National Standards for Diabetes Self-Management Education Programs and American Diabetes Association Review Criteria

AMERICAN DIABETES ASSOCIATION

In 1993, the National Diabetes Advisory Board charged the American Diabetes Association to coordinate a task force of representatives of diabetes and other organizations to review, and revise if indicated, the National Standards for Diabetes Patient Education Programs. The Task Force consisted of representatives from the following organizations: The American Association of Diabetes Educators, The American Diabetes Association, The American Dietetic Association, the Centers for Disease Control and Prevention, the Department of Defense, the Department of Veterans Affairs, the Diabetes Research and Training Centers, the Indian Health Service, and the Juvenile Diabetes Foundation, Inc. The task force decided to revise the standards to reflect recent research and current health care trends. Thus, the standards were revised and are now termed the National Standards for Diabetes Self- Management Education Programs. These revised standards have been endorsed by the organizations involved in their development.

NATIONAL STANDARDS FOR DIABETES SELF-MANAGEMENT EDUCATION PROGRAMS AND AMERICAN DIABETES ASSOCIATION REVIEW CRITERIA

— Diabetes mellitus is a chronic metabolic disorder. Individuals affected by diabetes must learn self-management skills and make lifestyle changes to effectively manage diabetes and avoid or delay the complications associated with this disorder. For these reasons, self-management education is the cornerstone of treatment for all people with diabetes. These National Standards, which were developed in collaboration with diabetes organizations, will provide guidance for the establishment and maintenance of quality diabetes self-management education programs.

The process whereby people with chronic diseases, such as diabetes, learn to take care of these disorders has traditionally been termed "patient education." However, over time, this designation has changed and is currently termed "self-management training" and "self-management education," as well as patient education. This document will use the term self-management education to refer to the process whereby individuals learn to manage their diabetes.

These standards provide:

1. Diabetes educators with the means to:

- develop quality self-management education programs.
- assess the quality of their education programs.
- identify areas in their programs where changes and improvements are needed.

2. People with diabetes with the means to:

- assess the quality of the diabetes-related services they receive.
- gain an understanding of the skills needed for self-management.

3. Referral sources, insurers, employers, government agencies, and the general public with:

- a description of quality self-management education services for people with diabetes.
- an awareness of the importance of comprehensive self-management education to enable people with diabetes to effectively manage this disorder.

Quality diabetes self-management education programs can be measured in terms of structure, process, and outcomes. Each of these program components includes one or more elements with specific standards. The broad outline of the National Standards for Diabetes Self-Management Education Programs is as follows:

Structure

- Organization
- Needs assessment
- Program management
- Program staff
- Curriculum
- Participant access

Process

- Assessment
- Plan and implementation
- Follow-up

Outcomes

- Program outcome evaluation
- Participant outcome evaluation

STRUCTURE — The structure necessary to provide quality diabetes self-management education consists of the human and material resources and the

management systems needed to achieve program and participant goals. Such structure includes the support and commitment of the organization that is sponsoring the program, the program administration and management systems, the qualifications and diversity of the personnel involved in the program, the curriculum and instructional methods and materials, and the accessibility of the program.

Organization

The sponsoring organization must provide the support and structure within which the program functions. Organizational commitment to self-management education including operational support, adequate space, personnel, budget, and materials must be clearly evident. Since multiple health care professionals from a variety of disciplines are involved in diabetes care, clear lines of authority and efficient communication systems should be established.

Standard 1. The sponsoring organization shall have a written policy that affirms education as an integral component of diabetes care.

Review criterion

1–1. There is a written statement from the sponsoring organization to reflect that self-management education is an integral component of diabetes care.

Standard 2. The sponsoring organization shall identify and provide the educational resources required to achieve its educational objectives in terms of its target population. These resources include adequate space, personnel, budget, and instructional materials.

Review criterion

2–1. For both individual and group instruction, resources (including space, staff, budget, and educational materials) are adequate to support the programs offered and the participants served.

Standard 3. The organizational relationships, lines of authority, staffing, job descriptions, and operational policies shall be clearly defined and documented.

