AADE and ADA Requirements for Each Standard

Standard	AADE – Essential Elements/Indicators to Meet Each Standard	ADA – Essential Elements/Indicators to Meet Each Standard
Standard 1 – Internal Structure: ***The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization - large, small, or independently operated.***	A. The DSMES service will have documentation that addresses where the DSMES services fit into the greater organization and clear channels of communication to the service from sponsorship, including all DSMES team members. The DSMES service will document its mission statement and program goals. 1. There is evidence of the DSMES service's: a. Organization structure b. Mission statement and program goals c. Letter of support from sponsoring organization/owner	A. The DSMES service will have documentation that addresses its organizational structure, mission, and goals and its relationship to the larger sponsoring organization annually. 1. There is evidence of the DSMES service's: a. Organization structure b. Mission statement c. Service goals and their outcomes reviewed annually B. There is annual evidence of the organization's support and commitment to the DSMES services. (e.g. Letter of support, participation of senior administrative personnel in the advisory process or onsite audit)
Standard 2 – Stakeholder Input: ***The provider(s) of DSMES will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.***	A. A formal advisory board or committee is not required, but the DSMES provider must engage key stakeholders to elicit input on DSMES services and outcomes. 1. There is evidence of a documented process for seeking outside input, including a list of identified stakeholders. Stakeholders should be representative of the community where the services are provided and can be identified from DSMES participants, referring practitioners, and community based groups that support DSMES. (e.g. of stakeholders - health clubs and health care professionals [both within and outside of the organization] who provide input to promote value, quality, access, and increased utilization) 2. There is documentation of the service's outreach to community stakeholders and the input from these stakeholders must be documented annually and available for review as requested.	A. An Advisory Group is in place and is representative of diabetes stakeholders in the provider's service community. 1. There is evidence of a process for seeking external input and/or describing activities involving diverse stakeholders providing input or feedback for the DSMES services development, access, and/or improvement. (e.g. of documentation: meeting minutes, stakeholder emails, conference call documentation, surveys, or ballots) (e.g. of external stakeholders – person with diabetes, person affected by diabetes, community group representative(s), and health care professionals outside of the DSMES service) 2. Single discipline DSMES services must also have a health care professional(s) of a different discipline-other than that of the single discipline DSMES service-and this must be reflected in the documentation of the activity. B. Activities of the Advisory Group, reflecting its input in enhancing the quality of the DSMES services, are documented at least annually. 1. There is documented evidence of at least annual input from external stakeholders of the services. (e.g. meeting minutes, stakeholder ballots, surveys, documented phone consults, or emails) 2. The names of the external

		stakeholders are identified and reflected on the annual activity documentation.
Standard 3 – Evaluation of Population Served: ***The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services.***	A. The DSMES service will document and review available demographic data for their area and update as needed. The DSMES service will determine the factors that may prevent people with diabetes from attending DSMES. Services such as learning session frequency and length should be designed based on the population's needs and accessibility. 1. Documentation exists that describes community demographics for the area where DSMES services are provided. 2. Documentation exists describing the allocation of resources to meet population specific needs. (e.g. space, equipment, materials, curriculum, staff, interpreter services, accommodations for low vision, hearing impaired, disabled, low literacy, etc.) 3. Documentation exists of the actions taken to overcome access-related problems.	A. The DSMES service will identify who to serve in its community, and assess factors that may prevent the population served from accessing the DSMES services. 1. Documentation exists that reflects an annual assessment of: a. The population served and b. The population the DSMES services wish to serve. (e. g. demographics, cultural influences, access to health care services, and barriers to education) 2. Documentation exists that reflects the DSMES resources relative to the population served and the population the DSMES services wish to serve. (e. g. physical space, staffing, scheduling, equipment, interpreter services, multi-language education materials, low literacy materials, large print education materials, mobile devices, and upload software) 3. Documentation exists reflecting a plan to address any identified gaps in services. (e. g. identification of DSMES resources, additional services, locations, hours of operations, and group services times)
