2022 Michigan Department of Health & Human Services Review Criteria for DSMES

National Standard 1: **Support for DSMES Services**	**The DSMES team will seek leadership support for implementation and sustainability of DSMES services. The sponsor organization will recognize and support quality DSMES services as an integral component of diabetes care. Sponsor organizations will provide guidance and support for DSMES services to facilitate alignment with organizational resources and the needs of the community being served.**

Guidance	Required Documentation
Support from your organization is crucial to sustain DSMES services. Demonstration of support should be from someone within your sponsoring organization who has influence to support sustainability of your DSMES services. If a change in leadership occurs, new proof of support should be obtained and kept on file. Input from stakeholders such as referring providers, other health care professionals, DSMES service participants and community-based groups that support DSMES and people with diabetes remain an important piece when evaluating and revising DSMES services.	Letter of support dated within 6 months of application (initial or renewal) **OR** List of external stakeholders by name and title with an explanation of how each may provide benefit to DSMES services. This list must be updated annually. Appendix A contains a sample collection tool.

2022 National Standards for DSMES Review Criteria

National Standard 2:

Population and Service Assessment

The DSMES service will evaluate their chosen target population† to determine, develop, and enhance the resources, design, and delivery methods that align with the target populations' needs and preferences.

† - MDHHS will use the term priority population throughout the document

Guidance	Required Documentation
To provide effective DSMES services, the priority population must be identified, and their social determinates of health (SDOH) understood. Consider whether your priority population knows and understands their risks associated with diabetes. Once information on your priority population has been collected and assessed (including the SDOH), the information should be used in the development, the design, and delivery of DSMES services to ensure the needs of the population will be met.	Written description of the DSMES priority populations' demographics and social determinates of health. * Documentation of priority population's identified barriers to DSMES and plans to address them. * Annual documentation of gaps between the population served and the priority population with a plan to address the gap.
	*This documentation must be created at least once during the 4-year certification cycle. It does not necessarily have to be at the beginning of the cycle. For example, DSMES services may wish to update this when the hospital's Community Health Needs Assessment is completed.
	RWJ County Health Rankings

	US Census Bureau RWJ Where You Live Affects How Long You Live Additional Robert Wood Johnson Resources

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National Standard 3:

DSMES Team

All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement. At least one team member will be identified as the DSMES quality coordinator and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes.

Guidance	Required Documentation
The Quality Coordinator does not have to be a healthcare professional. However, ongoing education in diabetes is required. The DSMES Team may consist of one or multiple disciplines. New educators must obtain 15 hours of continuing education (if not a CDCES or BC-ADM) within four months of joining the team.	Documentation of at least one Quality Coordinator at all times. Documentation of the Quality Coordinator's responsibilities within the health system. Documentation that at least one member of the DSMES Team is a RDN or RN or pharmacist or other healthcare professional holding a CDCES certificate. Proof of professional license for the entirety of the certification period for all healthcare professionals. Proof of BC-ADM and CDCES credentials must be kept on file. If educator is not a BC-ADM or CDCES then 15 hours of continuing education in diabetes related topics must be kept on file.

Diabetes Community Care Coordinators (formerly referred to as paraprofessionals) (DCCC) may be involved in DSMES services and must be supervised by a professional DSMES team member.	Attestation that DCCC reports to a DSMES team member. Evidence that DCCC has 15 hours of training related to their role on the team prior to providing DSMES services and annually. All continuing education/training can be obtained based on either the calendar year or the DSMES service's certification year. All DSMES team members must use the same timeframe.