Review criteria

3–1. The sponsoring institution's organizational chart delineates the placement of the diabetes program, staff, and advisory committee.

3–2. There is a description of the following for the coordinator and each instructional staff member:

- role in the program.
- teaching responsibilities.
- other program responsibilities.
- amount of time spent in the program.

3–3. There are written policies approved by the advisory committee concerning the operation of the program.

Needs assessment

A successful program is based on the needs of the population that the program is intended to serve. Because diabetes populations vary, each organization should assess its service area and match resources to the needs of the defined target population. Needs assessments should guide program planning and management. Periodic reassessment should be done to allow the program to adapt to changing needs.

Standard 4. The service area shall be assessed in order to define the target population and determine appropriate allocation of personnel and resources to serve the educational needs of the target population.

Review Criterion

4–1. The target population is defined (specifically the potential number to be served, types of diabetes, age range, language, ethnicity, unique characteristics, and special educational needs) based on an assessment of the service area.

Program management

Effective management is essential to implement and maintain a successful program and to ensure that resources are adequate for the defined tasks. To ensure that management policies and program design reflect broad perspectives relevant to diabetes, the organization should designate a standing advisory committee that includes health care professionals and people with diabetes to assist staff with program planning and review. Involvement and support from the medical community are also necessary. At times resources outside the sponsoring institution may be required to enable individuals affected by diabetes to maximize their health outcomes.

Standard 5. A standing advisory committee consisting of a physician, nurse educator, dietitian, an individual with behavioral science expertise, a consumer, and a community representative, at a minimum, shall be established to oversee the program.

Review criteria

5–1. The advisory committee members specified above attend at least two meetings a year.

5–2. The health professional members include at least one physician, one nurse educator, and one dietitian, each with expertise in diabetes.

5–3. The individual with behavioral science expertise is any professional with academic preparation in the behavioral sciences: e.g., counseling, health behavior, psychology, social work, sociology.

5–4. The consumer is any individual with diabetes or the caretaker thereof.

5–5. The community representative is any individual not employed by the institution.

5–6. There is a written policy concerning the membership and responsibilities of the advisory committee.

5–7. The advisory committee minutes document that the committee is fulfilling its responsibilities to approve the program plan, recommend and approve policy, and review the program annually.

Standard 6. The advisory committee shall participate in the annual planning process, including determination of target audience, program objectives, participant access mechanisms, instructional methods, resource requirements (including space, personnel, budget, and materials), participant follow-up mechanisms, and program evaluation.

Review criterion

6–1. The advisory committee minutes document the approval each year of a written program plan which includes the items specified above.

Standard 7. Professional program staff shall have sufficient time and resources for lesson planning, instruction, documentation, evaluation, and follow-up.

Review criterion

7–1. The instructors' available hours and resources are adequate to meet the needs of the program and the participants.

Standard 8. Community resources shall be assessed periodically.

Review criterion

8–1. There is a list (including name, address, and telephone number) of community resources within the service area that serve the target population and their families. This list is updated yearly.

Program staff

Qualified personnel are essential to the success of a diabetes self-management education program. The sponsoring organization should identify the program personnel, which must include a program coordinator who has overall responsibility for the program. Because diabetes is a chronic disorder requiring lifestyle changes, instructors need to be skilled and experienced health care professionals with recent education in diabetes, educational principles, and behavior change strategies.

Standard 9. A coordinator shall be designated who is responsible for program planning, implementation, and evaluation.

Review Criteria

9–1. The job description for the program coordinator includes his/her responsibility for:

- acting as a liaison between the program staff, the advisory committee, and the administration of the institution.
- providing and/or coordinating the orientation and continuing education for the professional program staff.
- participating in the planning and review of the program each year.
- participating in the preparation of the program budget.
- evaluating program effectiveness.
- serving as the chair or a member of the advisory committee.

9–2. The program coordinator is a Certified Diabetes Educator (CDE) or has completed at least 24 hours of approved continuing education that includes a combination of diabetes, educational principles, and behavioral strategies.