Standard 4 – Quality Coordinator Overseeing DSMES Services: ***A quality coordinator will be designated to ensure implementation of the Standards and oversee the DSMES services. The quality coordinator is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement.***	A. The DSMES service has a quality coordinator who is responsible for all components of DSMES, including evidence-based practice, service design, evaluation, and continuous quality improvement. 1. There is a résumé or CV that demonstrates the quality coordinator's experience with chronic disease management, facilitating behavior change, and managing clinical services. 2. There is evidence of documentation that the quality coordinator provides oversight of DSMES services, which includes: a. Implementation of the standards b. Ensuring services are evidence-based c. Making sure service design incorporates population needs d. Ensuring ongoing service evaluation and continuous quality improvement plan is reviewed at least annually	A. The DSMES service has a designated coordinator who oversees the planning, implementation, and evaluation of the services at all sites. 1. There is documentation of one quality coordinator as evidenced by a position description or performance appraisal tool. B. The coordinator is academically or experientially prepared in areas of chronic disease care, patient education, and/or program management. 1. Curriculum Vitae, résumé, or position description of the coordinator reflects appropriate qualifications. 2. The coordinator is a CDE or BC-ADM**,** or annually accrues 15 hours of CE credits provided by National Certification Board for Diabetes Educators (NCBDE) approved CE providers based on the DSMES service's anniversary month. (e. g. of CE topics: chronic disease care, patient education, marketing, health care administration, and business management.)

	3. Documentation exists that the quality coordinator received a minimum of 15 hours of CE credits per year (service management, education, chronic disease care, behavior change) OR credential maintenance (CDE or BC-ADM).	
Standard 5 – DSMES Team: ***At least one of the team members responsible for facilitating DSMES will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or be another health care professional holding certification as a diabetes educator (CDE®) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.***	A. The DSMES service team has an RN, RD or pharmacist with training and experience pertinent to DSMES, OR a member of a health care discipline that holds certification as a CDE or BC-ADM. B. Professional DSMES team members must maintain their current credentials. Professional team members must document appropriate continuing education of diabetes-related content, which can include chronic disease management, diabetes specific or related content, behavior change, marketing, and healthcare administration. 1. Evidence exists of current credentials for every professional team member including valid licensure, registration and/or certification. 2. Documentation exists of at least 15 hours of diabetes-related continuing education annually for all professional team members OR evidence of current CDE or BC-ADM credential. C. Paraprofessional Team Members must demonstrate previous experience or training, in diabetes, chronic disease, health and wellness, community health, community support, healthcare, and/or education methods either through a resume or certificate. Training obtained within the required timeframe may also fulfill the continuing education requirement for paraprofessionals. 1. Evidence exists of at least 15 hours of diabetes-related continuing education annually specific to the role they serve within the team. 2. Documentation exists that the diabetes paraprofessional directly reports to the quality coordinator (if a healthcare professional) or one of the professional DSMES team members. D. Documentation exists explaining a mechanism for ensuring participant needs are met if needs are outside of the diabetes professional or paraprofessional's scope of practice and expertise.	A. The DSMES team must include at least one RN or one RD/N or one pharmacist or one CDE or one BC-ADM. 1. At least one RN or one RD/N or one pharmacist or one CDE or one BC-ADM is part of the DSMES team and is involved in the education of service participant/s. B. Professional DSMES team members must be qualified and provide diabetes education within each discipline's scope of practice. 1. Professional team members must have valid, discipline-specific licenses and/or registrations. 2. Professional team members must demonstrate ongoing training in DSMES topics. a. Non-CDE or BC-ADM professional team members must have documentation reflecting 15 hours CE from an NCBDE approved CE provider annually based on the DSMES services anniversary month. The CEU must be a topic included in the NCBDE examination content outline. b. Non-CDE or BC-ADM professional team members who do not have 15 hours of diabetes or diabetes related CE within the 12 months of joining the DSMES team must accrue 15 CE within the first four months of joining the DSMES service as a team member. C. Paraprofessional DSMES team members must be qualified to provide diabetes education within each discipline's scope of practice. 1. Paraprofessional team members must demonstrate previous experience or training in: diabetes, chronic disease, health and wellness, health care, community health, community support, and/or educational methods as evidences by résumé or certificate. (e.g. lab tech, medical technician, medical aid, or community health worker, etc.) 2. Paraprofessional DSMES team members must have supervision by the quality coordinator or health care professional DSMES team member (identified in A.1. above) Supervision can be demonstrated by position description or performance appraisal tool. 3. Paraprofessional team members must demonstrate ongoing training in DSMES topics. a. Paraprofessional team members must have documentation reflecting 15 hours of training in diabetes or diabetes related topics initially before instructing

		participants and annually based on the DSMES services anniversary month. (e.g. documented in-service training, drug or device training, etc.) b. Paraprofessional instructors must have initial and annual documentation based on the DSMES services anniversary month reflecting competency in the area(s) of the DSMES services they instruct on. D. A mechanism must be in place to meet the needs of participants if they cannot be met within the scope of practice of the DSMES team. 1. Documentation reflecting procedures for meeting participants' educational needs when they are outside the scope of practice of the DSMES team member(s).
