

**Michigan Department of Community Health
Diabetes Self-Management Education Program Standards**

Standard 1: Internal Structure: The provider(s) of DSME will document their organizational structure, mission statement, and goals. For those providers working within a larger organization, that organization will recognize and support quality DSME as an integral component of diabetes care.

Review Criteria	Interpretive Guidelines
<p>1.1 A signed mission statement encompassing the purpose(s) of the DSME program (DSMEP) is required.</p> <p>1.2 At certification and re-certification times the mission statement must be signed by the CEO (or designee*) and the DSME Program Coordinator.</p> <p>1.3 The program goal(s) and/or objective(s) established for the DSMEP will be reviewed at least annually.</p> <p>1.4 A DSMEP organizational chart is required.</p>	<p>Statement of support will be signed by CEO or designee* every 4 years. *Designee should be at least Vice President level in the organization.</p> <p>There is evidence of an annual review by the program coordinator.</p> <ul style="list-style-type: none"> ✓ A minimum of one goal will be in SMART format (specific, measurable, attainable, realistic, and time-framed). <p>LINK: http://www.cdc.gov/dhdSP/programs/nhdsp_program/evaluation_guides/docs/smart_objectives.pdf</p> <p>The organizational chart will include:</p> <ul style="list-style-type: none"> ✓ Placement of the DSMEP within the organization ✓ Program staff ✓ DSMEP’s link to external inputs <p align="center">Sample Organizational Chart</p> <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: fit-content;"> <p align="center">Name of sponsoring organization VP or designee responsible for DSMEP Manager/Department responsible for DSMEP Coordinator</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; padding: 2px 10px; margin: 2px;">DSMEP Staff</div> <div style="border: 1px solid black; padding: 2px 10px; margin: 2px;">External</div> </div> </div>

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Standard 2: External Input: The provider(s) of DSME will seek ongoing input from external stakeholders and experts in order to promote program quality.

Review Criteria	Interpretive Guidelines
<p>2.1 An system for seeking input from <u>at least one of each</u> of the following professionals and diabetes advocates, identified by name and discipline, will be established and maintained:</p> <ul style="list-style-type: none"> ✓ Physician ✓ Registered nurse ✓ Registered dietitian ✓ Behavioral science specialist ✓ Consumer ✓ Community representative ✓ If needed, individuals knowledgeable about special populations (e.g., migrants, adolescents, and others) 	<p>The behavioral science expert may be:</p> <ul style="list-style-type: none"> ✓ Social worker ✓ Psychologist ✓ Psychiatric nurse specialist ✓ Chaplain ✓ Other professional with counseling credentials <p>The consumer would preferably be a graduate of the DSMEP. The community representative can be any individual representing the service area. The consumer and community representative may be the same person if not employed by the sponsoring organization.</p> <p>Other possible stakeholders/experts to contact might be persons in the community living with diabetes, persons affected by diabetes, or healthcare professionals outside the DSME program.</p>
<p>2.2 There will be evidence that external input was sought and documented at least annually for quality improvement purposes.</p>	<p>Minutes or other forms of documentation may be used.</p>
<p>2.3 There will be an annual report submitted to the Michigan Department of Community Health. The Annual Report, based on the findings of an annual program review <u>and focused on quality processes</u>, will define and guide activities of the DSMEP for the next year and will include:</p> <ul style="list-style-type: none"> ✓ Target audience ✓ Program goal(s) ✓ Participant access, retention and follow-up problems and concerns ✓ Instructional methods and resource 	<p>The annual program review process will:</p> <ul style="list-style-type: none"> ✓ Review status of goal(s) established for the DSMEP ✓ Review mission statement and appropriateness to DSMEP operations ✓ Review organizational structure to assess if the current structure is meeting the needs of the DSMEP operations and participants it is serving ✓ Analyze and review participant population data and how DSMEP is meeting the needs of the population <ul style="list-style-type: none"> ✓ Review adequacy of resources, including personnel, budget, space equipment,

- requirements (including, personnel, budget, space, equipment/materials, curriculum, community resources)
- ✓ Outcome measure (s) chosen and means of measuring and evaluating the outcomes
- ✓ Community needs.

