



North Carolina Diabetes Education Recognition Program

Standards and Procedures for Diabetes Self-Management Education For Local Health Departments

September 2009

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North Carolina Diabetes Education Recognition Program Standards and Procedures for Diabetes Self-Management Education

POLICY

The policy of the NC Diabetes Education Recognition Program and its participating local health departments is to adhere to the standards for diabetes self-management education (DSME) issued by the American Diabetes Association (ADA). These national standards are updated and published each year in *Diabetes Care*.

ADA NATIONAL STANDARDS FOR DIABETES SELF MANAGEMENT EDUCATION

Diabetes self-management education (DSME) is a critical element of care for all people with diabetes and is necessary in order to improve patient outcomes. The National Standards for DSME are designed to define quality diabetes self-management education and to assist diabetes educators in a variety of settings to provide evidence-based education. Because of the dynamic nature of health care and diabetes-related research, these Standards are reviewed and revised approximately every 5 years by key organizations and federal agencies within the diabetes education community.

DEFINITION AND OBJECTIVES

Diabetes self-management education (DSME) is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.

GUIDING PRINCIPLES

Before the review of the individual Standards, the ADA Task Force identified overriding principles based on existing evidence that would be used to guide the review and revision of the DSME Standards. These are:

1. Diabetes education is effective for improving clinical outcomes and quality of life, at least in the short-term.
2. DSME has evolved from primarily didactic presentations to more theoretically based empowerment models.
3. There is no one “best” education program or approach; however, programs incorporating behavioral and psychosocial strategies demonstrate improved outcomes. Additional studies show that culturally and age-appropriate programs improve outcomes and that group education is effective.
4. Ongoing support is critical to sustain progress made by participants during the DSME program.
5. Behavioral goal-setting is an effective strategy to support self-management behaviors.

STANDARDS

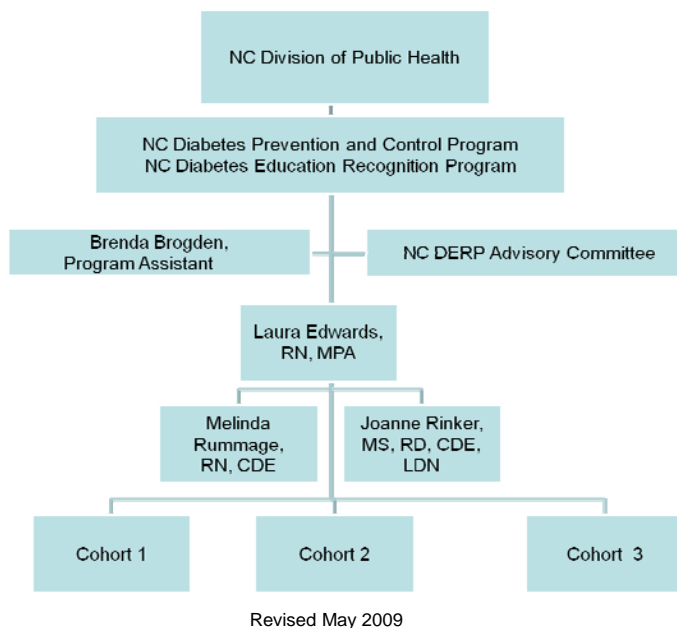
Structure

Standard 1 - Structure, Mission Statement and Goals

The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.

How NC DERP meets this standard:

The NC Division of Public Health is the sponsoring agency for the NC DERP, and the program is housed within the NC Diabetes Prevention and Control Program. The NC DERP has an established Advisory Committee that is responsible for oversight of the program, which is administered by the state program staff (Coordinator and Diabetes Education Specialists) and participating local health departments.



Mission: The NC DERP’s mission is to provide quality comprehensive diabetes self-management education to empower persons with diabetes.

Goals: NC DERP goals for this program are:

Participant Behavioral Outcomes: Self Foot Exams

Goal: 75% of patients report they are checking their feet daily.

Program Outcome Measure: Hemoglobin A1c

Goal: 75% of patients with a pre- and post-test will have a Hgb A1c of 7% or less.

Standard 2 – Advisory Group

The DSME entity shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.

How NC DERP meets this standard:

The NC Diabetes Education Recognition Program has an advisory committee that meets at least once each year. The Advisory Committee membership includes health professionals, persons with diabetes, community partners and other stakeholders. There is at least one member from each Cohort, as well as representation from the eastern and western geographic regions.

