
Special Announcement

National Standards for Diabetes Patient Education Programs

(National Diabetes Advisory Board, November 1983)

National standards for diabetes patient education programs have been endorsed by the National Diabetes Advisory Board. These standards were developed under the auspices of the Board and in collaboration with the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse.

This statement presents the rationale for the standards and a plan for their implementation. It includes a summary and description of the standards and a tabular presentation for easy reference.

THE NEED FOR NATIONAL STANDARDS

Major strides have been made in the treatment of diabetes during the last decade as a result of biomedical research, technological advances, and improved application of currently available knowledge and resources. Dramatic increases in our knowledge of effective approaches to prevention of some of the complications of diabetes include better methods to assess and control blood glucose. It is now possible to limit the severity of some long-term effects of the disease and thus reduce its medical, social, and economic impact.

Several barriers, however, still preclude the widespread availability of preventive approaches in self-care. These barriers include lack of patient and provider knowledge about diabetes, inadequate reimbursement policies, and lack of coordination among key components of the health care system. One major impediment has been the lack of national standards to assure that the education provided to people with diabetes is of an acceptable quality and appropriate for the individual.

The National Diabetes Advisory Board, in collaboration with experts from within and outside the diabetes community, has developed national standards for diabetes patient education programs. These standards establish specific parameters against which programs can measure themselves. The standards are rigorous enough to be acceptable to the diabetes community, yet flexible enough to be practical for the primary care community. They are applicable in any

health care setting. The Board encourages adoption of these standards by all diabetes patient education programs.

NATIONAL PLAN FOR IMPLEMENTATION OF THE STANDARDS

The National Diabetes Advisory Board (NDAB) is mandated by Congress to oversee the Long Range Plan to Combat Diabetes. In addition to its advisory role, the Board has come to serve as a forum through which the diabetes community can focus on common needs and problems and share in their solutions. Through a series of workgroups, the Board and cooperating organizations determined that the availability of the standards would be enhanced by a process to ensure their widespread application. They are therefore developing a national system of *recognition* for diabetes patient education programs that meet the standards. Recognition is a voluntary process through which programs meeting the standards are formally identified for a level of performance, integrity, and quality entitling them to the confidence of the community they serve. The process is flexible enough to apply to programs that conform to other standards, provided the other standards adhere to the national consensus standards or are modified to do so.

The standards and the recognition process will be pilot tested during 1984 and 1985. Pilot testing will be conducted under the auspices of a Board-appointed steering committee consisting of representatives of the diabetes-related organizations involved with the Board in the development of both the standards and the recognition process. These organizations include the American Association of Diabetes Educators, American Diabetes Association, Centers for Disease Control, Diabetes Research and Training Centers, International Diabetes Center (Minneapolis), Juvenile Diabetes Foundation, and National Diabetes Information Clearinghouse. The results of the pilot testing will form the basis for modifications in the standards and for any required adjustments in the recognition process prior to nationwide implementation. Support materials will be available to provide diabetes patient education programs with additional information on (1) how to meet the standards, (2) how to initiate or upgrade a program to meet them, and (3) how to apply for recognition.

National Standards for Diabetes Patient Education Programs

This table presents the standards in a form for easy reference. Standards applicable to the facility offering the program are designated "institution standards" and are separated from those applicable to the education program itself, which are designated "program standards."

| COMPONENTS | STANDARDS | |
|-----------------------------------|--|--|
| | Institution | Program |
| 1. Needs Assessment | <ul style="list-style-type: none"> ● The institution shall assess its diabetic caseload to determine the allocation of personnel and resources to serve the instructional needs of the caseload. ● There shall be a reasonable match between caseload requirements and resources allocated. | <ul style="list-style-type: none"> ● An individualized and documented ongoing assessment of needs shall be developed with the patient's participation. This shall include medical history, present health status, previous diabetes education, health services utilization, associated medical conditions or risk factors, diabetes knowledge, skills, attitudes, self-assessment, identification of support system, barriers to learning, and financial status. ● The needs assessment shall be the basis for the education program delivered to each patient. |
| 2. Planning | <ul style="list-style-type: none"> ● The institution shall have a written policy that affirms patient education as an integral component of quality diabetes care. | <ul style="list-style-type: none"> ● The participants in planning shall include health professionals involved in the care and education of persons with diabetes and persons with diabetes and their families. ● The planning process shall define (in order): <ol style="list-style-type: none"> a) Program goals and objectives b) Target audience c) Program setting d) Patient access mechanisms e) Instructional methods f) Resource requirements g) Patient followup mechanisms h) Evaluation |
| 3. Program Management | <ul style="list-style-type: none"> ● A coordinator shall be designated and responsible for all aspects of the program. ● The organizational relationships, lines of authority, staffing, and operational policies shall be defined. ● A standing advisory committee with both medical and community/consumer representation shall be established. | <ul style="list-style-type: none"> ● Not applicable. |
| 4. Communication/ Coordination | <ul style="list-style-type: none"> ● A physician shall be identified to serve as liaison between the program coordinator and the medical staff. ● The institution shall regularly inform its staff and the patients (and potential patients) it serves of the availability of its diabetes patient education program. | <ul style="list-style-type: none"> ● All information about the patient's educational experience shall be permanently incorporated into the patient's (medical) records maintained by the institution. ● The role of each education team member shall be clearly defined, and the intercommunication between each shall be documented in the patient's record. ● There shall be written evidence of coordination between different care settings. |
| 5. Patient Access to Teaching | <ul style="list-style-type: none"> ● The applicant institution shall have a policy to inform patients routinely about the benefits and availability of patient education. | <ul style="list-style-type: none"> ● The program shall be regularly and conveniently available. ● The program shall be responsive to patient-initiated requests for information and/or participation in the program's activities. |