- 2.4** DSMEP will annually submit to MDCH:
- ✓ Statistical Report: no later than November 30 (data as determined by MDCH).
 - ✓ Annual Report: no later than January 31.

- curriculum, community resources
- ✓ Analyze and review participants' access data, referrals, enrollment, follow-up rates and other relevant data
- ✓ Review effectiveness of DSMEP based on behavioral goals and other program outcome measure data
- ✓ Review and evaluate the continuous quality improvement (CQI) process

The statistical data reporting period is October 1 to September 30.

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Standard 3: Access: The provider(s) of DSME will determine who to serve, how best to deliver diabetes education to that population, and what resources can provide ongoing support for that population.

Review Criteria	Interpretive Guidelines
<p>3.1 Specific indicators of the target population(s) will include, as appropriate:</p> <ul style="list-style-type: none"> ✓ Types of diabetes ✓ Age groups ✓ Race and ethnicity ✓ Disabilities ✓ Languages ✓ Service area 	<p>The <u>target population</u> determination is facilitated by review and analysis of the following information:</p> <ul style="list-style-type: none"> ✓ Prevalence of diabetes in the United States ✓ Prevalence of diabetes in Michigan ✓ Prevalence of diabetes in the organization’s service area ✓ Demographic data related to race, ethnic backgrounds, gender, poverty level ✓ Community resources (such as financial stability, economic indicators such as unemployment rate, types of insurance reimbursement) ✓ Unique characteristics and unique characteristics and educational needs (e.g., people with disabilities, including sensory, cognitive, developmental, or learning disabilities, mobility limitations, or serious mental illness; grade level, languages spoken or read, literacy rates, transportation systems, rates of uninsured or under-insured)
<p>3.2 Specific indicators necessary to meet the self-management educational needs of the target population(s) will include:</p> <ul style="list-style-type: none"> ✓ Personnel ✓ Budget ✓ Space/accessibility ✓ Equipment/material ✓ Curriculum ✓ Community resources 	<p>There should be evidence in writing that each of the indicators in 3.1 and 3.2 are addressed by the DSME entity annually.</p>

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Standard 4: Program coordination: A coordinator will be designated to oversee the DSME program. The coordinator will have oversight responsibility for the planning, implementation, and evaluation of education services.

Review Criteria	Interpretive Guidelines
<p>4.1 The DSME entity has a designated coordinator.</p>	<p>There is a written job description of the Program Coordinator role which addresses:</p> <ul style="list-style-type: none"> ✓ Academic preparation and/or experience in program management and the care of persons with a chronic disease ✓ Oversight of program including planning, implementation and evaluation of DSMEP ✓ Liaison role between program staff, DSMEP advisory system and the agency administration
<p>4.2 The program coordinator is academically or experientially prepared in areas of chronic disease care, patient education and/or program management.</p> <p>Coordinator will meet <u>one</u> of the following requirements:</p> <ul style="list-style-type: none"> ✓ Certified Diabetes Educator (CDE) or BC-ADM <u>or</u> ✓ Annually accrues 15 hours of approved continuing education (CE) based on the DSME program anniversary date. 	<p>Documents verifying the designated coordinator meets the role requirements will be available for review and will include one or more of the following: resume or CV, discipline specific license and/or registration, credentials and continuing education certificates.</p>
<p>4.3 The coordinator oversees the planning, implementation, and evaluation of the DSME.</p>	<p>Continuing education can include a combination of diabetes/chronic disease management, behavioral interventions, teaching and learning principles, program management and/or counseling skills.</p>

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Standard 5: Instructional staff: One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be a registered nurse, registered dietitian, or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes and with supervision and support.