Standard 10. Health care professionals with recent didactic and experiential preparation in diabetes clinical and educational issues shall serve as the program instructors. The staff shall include at least a nurse educator and a dietitian who collaborate routinely. Certification as a diabetes educator by the National Certification Board for Diabetes Educators (NCBDE) is recommended.

Review criteria

10–1. Program instructors are professional staff who routinely teach in the diabetes self-management education program and include at least one nurse educator and one dietitian.

10–2. Program instructors are health care professionals with a valid license, registration, or certification and who are CDEs or have completed at least 16 hours of approved continuing education that includes a combination of diabetes, educational principles, and behavioral strategies.

Standard 11. Professional program staff shall obtain education about diabetes, educational principles, and behavioral change strategies on a continuing basis.

Review criterion

11–1. The program coordinator and all instructors complete at least 6 hours per year of approved continuing education that includes a combination of diabetes, educational principles, and behavioral strategies.

Curriculum

A quality diabetes self-management education program should provide comprehensive instruction in the content areas relevant to the target population and to the participants being served. The curriculum, instructional methods, and materials should be appropriate for the specified target population, considering type and duration of diabetes, age, cultural influences, and individual learning abilities.

Standard 12. Based on the needs of the target population, the program shall be capable of offering instruction in the following content areas:

a. Diabetes overview
b. Stress and psychosocial adjustment
c. Family involvement and social support
d. Nutrition
e. Exercise and activity
f. Medications
g. Monitoring and use of results
h. Relationships among nutrition, exercise, medication, and blood glucose levels
i. Prevention, detection, and treatment of acute complications
j. Prevention, detection, and treatment of chronic complications
k. Foot, skin, and dental care
l. Behavior change strategies, goal setting, risk factor reduction, and problem solving
m. Benefits, risks, and management options for improving glucose control
n. Preconception care, pregnancy, and gestational diabetes
o. Use of health care systems and community resources.

Review criteria

12–1. There is a written curriculum that includes educational objectives, content outline, instructional methods and materials, and the means for evaluating achievement of the objectives for each content area or session of the program.

12–2. The curriculum is current and includes all 15 content areas as appropriate for the identified target population.

Standard 13. The program shall use instructional methods and materials that are appropriate for the target population and the participants being served.

Review criterion
13–1. Instructional methods and materials are appropriate for the target population and participants in terms of cultural relevance, age, language, reading level, and special educational needs.

Participant access
Quality programs must be readily accessible to those in need of education. The sponsoring organization should facilitate access to self-management education for the target population identified in the needs assessment. Access is promoted by a commitment to routinely inform referral sources and the target population of the availability and benefits of the program.
Standard 14. A system shall be in place to inform the target population and potential referral sources of the availability and benefits of the program.
Review criterion
14–1. The program informs its identified target population and potential referral sources about the program at least once a year.
Standard 15. The program shall be conveniently and regularly available.
Review criterion
15–1. Program utilization, attrition rates, and waiting periods are assessed yearly.
Standard 16. The program shall be responsive to requests for information and referrals from consumers, health care professionals, and health care agencies.
Review criterion
16–1. There is a written policy and procedure that stipulates that all requests for information and referrals receive a timely response.

PROCESS— Process refers to the methods or means by which resources are used to attain stated goals. The process of providing diabetes self-management education involves the integration of an individual assessment, goal setting, education plan development, implementation, evaluation, and follow-up. Each component requires documentation that can be evaluated.

Assessment
Because individuals are unique, their educational needs will vary with age, disease processes, culture, and lifestyles. Effective instruction can only be accomplished by a collaborative effort between educators and participants to identify individualized educational needs.
Standard 17. An individualized assessment shall be developed and updated in collaboration with each participant. The assessment shall include relevant medical history, present health status, health service or resource utilization, risk factors, diabetes knowledge and skills, cultural influences, health beliefs and attitudes, health behaviors and goals, support systems, barriers to learning, and socioeconomic factors.
Review criteria
17–1. An initial assessment of the items specified above is documented in the education record and updated as needed.
17–2. The participant's pre-program knowledge of and skill level in each of the appropriate content areas of the National Standards is documented in the education record and updated as needed.