The members are: Laura Edwards, RN, MPA, Chair (NC DERP Program Coordinator); Donald J. Yousey (Health Director, Brunswick County Health Department); Janice Patterson, RN (Health Director, Clay County Health Department); William J. Smith (Health Director, Robeson County Health Department); Elizabeth MacLachlan, MPH, RD(Executive Director, North Carolina Public Health Foundation); Melvin Jackson (Program Manager, Wake County Human Services/Project DIRECT/Strengthening the Black Family); Wanda Robinson (Health Director, Sampson County Health Department); Deborah Porterfield, MD, MPH (University of NC at Chapel Hill); Bryan Belcher (Watauga County Healthy Carolinians); Cindy Haynes-Morgan, MSA-PA, CHES, RHED (Education and Community Program Coordinator, NC Diabetes Prevention and Control Program); Phillip Tarte, Jr. (Health Director, Union County Health Department) and Beth Lovette, RN (Health Director, Wilkes County Health Department).

Standard 3 – Identify Needs and Resources

The DSME entity will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.

How NC DERP meets this standard:

The NC DERP requires each site that applies to participate in the program to describe and document the target population and community resources. The data is reported to ADA during the application process. In addition, each participating site is asked for an annual update on the target population, access to care, populations served, barriers to care, education levels, cultural influences, transportation issues, economic issues, resources and community concerns.

Standard 4 – Program Coordinator

A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.

How NC DERP meets this standard:

The coordinator for the NC Diabetes Education Recognition Program is Laura Edwards, RN, MPA.

PROCESS

Standard 5 - Instructors

DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.

How NC DERP meets this standard:

The NC Diabetes Education Recognition Program requires each site to have an RN, RD, or Pharmacist. Instructional staff must submit copies of relevant licensure and certifications to NC DERP. Other instructional staff members must be CDE-eligible.

Resource persons (non-CDE eligible staff such as health educators) must provide less than 10% of the educational content of the program and only in the subject matter of the resource person's area of expertise. Instructional staff is responsible for content taught by resource persons and oversees the work of the resource persons.

The NC Diabetes Education Recognition Program requires all non-CDE instructional staff to have 20 hours of continuing education per year (April to April) and submit proof to the NC DERP.

The hours of continuing education may be in any one or any combination of the following topics: diabetes specific, diabetes related, psychosocial, education and program management. These topics are defined as follows:

- Diabetes specific is any program or session topic or any program objective or course outline heading that specifically addresses diabetes.
- Diabetes related is any program or session topic or any program objective or course outline heading that clearly states issues related to diabetes, but does not specifically use the word, "diabetes." These topics can be, but not limited to the following: nutrition, exercise, retinopathy, nephropathy, neuropathy, cardiovascular disease, stroke, lipids, obesity, metabolic syndrome, etc.
- Psychosocial is any program or session topic or any program objective or course outline heading that clearly articulates psychiatric, psychological, behavior modification or social content.
- Educational is any program or session topic or any program objective or course outline heading that uses any one of the following words: teaching, knowledge, learning, education, training, instruction, or culture.
- Program Management is any program or session topic or any program objective or course outline heading pertaining to the operations of the DSME, including business operations, performance improvement, case and disease management.

All Continuing Education Units (CEUs) must be awarded from an agency that accredits Continuing Education Programs. Examples of these agencies are AADE, ACCME, ADA, ACPE, ANCC, CDR.

Standard 6 - Curriculum

A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME entity. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided:

Describing the *diabetes disease process* and *treatment options*

Incorporating *nutritional management* into lifestyle

Incorporating *physical activity* into lifestyle

Using *medication(s)* safely and for maximum therapeutic effectiveness

Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making

Preventing, detecting, and treating *acute complications*

Preventing detecting, and treating *chronic complications*

Developing personal strategies to address psychosocial issues and concerns

Developing personal strategies to promote health and behavior change

How NC DERP meets this standard:

The NC Diabetes Education Recognition Program uses the NC DSME curriculum developed by the NC DHHS Division of Public Health, Diabetes Prevention and Control Program. All participating sites are required to use this curriculum.

Standard 7 – Assessment and Education Plan

An individual assessment and education plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.

How NC DERP meets this standard:

Each site must establish and maintain an individual education record for each participant. The NC Diabetes Education Recognition Program requires all sites to use the same forms. Forms are reviewed with each site prior to implementation, and a copy of each form is to each site on a CD for easy replication.

The Education Record should include:

1) Referral from a primary care provider.