Review Criteria	Interpretive Guidelines
<p>5.1 The instructional team must include a registered dietitian and a registered nurse.</p> <ul style="list-style-type: none"> ✓ If a contract instructor is employed, there is evidence the contractor is used <u>at least monthly</u> in the DSME process. ✓ There is evidence of care coordination/collaboration. 	<p>Documents verifying the instructors meet requirements will be available for review and may include: discipline specific licenses and/or registrations, resume or CV, documentation of credentials, specialized pump training documents/certificates and continuing education certificates.</p>
<p>5.2 All instructional staff will meet <u>one</u> of the following requirements:</p> <ul style="list-style-type: none"> ✓ Certified Diabetes Educator (CDE) or 15 hours of approved continuing education accrued annually based on the DSME program anniversary date. ✓ New instructional staff will have 15 hours of approved continuing education within 3 months of date of hire (includes contractors and paraprofessionals). 	<p>The continuing education option can include a combination of diabetes/chronic disease management, behavioral interventions, teaching and learning principles, and/or counseling skills. Topics should be diabetes-related, diabetes-specific, education or psycho-social related and relevant to DSME or DSMS.</p> <p>Disciplines function within their own scope of practice. There is a policy or guidelines for meeting participant needs if they are outside the DSME instructor’s scope of practice and expertise. The policy/guidelines should include contract instructors and paraprofessional staff.</p>
<p>5.3 If Community Health Workers (CHWs, lay health workers, peer counselors, etc.) are employed there will be a policy in place regarding their role within the DSMEP.</p>	<p>T The policy re: CHWs must address pre-determined training and competencies, supervision by DSME instructional staff, on-going training and/or education, and role expectations relative to DSME and DSMS.</p>

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Standard 6: Curriculum: A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSME. The needs of the individual participant will determine which parts of the curriculum will be provided to that individual.

Review Criteria	Interpretive Guidelines
<p>6.1 There is a written curriculum which is the framework for DSME and DSMS and includes</p> <ul style="list-style-type: none"> ✓ Measurable learning objectives ✓ Detailed content outlines ✓ Instructional methods (specified methods of delivery) ✓ A means of evaluating if participants achieved their learning objectives (successful learning outcomes) 	<p>The participant’s educational experience will be interactive and tailored to the learner’s needs.</p> <p>The curriculum be made available to all populations served and will be used as reference in the following nine topics :</p> <ul style="list-style-type: none"> ✓ Describing the diabetes disease process and treatment options ✓ Incorporating nutritional management into lifestyle ✓ Incorporating physical activity into lifestyle ✓ Using medication 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 personalized strategies to address psychosocial issues and concerns ✓ Developing personalized strategies to prompt health and behavior change
<p>6.2 There is a periodic review with revisions of the curriculum and/or course materials to reflect current evidence.</p>	<p>There is documentation of the curriculum review and revisions by the DSME instructor(s) at least annually.</p>
<p>6.3 The curriculum will include content on influenza and pneumococcal immunizations</p>	<p>There is evidence of the curriculum being tailored to the DSMEP’s target population.</p> <p>Other adult immunizations may be included.</p>

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Standard 7: Individualization: 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.

Review Criteria	Interpretive Guidelines
<p>7.1 An individualized, initial assessment will be completed with each participant before DSME begins.</p> <p>7.2 The assessment will include information on participant's:</p> <ul style="list-style-type: none"> ✓ clinical information (diabetes and other pertinent clinical history) ✓ cognitive (diabetes self management knowledge and skills, functional health literacy) ✓ psychosocial and self care behaviors (readiness to change, support systems, lifestyle practices, behavior change potential) ✓ Influenza and pneumococcal vaccinations. <p>7.3 An individualized education plan with measurable learning objectives and at least one participant selected behavioral goal, based on the individualized assessment, will be collaboratively developed and implemented with each participant. The behavioral change goal will:</p> <ul style="list-style-type: none"> ✓ be specific and measurable 	<p>Face to face contact does not have to occur in a 1:1 setting, but is preferred.</p> <p>Parts of the complete assessment may be deferred if applicable. Rationale for the deferment must be documented.</p> <p>A self-assessment or knowledge pre-test should not serve as the sole means of assessing and documenting the participant's knowledge, skill level and behaviors.</p> <p>If applicable, the assessment should include a participant caretaker's ability to assist with or assume diabetes management.</p> <p>For pump programs: document participant appropriateness for insulin pump therapy and willingness to assume ongoing self-care and pump maintenance.</p> <p>There is evidence of ongoing education planning and behavioral goal-setting based on the assessed and/or re-assessed needs of the participant. <u>SMART goal format is preferred.</u></p>