Standard 6 – Curriculum: A curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.	A. The curriculum is the evidence-based foundation from which the appropriate content is drawn to build an individualized education plan based on each participant's concerns and needs. 1. Evidence is submitted of a written curriculum, tailored to meet the needs of the target population, and including all content areas listed in the essential elements: a. Pathophysiology and treatment options b. Healthy eating c. Physical activity d. Medication usage e. Monitoring, including pattern management f. Preventing, detecting and treating acute (hypoglycemia, hyperglycemia, diabetic ketoacidosis, sick days, severe weather or crisis supply management) and chronic complications (immunizations, eye, foot, dental, exams and kidney function testing as indicated) g. Healthy coping h. Problem solving B. There is evidence the curriculum is reviewed at least annually and updated as appropriate to reflect current evidence, practice guidelines, and cultural appropriateness.	A. A written curriculum, with learning objectives and criteria for methods of delivery and evaluating successful learning outcomes, is the framework for DSMES services. 1. Documentation is present validating that the education process is guided by a reference curriculum with content, learning objectives, methods of delivery, and criteria for evaluating learning for the populations served (including type 1 diabetes, type 2 diabetes, secondary diabetes, gestational diabetes, or pregnancy complicated by diabetes) in the following 9 content areas: a. Diabetes pathophysiology and treatment options b. Healthy eating c. Physical activity d. Medication usage e. Monitoring and using patient-generated health data (PGHD) f. Preventing, detecting, and treating acute complications including hypoglycemia, hyperglycemia, diabetes ketoacidosis, sick day guidelines, and severe weather or situation crisis and diabetes supplies management g. Preventing, detecting, and treating chronic complications including immunizations and preventive eye, foot, dental, and renal examinations as indicated per the individual participant's duration of diabetes and health status h. Healthy coping with psychosocial issues and concerns i. Problem solving 2. There are supporting materials relevant to the population served. B. There is periodic review and revision of the curriculum and/or course materials to reflect current evidence.

		1. There is evidence of regular review and/or revisions as needed, or at least annually, of the curriculum and/or materials by the DSMES team and/or advisory group. C. There is evidence that the teaching approach is interactive, patient-centered, and incorporates problem solving. 1. There is documentation in the curriculum or other supporting documents which demonstrate that instruction is tailored/individualized and involves interaction.