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National Standard 4: **Delivery and Design of DSMES Services**	**DSMES services will utilize a curriculum to guide evidence-based content and delivery; to ensure consistency of teaching concepts, methods, and strategies within the team; and to serve as a resource for the team. DSMES teams will have knowledge of and be responsive to emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies relevant to the population they serve.**

Guidance	Required Documentation
A comprehensive, published, up to date curriculum must be utilized as the basis for all content, teaching strategies, learner evaluation. The curriculum must contain the following content areas for Type 1, 2 and GDM: • Pathophysiology of diabetes and treatment options • Healthy coping • Healthy eating • Being active • Taking medication • Monitoring • Reducing risks (treating acute and chronic complications) * • Problem solving and behavior change strategies † *The curriculum must have disaster preparedness included.	Proof that a published, up to date curriculum is in place and is appropriate for the priority population. This could be a written curriculum book or an electronic copy. Either version must be available to all team members. Proof that the curriculum, supporting materials, and modes of delivery are reviewed/revised annually and that they continue to meet the needs of the priority population.

† Diabetes Distress must be included It is recommended that interactive teaching styles including meaningful discussions to address individual questions while fostering positivity be utilized. The curriculum content and delivery should be tailored to your priority population, be creative and culturally appropriate. People with diabetes benefit from connecting them to support options to encourage practical integration of diabetes self-management.	
	ADCES - Dealing with Diabetes During a Disaster Disaster Relief | ADA (diabetes.org) ADA Statement on Emergency and Disaster Preparedness CDC - Diabetes Care During Emergencies CDC - When DSMES is Emergency Medicine

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National Standard 5:

Person-Centered DSMES

Person-centered DSMES is a recurring process over the life span for PWD. Each person's DSMES plan will be unique and based on the person's concerns, needs, and priorities collaboratively determined as part of a DSMES assessment. The DSMES team will monitor and communicate the outcomes of the DSMES services to the diabetes care team and/or referring physician/other qualified health care professional.

Guidance	Required Documentation
Assessment: Each DSMES intervention should be person-centered and address the individual needs of the person with diabetes. It should be initiated with an assessment of the current concerns, needs and priorities of the person with diabetes. DSMES Plan: Following the assessment, a plan should be developed. The ADCES7 may be used as a base for the plan. An evaluation of learner understanding must be included with the topics covered during each session. An action-oriented behavior change goal must be set by the participant and the outcome obtained and documented. One clinical outcome must be measured, documented, and shared with the healthcare team including the referring provider.	Explanation of the assessment process including the collaboration between educator and participant. The following components will be available in the participant record: • DSMES Assessment • DSMES Plan • Topics covered at each visit including date/time and identification of the educator and evaluation of learner for each topic. • Behavior change goal with the outcome* • Participant outcome measured and baseline and follow-up • Evidence the DSMES as planned or provided, and outcomes are communicated to the referring provider.

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National Standard 6: **Measuring and Demonstrating Outcomes of DSMES Services**	**DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services. Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services optimization and/or redesign.**

Guidance	Required Documentation
To effectively measure the impact of DSMES services ongoing continuous quality improvement must be implemented. Evaluation of the data should be used to improve services.	At least one behavior change category will be selected to report aggregated participant data annually (this will be reported on the MDHHS Annual Report). One CQI project will be reported annually and include the following details: • The opportunity that is being improved or changed. • What will success look like. • Routine measurements of progress (minimum every 6 months) • Outcome (e.g., changes adopted) One additional program level outcome will be reported.
	Fillable Plan Do Study Act (PDSA) Fillable Form Tool for Healthcare Quality Improvement (QI) - Agency for Healthcare Research and Policy CDC DSMES Toolkit – Quality Improvement (still labeled as Standard 10 but the information is accurate) ADCES created a helpful table with examples of DSMES Outcomes.

Appendix A:

Standard 1

Identification of Stakeholders

Annual Review/Revision Date:_____

External Stakeholder Name	External Stakeholder Title	Explanation of how the stakeholder may provide benefit to DSMES services
EXAMPLE: Jane Smith, RN	Office Manager, Family Care Clinic	Jane can help us with referrals by reminding providers at the practice of the service. She can also provide feedback on the referral processes.