified version to submit via DEAP Dashboard
- If the electronic health record does not include the actual assessment questions, (e.g., only the "answers"), submit a template of the assessment form so the reviewer can determine that the assessment process included the necessary

Additional Resources

- Sample Referral Form
- Sample Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

AADE Resources Available

- DEAP webinar on Charting for DSMT and Webinar Slides

DEAP
Diabetes Education Accreditation Program
AADE American Association of Diabetes Educators

AADE American Association of Diabetes Educators

DSMES Chart Review Form

Category	Item	#	Comments
Referral Order	Referral for DSME/T in chart (Medicare requirement)	1	
Assessment of Health Status	Relevant medical and diabetes history	2	
	Physical limitations	3	
	Current health service or resource utilization (hospitalizations, ER visits related to diabetes)	4	
Assessment of Psychosocial Adjustment	Emotional response to diabetes/diabetes distress	5	
	Social Support systems	6	
	Readiness to learn	7	
	Financial Means	8	
Assessment of Learning Level	Diabetes knowledge	9	
	Literacy and numeracy level	10	
Assessment of Lifestyle Practices	Cultural influences	11	
	Health beliefs and attitudes	12	
	Diabetes self-management skills and behaviors	13	
Standard 7	Ongoing education planning and behavioral goal setting with follow up, based on collaboratively identified participant needs	14	
	Documented individualized follow-up on education and goals	15	
	For Medicare participants, communication back to the referring provider including the education provided, and the participant outcomes	16	
Standard 8	Ongoing self-management support options specific to the community where the DSMES services are delivered, with participant preferences noted	17	
Standard 9	At least one clinical outcome measure to evaluate the effectiveness of the educational intervention	18	
	Collaborative development of at least one SMART behavioral goal with follow up and measurement achievement	19	
	For Medicare participants, communication back to referring provider with education provided and participant outcomes	20	