Standard 7 – Individualization: The DSMES needs will be identified and led by the participant with assessment and support by one or more DSMES team members. Together, the participant and DSMES team members will develop an individualized DSMES plan.	A. There is evidence that professional members of the team assess each participant to collaboratively determine the best interventions and support strategies for them. 1. The assessment must incorporate information about the individual's: a. Health status 1. Relevant medical and diabetes history 2. Physical limitations 3. Hospitalizations or ER visits related to diabetes b. Psychosocial adjustment 1. Emotional response to diabetes/diabetes distress 2. Social support systems 3. Readiness to change 4. Financial means c. Learning level 1. Diabetes knowledge 2. Health literacy and numeracy d. Lifestyle practices 1. Cultural influences 2. Health beliefs and attitudes 3. Diabetes self-management skills and behaviors B. The assessment may be done individually or in a group. The participant may complete a self-assessment before the initial visit. The process should be appropriate for the population served. C. There is evidence that the health care professional uses the information gleaned from the assessment to determine the appropriate	A. Participants receive a comprehensive assessment, including baseline diabetes self-management knowledge and skills and readiness for behavior change. 1. An assessment of the participant is performed in the following areas in preparation for the education plan: a. Diabetes disease process b. Nutritional management c. Physical activity d. Using medications e. Monitoring blood glucose f. Preventing, detecting, and treating acute complications g. Preventing, detecting, and treating chronic complications h. Clinical (diabetes and other pertinent clinical history) i. Cognitive (knowledge of self-management skills and functional health literacy) j. Psychosocial (emotional response to diabetes) k. Diabetes distress and support systems l. Behavioral (readiness for change, lifestyle practices, and self-care behaviors) 2. Parts of the complete initial assessment may be deferred if applicable and the rationale for deferment is documented. B. Participants' concerns, needs, and self-management skills and knowledge lead the development of the individualized education plan. 1. There is evidence of ongoing education planning and behavioral goal-setting based on the assessed and/or re-assessed needs led by the participant's individual needs. C. There is implementation of the education plan. 1. Education is provided based on participant need(s) and the education plan. D. The education process is documented in the permanent record. 1. Documentation in the participant's health record includes the DSMES professional team member's assessment of the participant's service needs, education plan, intervention, and outcomes of education provided.

	educational and behavioral interventions, including enhancing the participant's problem-solving skills. 1. The plan needs to be developed collaboratively with the participant and family or others involved with the participant's care as required. 2. This will guide the process of working with the participant and must be documented in the education records. D. This evidence is to be submitted via a completely de-identified participant record. According to HIPAA regulations, the participant's name, date of birth, address, provider, names, addresses, telephone numbers, email addresses, medical record numbers, health plan beneficiary numbers, and account numbers need to be deleted from the record.	
Standard 8 – Ongoing Support: ***The participant will be made aware of options and resources available for ongoing support of his/her initial education, and will select the option(s) that will best maintain his/her self-management needs.***	A. The de-identified chart must include documentation of ongoing self-management support options specific to the community where the DSMES services are delivered, with participant preferences noted. B. Participant's plans of support can include for example: 1. Internal or external group meetings (connection to community and peer groups online or locally) 2. Ongoing medication management 3. Continuing education 4. Resources to support new or adjustments to existing behavior change goal setting 5. Physical activity programs 6. Weight loss support 7. Smoking cessation 8. Psychological support C. DSMES providers must provide evidence of identified community resources that may benefit their participants and support their ongoing efforts to maintain their achievements reached during active participation in the DSMES services. 1. The community resource ongoing support list must be reviewed periodically to keep it up to date. 2. Examples of community resources include: a. The local YMCA b. Activity-related classes at a senior center c. Local support groups d. Grocery store tours e. Walking groups or local walking trails f. Community center swimming pool g. Church group h. Dental school for discounted or free cleanings i. Local mental health services	A. Participants will have a plan for post education self-management support for ongoing diabetes self-care beyond the formal self- management education process. 1. The DSMES participant will select his/her personalized support plan outside of the DSMES services. (e. g. worksite programs, support groups, community programs, on-line diabetes support services, exercise programs, walking groups, etc.) 2. The DSMES provider has a current list of participant support options that the participant may consider when selecting his/her support plan. 3. The listing of support options is reviewed/revised when needed or annually at a minimum.