Plan and implementation
For the educational experience to meet the participant's needs, an individual assessment should be used to develop the education plan. All information about the educational experience should be documented in the participant's permanent medical or education record. Since different health care professionals may be involved in the provision of the educational experience, effective communication and coordination is essential.
Standard 18. An individualized education plan, based on the assessment, shall be developed in collaboration with each participant.
Review criterion
18–1. An education plan, developed in collaboration with the participant and based on the educational needs identified in the initial assessment, is documented in the education record.
Standard 19. The participant's educational experience, including assessment, intervention, evaluation, and follow-up, shall be documented in a permanent medical or education record. There shall be documentation of collaboration and coordination among program staff and other providers.
Review Criteria
19–1. The participant's progress through the program is documented in the education record and includes:

- the initial assessment and education plan as specified above.
- an indication of the content taught, dates of instruction, and the instructors.
- post-program assessment of the participant's knowledge and skill level of each of the appropriate content areas of the National Standards.
- behavior change goals.
- a plan for follow-up.
- communication of participant's progress and any follow-up recommendations to the primary care provider.
- follow-up assessment and any resulting interventions.

19–2. Each program instructor documents his/her own interventions with the participants.
19–3. Communication and collaboration among program staff are facilitated by and documented in the education record.
19–4. There is a written policy that the education record is made available to external health care providers with permission from the participant.
19–5. There is a written policy that participants are given a copy or summary of their education record, if requested.

Follow-up
Because diabetes is a chronic disorder requiring a lifetime of self-management, follow-up services will be needed. Participants' lifestyles, knowledge, skills, attitudes, and disease characteristics change over time, so that ongoing education is

necessary and appropriate. Programs should be able to offer periodic reassessment and education as part of comprehensive services.

Standard 20. The program shall offer appropriate and timely educational interventions based on periodic reassessments of health status, knowledge, skills, attitudes, goals, and self-care behaviors.

Review criteria

20–1. There is a written policy for the provision of follow-up assessment of the items specified above and any resulting interventions.

20–2. At least one follow-up assessment of the items specified above and any interventions are documented in the education record.

20–3. Participant achievement of behavior change goals is assessed and documented 1–3 months after goal setting.

OUTCOMES — Outcomes are the desired results for the program and participants. For programs, the desired results include achievement of stated objectives, reaching the defined target population, and helping participants improve their health outcomes. For participants, outcomes include the knowledge and skills necessary for self-management, desired self-management behaviors, and improved health outcomes. Assessing outcomes and using the assessments in regular program evaluation and subsequent planning are essential to maintain quality programs.

Program outcome evaluation

The advisory committee should periodically review the program to ascertain that the program continues to meet the National Standards for Diabetes Self-Management Education Programs. The results of this review should be documented and used in subsequent program planning and modification.

Standard 21. The advisory committee shall review program performance annually, including all components of the annual program plan and curriculum, and use the information in subsequent planning and program modification.

Review criteria

21–1. The advisory committee minutes document the results of an annual review of the program including:

- program objectives
- the curriculum, instructional methods, and materials
- actual audience compared to the target population
- participant access and follow-up mechanisms
- program resources (space, personnel, and budget)
- program effectiveness/participant outcomes.

21–2. The results of the annual review are reflected in the next annual program plan.

Participant outcome evaluation

Participant outcomes, such as success in incorporating self-management into their lifestyles, should be periodically reviewed. The specific outcomes evaluated will vary with the program, but the program's effectiveness in helping participants improve their health outcomes should be documented and used for future program planning and modification.

Standard 22. The advisory committee shall annually review and evaluate predetermined outcomes for program participants.

Review criteria

22–1. Participants' outcomes are measured and evaluated, specifically, the degree to which the participants achieve their behavior change goals and **one** other outcome measure (e.g. monitoring for complications, lost work or school days, metabolic control, or others).

22–2. The program's effectiveness at improving outcomes among participants is evaluated by the advisory committee and the results of this evaluation are reflected in the next annual program plan.