2) Comprehensive assessment – A comprehensive assessment must be done with each participant. This assessment must include the participant’s diabetes knowledge, self-management skills, diabetes and health related behaviors, behavioral change potential and other relevant information, including medical history. The assessment can be ongoing; parts of it may be deferred and documented as such with rationale for the deferment.

A self-assessment or knowledge pre-test **may not** serve as the sole means of assessing and documenting the participant's knowledge, skill level and behaviors.

3) Education plan with participant selected behavioral objectives based on the assessed needs of the participant – The education record should document a plan which includes at least one patient identified behavioral objective (with educator assistance as needed.) The behavioral objective documentation should include the specific behavior that the participant is interested in changing, how the participant will change that behavior, and how that change in behavior will help to improve the participant’s health or quality of life.

4) Educational interventions which include date of intervention, content taught and name(s) of instructors – The instruction should be based on the assessed needs of the participants, education plan and behavioral objectives. The content areas taught should be documented, along with the date of instruction and identification of each instructor who taught the specific objective or content area.

5) Evaluation of progress towards behavioral goals and related health or quality of life outcomes, and/or achievement of learning objectives – After the educational intervention, the educator must assess and document whether the participant is making progress towards or has met the learning and behavioral objectives. As the participant meets the outlined objectives, new objectives should be developed as appropriate. If the participant is unable to meet the outlined objectives the participant’s needs should be reassessed and new achievable objectives should be developed. The follow-up assessments and progress toward objectives, both learning and behavioral should be documented.

6) Communication with the referring provider, including plan for Diabetes Self-Management Support (DSMS) - DSMS is a plan, developed by the participant and the educator(s), for ongoing self-management support after completing formal DSMT. The purpose is to identify and link the participant to diabetes resources in her or his home/work/school community that will sustain learning achieved in the DSME. This can include returning to referring provider services, support groups, refresher courses, community programs, etc. The DSME is not required to follow-up on the plan. Providing a list of resources to the patient will NOT meet this criteria.

Standard 8 – Ongoing Self Management Support

A personalized follow-up plan for ongoing self management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self management support will be communicated to the referring provider.

How NC DERP meets this standard:

Each site will work with participants to establish a follow up plan for ongoing self management support (Refer to item number 6 in Standard 7). Each site will identify community resources appropriate for participants needs. The NC Diabetes Education Recognition Program supplies each site with a 3-month follow up form, which can be used for physician communication, or sites may use the Tiara software program to generate a follow up letter.

OUTCOMES

Standard 9 – Goals and Outcomes

The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.

How NC DERP meets this standard:

The NC Diabetes Education Recognition Program maintains the ADA standard that all patients set a behavior change goal at patient contact. These forms are kept in the patient chart for re-assessment at subsequent visits. Forms include (but are not limited to) : assessment, additions to the assessment, medication list, goal sheet, education record—part 1, interdisciplinary form, progress note and blood glucose monitoring form.

Standard 10 – Continuous Quality Improvement

The DSME entity will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.

How NC DERP meets this standard:

Continuous Quality Improvement (CQI) is a formal process/plan that is a cyclic series of steps designed to enhance DSME processes leading to improved participant and DSME outcomes. The N.C. Division of Public Health has adopted the PDSA (Plan, Do, Study, Act) methodology for quality improvement.

In addition, participating local health departments will utilize a formal continuous quality improvement plan/process to evaluate the effectiveness of the DSME program at the site, and whether the results of the continuous quality improvement evaluation are used to determine opportunities for improving DSME services at the site.

Results of all performance improvement activities will be reported during the annual meeting of the Advisory Committee, and recommendations for action will be made. The results obtained will be used as part of the PDSA process to improve the diabetes self-management education program offered at the sites to ensure that all ADA Standards are met.

Monthly PDSA

Each site will participate in quality improvement activities, and will have a current project in progress. The NC DERP will provide CQI and PDSA education. Each site will submit a monthly PDSA report. The Diabetes Education Specialist(s) will review each PDSA report and track progress and outcomes. For each monthly conference call, one site will be asked to report on a PDSA.

Increase in Hemoglobin A1C

For any patient that demonstrates an increase in Hemoglobin A1C (A1C) of 0.5% or greater, the patient should be contacted to return to the health department for an A1C follow-up visit. The patient's education needs should be assessed, as well as any psychosocial factors that may be impacting the patient. Three contact attempts should be made and documented. If the patient does not respond to follow up requests, a note should be sent to their physician stating that three attempts have been made to contact the patient. After three attempts, release the patient back to their physician.

