Auditor Checklist Date of Audit:

Program Name and ID#: Auditor:

Location (city, state):

YES ☐ NO ☐ Certificate is posted in area where participants are seen and not expired

YES ☐ NO ☐ Complaints and Patient Rights posters posted in area where participants are seen

YES ☐ NO ☐ Classroom size is adequate for population

YES ☐ NO ☐ Resources sufficient to meet population needs (E.g. materials, curriculum staff, support etc…)

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| **Standard 1:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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. | **AUDITOR’S COMMENTS** |

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| **Standard 2:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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. | **AUDITOR’S COMMENTS** |

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| **Standard 3:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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. | **AUDITOR’S COMMENTS** |

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| **Standard 4:**  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  •Ensuringongoing 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 ☐ | **INTERPRETIVE GUIDANCE**  *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. | **AUDITOR’S COMMENTS** |

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| **Standard 5:**  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 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 ☐ | **INTERPRETIVE GUIDANCE**  *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.  PARARPROFESSIONALS  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 requires credits to be obtained within the 12 months prior to applying for accreditation. | **AUDITOR’S COMMENTS** |

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| **Standard 6:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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 | **AUDITOR’S COMMENTS** |

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| **Standard 7:**  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 order to prepare the education plan (see interpretive guidance for areas that must be assessed)  YES ☐ NO ☐ | **INTERPRETIVE GUIDANCE**  *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  **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. | **AUDITOR’S COMMENTS** |

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| **Standard 8:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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, available 24 hours a day, 7 days a week, when it is convenient for them to engage.  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. | **AUDITOR’S COMMENTS** |

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| **Standard 9:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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 PROVIDERS  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. | **AUDITOR’S COMMENTS** |

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| **Standard 10:**  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 ☐ | **INTERPRETIVE GUIDANCE**  *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. | **AUDITOR’S COMMENTS** |

**AUDITOR’S SUMMARY/RECOMMENDATIONS:**