SPECIAL ANNOUNCEMENT

| COMPONENTS | STANDARDS | |
|-----------------------|--|---|
| | Institution | Program |
| 6. Content/Curriculum | <ul style="list-style-type: none"> ● The institution shall provide space, personnel, budget, and instructional materials adequate for the program. ● Assessment of available community resources shall be performed periodically. | <ul style="list-style-type: none"> ● The program shall be capable of offering information on each of the following content items as needed: <ul style="list-style-type: none"> a) General facts b) Psychological adjustment c) Family involvement d) Nutrition e) Exercise f) Medications g) Relationship between nutrition/exercise/medication h) Monitoring i) Hyperglycemia and hypoglycemia j) Illness k) Complications (prevent, treat, rehabilitate) l) Hygiene m) Benefits and responsibilities of care n) Use of health care systems o) Community resources ● The institution shall specify the mechanism by which the curriculum shall be reviewed, approved, and updated. |
| 7. Instructor | <ul style="list-style-type: none"> ● The institution shall identify appropriate instructional personnel and ascertain their competence. ● The numbers of personnel identified shall be suitable for the diabetic caseload within the institution. ● Designation of time for identified instructors shall be appropriate to accomplish the necessary educational objectives. | <ul style="list-style-type: none"> ● Instructors (health professionals and others) shall be part of a comprehensive care and education program. ● Instructors shall have recent experience and training in diabetes and knowledge and skills in educational principles and their application. |
| 8. Followup | <ul style="list-style-type: none"> ● The institution shall transmit the educational record to other appropriate health care settings when a patient transfers his or her care responsibilities. | <ul style="list-style-type: none"> ● The program shall provide followup services for those patients who wish to maintain continuity of education within the institution. These services shall include: <ul style="list-style-type: none"> a) Periodic reassessment of knowledge and skills b) Timely reeducation based on reassessment c) Communication with the primary care provider about the need for professional and nonprofessional services. |
| 9. Evaluation | <ul style="list-style-type: none"> ● The institution shall review periodically the performance of the instructional program and ascertain that it continues to meet national standards. | <ul style="list-style-type: none"> ● The program shall conduct and record an individualized assessment of each patient's original needs and progress at regular intervals. ● The program shall be reviewed in ongoing fashion for both process and outcome, and the results of this review shall be used in subsequent planning and program modification. |
| 10. Documentation | <ul style="list-style-type: none"> ● All aspects of the evaluation shall be recorded by the sponsoring institution and reviewed periodically to ascertain that national standards are being maintained. | <ul style="list-style-type: none"> ● All aspects of the educational program offered to each patient shall be recorded in that patient's medical record as maintained by the institution. |

Downloaded from http://diabetesjournals.org/care/article-pdf/7/1/XXXI/496228/7-1-xxxI.pdf by guest on 31 January 2023

SUMMARY AND DESCRIPTION OF THE STANDARDS

Diabetes is a serious and common disease that is treated directly or indirectly in practically every health care facility in the nation, regardless of size or location.

In chronic diseases, especially diabetes, patients are required to assume a major share of responsibility for their own care. Only an informed and well-motivated person who has the support of the primary health care provider can carry out this responsibility effectively. Evidence is growing that inadequate patient knowledge results in multiple hospital admissions, excessive use of emergency rooms, unnecessary medication, and a high incidence of long-term complications of diabetes, all of which increase human suffering and escalate the costs of care. Studies testing patient education as the variable component of the treatment regimen have shown consistent reductions in these measures. Education for self-care is therefore recognized to be a fundamental component of quality treatment for the individual with diabetes.