Any site in which a patient has an increase in A1c of .5% or more must complete the Increased A1C form for each patient with an increase in A1C.

Chart Audits

All sites may be asked to complete a documentation chart audit to assure that ADA standards are being met. Audit sheets will be sent to the sites, and the sites will be asked to audit 10 charts, or 10%, whichever is greater. Sites will be given 30 days to complete the audit forms and return them to the Instructional Team. The Instructional Team will review the audit forms for missing components, and will follow up individually with each site to discuss any necessary action. Additionally, NCDERP education specialists will perform chart audits at annual site visits to assure ADA standards are being met.

NC DERP PROGRAM SPECIFIC STANDARDS

Health Department Financial Contributions

Each participating health department will contribute 10% of the income earned from the Diabetes Self-Management Program or \$1,000 (whichever is greater) to the NC Public Health Foundation to sustain the NC DERP.

Minimum Level of Participation

Each health department participating in the Diabetes Self-Management Program must see an average of three patients per month per year.

Data and Reports

Each site will keep ADA required data for each patient in the Tiara database. Each site is required to pay the set up fee and the per patient fee to maintain this data. Reports from this data will be submitted on the 5th of each month along with the current CQI activity for that site and increased A1c reports (as necessary).

Data Collection

For each new site, data collection will start in September of each year and will be continuous from that point forward. The data collection period for the ADA recognition is from January to April of the application year. (Specific beginning and ending dates will vary each year.)

Data tracked in Tiara includes:

1. Demographics
 - a. Age
 - b. Race/ethnicity
 - c. Type of Diabetes
 - d. Special Needs
 - e. Payer mix (Insured, Insured and < 200% poverty level, Uninsured, Medicare, Medicaid)
2. Education
 - a. Patient Visits
 - i. Date
 - ii. Type (initial, class, follow up)
 - b. Hours of education per patient
3. Program Outcome/Behavioral Goal Tracking
 - a. At the initial and follow up appointment, an A1c is completed and documented.
 - b. Foot exams dates are entered into the foot exam drop down spot ONLY when the patient reports checking their feet daily.

Monthly Conference Calls

An educator from each site will participate in a monthly conference call on the first Wednesday of each month from 12-1pm

Assessments

Assessments will be scheduled for one hour as a 1:1 with the Instructional Staff. Forms to be used at the assessment include: assessment, additions to the assessment, medication list, goal sheet, education record—part 1, interdisciplinary form, progress note and blood glucose monitoring form. Patient is then to be entered as a new patient in Tiara. A1c is obtained and entered into Tiara. If an A1c was not performed by the referring provider prior to the assessment, the site is responsible for obtaining A1c, regardless of patient's ability to pay.

Classes

There will be 8 hours of group instruction. All 10 content areas required by ADA must be covered during these classes. All 10 content areas are addressed in the NC diabetes self-management curriculum which is provided to each site and is reviewed at the annual program training. At each and every class, a behavior change goal sheet must be completed and previous goals must be assessed. The interdisciplinary form is used to document class participation, and the information should be entered in Tiara.

Follow Up

Follow up is scheduled as a 1 hour group follow-up. Education record—part 2 is used to assess patients understanding of what they have learned during 8 hours of classes. A1c is obtained and documented on interdisciplinary form as well as Tiara. Goal sheet is filled out and new goal is set. Previous goals are also assessed. Sites are encouraged to establish standing orders for obtaining A1c. Additional follow ups are required if the patient has an increase in a1c, regardless of the patients ability to pay.

Process for Establishing a New Patient

Each site will:

1. Get a signed referral form from the patient's medical provider.
2. Call the patient and set up an appointment with the educator.
3. See the patient for 1 hour initial assessment and address A1c status.
4. Schedule patient for class.
5. At each patient visit, set a behavior change goal.
6. Enter dates of appointments and enter goals into Tiara.
7. See patient in class, assess old goal and set another goal.
8. Have patient back 3 months after the last class for follow up, obtain follow up A1c, assess current goals and set a new goal.
9. Establish a plan for ongoing self-management support.
10. Enter all data into Tiara.
11. Communicate all patient information back to referring MD.

Clinical Policies and Procedures

The NC DERP does not set clinical policy for local health departments, it only sets DSME program policy and procedures. Each participating site is encouraged to establish clinical policies and procedures related to elevated blood pressure, elevated blood glucose, etc.

Source:

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