Standard 9 – Participant Progress: The provider(s) of DSMES services will monitor and communicate whether participants are achieving their personal diabetes self-management goals and other outcome(s) to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.	A. The DSMES service must focus on participant progress in behavioral and clinical outcome measures, and the effectiveness of the educational interventions. B. The AADE7™ Self-Care behaviors serve as a useful framework for documenting behavior change. 1. Participants do not need to work on all seven behaviors at once. 2. Most will select one or two initial goals. 3. All goals must be SMART goals (Specific, Measurable, Achievable, Relevant, and Time-bound). C. Clinical outcome measurements need to be chosen based on the population served, organizational practices, and availability of the outcome data. 1. To determine the impact of DSMES services, the coordinator must compare outcomes after engagement in DSMES services with a baseline. D. The de-identified participant record shows evidence of: 1. At least one SMART behavioral goal with follow up and measured achievement. 2. Documentation of at least one clinical outcome measure to evaluate the effectiveness of the educational intervention. 3. For all Medicare Providers, there must be documentation of communication back to the referring provider, including the education provided, and the participant outcomes.	A. The DSMES service measures the effectiveness of the educational intervention(s) through the evaluation of goals and other outcomes for each participant. 1. The DSMES service has a process for follow-up to evaluate and document at least one of each of the following: a. Behavioral goal achievement e. g. healthy eating, being active, monitoring, or other) b. Other participant outcome (e.g. clinical, quality of life, satisfaction, hospital days, ER visits, baby weight, C-section delivery rate, DKA, or A1C one year after insulin initiation/diagnosis, etc.). 2. Behavioral goal(s) and other participant outcome(s) assessment is personalized and reviewed at appropriate intervals. There must be evidence of communication with the referring provider, or if there is no referring provider, then with another health care provider outside of the DSMES services regarding the education planned or provided and participant outcomes. Note: Medicare and many insurers require a referral for reimbursement of DSMES services, and for these participants, the communication would need to be with the referring provider.
Standard 10 – Quality Improvement: The DSMES services quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.	A. The DSMES service must assess its operations, including the delivery of education and support. B. DSMES providers must submit evidence of a procedure to collect, aggregate, analyze, and report clinical and process outcomes and behavioral goal achievement. C. Examples of outcomes to measure include but are not limited to: 1. Process outcomes: a. Wait times b. Program attrition c. Referrals d. Education process e. Reimbursement issues f. Follow up 2. Clinical outcomes: a. A1c' b. Percentage of body weight lost c. Foot and eye exams d. ER visits e. Newborn weight	A. The DSMES provider has a quality improvement process and plan in place for evaluating the education process and service outcomes. 1. There is evidence of aggregation of the following participant outcomes: a. At least one participant behavioral goal outcome b. At least one other participant outcome 2. There is documentation of a Continuous Quality Improvement (CQI) project which will include: a. Opportunity for DSMES service improvement or change (what are you trying to improve, fix, or accomplish) b. Baseline project achievement (new providers may not have a baseline measure at the time of application)

	f. C-section delivery rate g. Hospitalization days 3. Behavioral outcomes a. Participant satisfaction b. Behavioral goal achievement c. Reduction in diabetes distress D. The DSMES service must submit documentation of a CQI project measuring the effectiveness and impact of the DSMES services that identifies areas of improvement through the evaluation of process and outcome data and is reviewed and reported annually. 1. Data for the CQI plan is collected and used to make positive changes-even when things are going well, rather than waiting for something to go wrong and then fixing it. 2. All DSMES sites, including new entities, must be able to show implementation of the CQI plan by the six-month mark. 3. A program may be randomly selected within their first year of accreditation to submit their CQI plan. 4. Annually, DSMES providers will need to submit a report of their CQI project from the previous 12 months through their anniversary date, and their CQI plan for the next 12 months.	c. Project target outcome d. Outcome assessment and evaluation schedule B. Quality improvement is based on regular aggregation of DSMES outcomes data and application of results to enhance quality of DSMES services and address gaps in services. 1. DSMES service providers will have documentation reflecting an ongoing quality improvement project and implementation of a new project when applicable. a. Existing DSMES service providers will have documented quality improvement project outcomes. b. Quality improvement outcomes will be measured annually at a minimum. c. Existing DSMES service providers will have documented plans and actions based on project outcomes.