At the present time, both the quantity and quality of education offered to people with diabetes vary considerably in the United States. Experience in other fields has demonstrated the ability of uniform standards to improve the quality, effectiveness, and availability of programs. It is hoped that the implementation of national standards will result in increased access to this fundamental component of treatment by stimulating adequate reimbursement for diabetes patient education.

The diabetes patient education standards consist of 10 components that will enable an institution to establish a new program or modify an existing one. Each standard offers the flexibility required to tailor a patient education program to the type of diabetes, its duration, and the life-stage of the diabetic person. Many of the standards are overlapping, reflecting the interdependence among all components of an effective diabetes education program.

1. *Needs assessment.* A successful program is the product of a flexible policy based upon the needs of the community it is intended to serve. Since the diabetes caseload varies from one institution to another, each institution should assess its own needs and match its resources to the needs of its caseload. The needs assessment should be performed initially to guide the management of the program and to form the basis for program planning. It should be a continuing process that will allow the program to adapt to changing service requirements. In addition to the needs of the program, the needs of the individual patient should be assessed to provide the basis for the instructional program offered to each patient. The person with diabetes is recognized to be an equal partner in all aspects of the educational process.

2. *Planning.* Planning is an essential component of a diabetes patient education program. The planning process should describe the program's goals and objectives, target audience, setting (inpatient, outpatient), patient-referral mechanisms, procedures, and evaluation methods. The planning process should be a cooperative effort involving people with diabetes as well as health professionals.

3. *Program management.* Effective management is required to implement a patient education program. A variety of health care professionals is involved in the total care of people with diabetes. Clear lines of authority and efficient systems for communication should be established among everyone involved in the program. The ultimate responsibility for all aspects of program management should rest with one person designated as the program coordinator. In addition, an advisory committee should be established to assist the coordinator and other members of the program staff in setting policy and managing the program.

4. *Communication and coordination.* Several levels of communication are essential to the effective coordination of the program. Physician leadership and participation are necessary to ensure the integration of patient education into the treatment regimen. A physician should be identified to serve as the liaison between the education program coordinator and the medical staff. In addition, the institution should maintain regular channels of communication with its staff and the community it serves to inform diabetes patients and their families about the availability of the program. All information on the patient's educational experience should be incorporated into the medical record.

5. *Patient access to teaching.* It should be the policy of the institution to facilitate access to patient education for the target audience specified in the plan. This is promoted by a commitment to routinely inform both patients and staff about the availability and benefits of patient self-care programs. Diabetes patient education should be regularly and conveniently accessible, and the instructional program should be able to respond to patient-initiated requests for information. The program permits referral by health professionals, health care agencies, or individual patients. The instructional design encourages active patient participation.

6. *Content/curriculum.* The individual patient's needs assessment provides the basis for the instructional program offered to each patient. The assessment should be documented and should include all relevant information regarding the patient's treatment, education, and support systems. Responsibility for various facets of the assessment can be divided among the instructional team members. Curriculum and instructional materials should be appropriate for the specified target audience, taking into consideration the type and duration of diabetes and the age and learning ability of the individual. Both curriculum and available community resources should be reviewed and updated periodically. The institution should provide the program with adequate space, personnel, budget, and materials.

7. *Instructor.* Qualified personnel are essential to the success of a diabetes patient education program. Each institution should be responsible for identifying and evaluating its instructors. Instructors should be skilled professionals with recent experience and training in both diabetes and educational principles. The number of instructors should be proportional to the caseload requirements. Instructors should be allotted sufficient time to complete the instructional program.

8. *Followup.* Followup services are important because diabetes requires a lifetime of proper care. The institution should

provide followup services that include periodic reassessment of the patient's knowledge and skills and should offer supplementary educational services when warranted. Written communication between the program staff and the primary care physician is essential for ongoing identification of the patient's needs. This is especially appropriate in regard to referral for early diagnosis and treatment of the complications of diabetes. Referral to community resources may also provide ongoing support for long-term psychosocial needs and behavioral modification skills. If a patient changes care settings, the institution should request the patient's permission to send his/her records to the new health care setting.

9. *Evaluation.* The institution should review the educational program periodically to ascertain that it continues to meet the national standards. This review should be con-

ducted by the advisory committee. The results of this review should be utilized in subsequent program planning and modification. An assessment of each patient's needs and progress should also be conducted at regular intervals.

10. *Documentation.* Program planning and evaluation should be documented to provide the basis for future program development and modification. All information about the patient's educational experience should be documented in the patient's medical records, as should communication among treatment and education professionals.

For further information contact the National Diabetes Advisory Board, 7550 Wisconsin Avenue, Room 616, Bethesda, Maryland 20205. Tel: (301) 496-6045.