Review Criteria	Interpretive Guidelines
<ul style="list-style-type: none"> ✓ indicate how the goal will change behavior ✓ indicate how the changed behavior will help improve health and quality of life 	<p>Documentation includes other evidence of the education process: referral from provider, assessments, education plan with dates of implementation/interventions, learning outcomes and plans for follow-up.</p>
<p>7.4 The ongoing education and reassessment process is documented in the permanent record.</p>	<p>Reassessment by the diabetes educator, including a need to re-teach or teach a support person, etc., will allow new achievable objectives to be developed for participants unable to meet outlined educational objectives.</p>
<p>7.5 There will be an ongoing assessment of a participant's progress to determine the attainment of the learning objectives and the need for revision of the education plan.</p>	<p>DSME should take into account education needs/factors such as vision impairment, mobility, mental state, functional status, financial resources, polypharmacy, social support, decreased psychomotor skills, etc.</p>
<p>7.6 Educators involved in patient care will demonstrate collaboration.</p>	<p>The DSME has a process for evaluating the education intervention(s) to determine success of the education plan, including evaluation of behavioral goal progress and/or achievement.</p> <p>Examples of collaboration may be found in:</p> <ul style="list-style-type: none"> ✓ Meal plans prepared with the participant ✓ Class notes ✓ Instructor team notes ✓ Social worker notes ✓ Staff meeting notes ✓ Letters to the referring physician, etc.

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Standard 8: Ongoing Support: The participant and instructor(s) will together develop a personalized follow-up plan for ongoing self-management support. The participant’s outcomes and goals and the plan for ongoing self-management support will be communicated to other members of the health care team.

Review Criteria	Interpretive Guidelines
<p>8.1 Participants will have a plan for post education self-management support for ongoing diabetes self-care beyond the formal self-management education process.</p>	<p>There must be evidence of a personalized plan for follow-up that addresses Diabetes Self Management Support (DSMS). Examples of support options that participants might choose include: worksite programs, on-line support, fitness clubs, support groups, community programs such as PATH, Diabetes PATH, Enhanced Fitness, walking groups, Weight Watchers, etc.</p> <p>There must be evidence that the DSMS follow-up plan was communication to the referring provider. Notation of when the participant should return for medical care to their primary care provider should be made.</p>

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Standard 9: Patient Progress: The provider(s) of DSMS and DSMS will monitor whether participants are achieving their personal diabetes self-management goals and other outcome(s) as a way to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

Review Criteria	Interpretive Guidelines
<p>9.1 Attainment of goal/outcomes shall be measured regularly in order to evaluate the effectiveness of the educational intervention.</p> <p>9.2 A summary of goals, using a systematic approach (e.g. AADE 7) will be included in the annual and statistical reports to MDCH.</p> <p>9.3 At least one program outcome will be addressed annually.</p>	<p>There is a process in place for the systematic collection and summary of participant behavior goal(s) achievement.</p> <p>Achievement of participant goals and other outcomes will be evaluated as a way to measure the effectiveness of the DSME program and will be used for ongoing program evaluation and planning.</p> <p>There is evidence of a collection and summary of other program outcomes to evaluate DSME effectiveness. Examples include; patient satisfaction, provider satisfaction, quality of life, A1C, BMI, weight loss, dilated eye exams, foot exams, etc.</p>

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Standard 10: Quality improvement: The provider(s) of DSME will measure the effectiveness of the education and support and look for ways to improve any identified gaps in services or service quality using a systematic review of process and outcome data.

Review Criteria	Interpretive Guidelines
<p>10.1 The DSME program has a quality improvement process, utilizing outcome data, to evaluate the education, program processes and program outcomes.</p>	<p>There is documentation of an identified CQI plan/process (e.g. written policy, annual program report, CQI meeting minutes).</p> <p>CQI is an ongoing process.</p>
<p>10.2 Quality improvement projects are developed and implemented according to the plan.</p>	<p>There is documentation of at least one project that follows the quality improvement process.</p>
<p>10.3 Results are used to make improvements in the DSME program and address identified gaps in care/service.</p>	<p>There is evidence aggregate data was applied in making improvements to DSME program processes.</p>

The above review criteria are based upon the 2012 National Standards for Diabetes Self-Management Education and Support, the American Diabetes Association “Review Criteria and Indicator Listing -9th Edition,” and the American Association of Diabetes Educators “Crosswalk for AADE’s Diabetes Education Accreditation Program: Essential Elements and Interpretive Guidance.”

The three documents were used for reference and portions have been cited directly.