Comparing the Processes: Accreditation and Recognition

Carolé Mensing, RN, MA, CDE

Diabetes education programs are developed to serve the diabetes community by offering quality education that meets a set of standards and is then eligible for third-party insurance reimbursement. Three organizations are authorized by the U.S. Centers for Medicare and Medicaid Services to determine whether diabetes education programs meet required standards. Each of the three relies on the 2007 edition of the national Standards for Diabetes Self-Management Education. This article summarizes similarities among and unique qualities of each of the organization's approaches to assuring quality.

Address correspondence to Carolé Mensing, RN, MA, CDE, Joslin Diabetes Center, One Joslin Place, Boston, MA 02215.

This article is being co-published by the American Diabetes Association's *Diabetes Spectrum* and the American Association of Diabetes Educators' *The Diabetes Educator.*

This article is being co-published by the American Diabetes Association's *Diabetes Spectrum* and the American Association of Diabetes Educators' *The Diabetes Educator.*

Diabetes self-management education (DSME) continues to be cited as a cornerstone of effective diabetes care and a crucial part of a patient's success in living well with diabetes. Supporting the philosophies of the Chronic Care Model[1,2] and effective self-management training,[3] DSME provides a forum for informing and activating patients to manage their illness, better interact with the available systems for diabetes care, and ultimately achieve the best possible outcomes. In addition, the practice of DSME has been established as crucial to the care and management of people with diabetes, and measurable behavior change has emerged as the unique proxy for evaluating the impact of working with a diabetes educator.[4,5] DSME is formally defined as the knowledge, skill, and ability necessary for self-care, through informed decision making, problem solving, and collaboration with the health care team to improve clinical outcomes, health status, and quality of life.[6]

Diabetes educators have become even more accountable for both their approaches to patient care and their comprehensive diabetes education programs. An educational standards framework such as the National Standards for Diabetes Self-Management Education (NSDSME)[6] plays an important role in standardizing the educational process, content, and outcome measurement for helping people with diabetes or at risk for diabetes enhance their quality of life and better manage their condition.

The National Diabetes Advisory Board (NDAB) pioneered this framework with the creation of the National Standards for Diabetes Self-Management Education[7] in the early 1980s. These standards were designed to define quality diabetes education and to assist diabetes educators in a variety of settings in providing evidence-based education and facilitate optimal health outcomes for patients with or at risk for diabetes.

To remain current, these standards are reviewed and revised approximately every 5 years to better reflect the changes and dynamic nature of the health care community. In this decade, two sets of updated NSDSME have been presented, first in 2000[8] and more recently in 2007.[6] The 2007 revised standards continue to offer educators a program framework of 10 standards. These

standards are based on the following five evidence-based principles:

- Diabetes education is effective for improving clinical outcomes and quality of life, at least in the short term.[3,9–14]
- DSME has evolved from primarily didactic presentations to more theoretically based empowerment models.[10,15]
- There is no one "best" education or approach; however, programs incorporating behavioral and psychosocial strategies demonstrate improved outcomes.[16–18] Additional studies show that age- and culturally appropriate programs improve outcomes[19–23] and that group education is effective.[11,13,14,24,25]
- Ongoing support is crucial to sustain progress made by participants during DSME programs.[10,20,26,27]
- Behavioral goal setting is an effective strategy to support self-management behaviors.[28]

The revised NSDSME[7] continue to address the framework format of structure, process, and outcome guidelines for establishing or maintaining an education program, influencing third-party reimbursement, and offering educators a framework for quality evidence-based program development, implementation, and evaluation.

Participating Organizations

In 1986, the American Diabetes Association (ADA), having partnered with NDAB and other well-known community organizations in developing the standards, became the first organization to develop an application and review process to identify programs meeting the standards. During the same time period, the Indian Health Service (IHS) was developing its own internal structure and process based on the NSDSME for review of diabetes education programs in tribal communities and provision of guidelines and technical assistance for program improvement.

In 1997, the federal Balanced Budget Act passed, permitting the U.S. Health Care Finance Administration (HCFA; now called the Centers for Medicare and Medicaid Services [CMS]) to provide coverage for diabetes self-management training (DSMT). Organizations were invited to develop and implement systems to publicly acknowledge those programs following the guidelines identified in the standards.

ADA's Education Recognition Program (ERP) process was well established at this time, with 530 recognized programs, and HCFA (now CMS) awarded the first national accrediting status to ADA in preparation for the final ruling on coverage for DSMT in 2001. This process identified programs that would later qualify for payments for delivering DSMT. The IHS was approved by CMS as a national accrediting organization in 2002. A third organization approved in 2009 was the American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program (DEAP). As the only organization dedicated solely to diabetes education, this was a natural step for AADE.

There are not enough DSME programs available to meet the needs of the increasing number of people with diabetes. ADA-recognized programs increased from 39 in 1986 to 2,038 as of October 2009, while diabetes prevalence grew from 6.4 million in 1986 to 24 million currently. The additional site provision in the ADA recognition process, which allows organizations to receive accreditation for multiple sites, has facilitated the expansion of programs from some of the existing primary program sites, for a total of 3,451 currently recognized sites.[29] IHS tribal and urban Indian diabetes education programs may apply for IHS accreditation. There are currently 42 IHS Diabetes Education Recognized Programs (IDERPs).[30] As of December 2009, programs accredited through the AADE have also increased from 13 to 82 in 250 sites.[31]

Because of the increased incidence of diabetes and increased demand for DSME, diabetes education programs are needed in a variety of settings beyond hospital outpatient and doctors' office settings. Such additional settings include pharmacies and community centers. However, nontraditional settings still must be held accountable for quality, reliability, and accuracy.

According to the ADA Recognition Program database, the predominant practice setting with ERP recognition remains the hospital outpatient setting. All three organizations (AADE, ADA, and IHS) offer program flexibility and multisite accreditation, while continuing the tradition of commitment to quality.

Comparing the Process: Similarities and Differences

All three organizations (AADE, ADA, and IHS) use the recently published NSDSME[6] and are deemed certifying bodies by CMS and other third-party insurers, which is required for reimbursement. Each certifying body has similar but unique requirements. Two comparative summaries are offered in this article. Table 1 (p. 68–70) offers a structured comparison of several of the key administrative points of each of the three certifying bodies (AADE's DEAP, ADA's ERP, and IHS's IDERP), including fees, application processes, audits, and a brief overview of standards.

Each certifying body has a formal application process and requires supporting documentation. AADE and ADA require a fee with applications. The certifying bodies also require annual reports and renewals and have a process for auditing existing programs to ensure continued compliance with accreditation criteria. All have volunteer auditors who are trained reviewers and conduct random program audits.

A second comparison, in Table 2 (p 71–78), offers a more detailed review of the similarities and differences related to each of the published standards[6] between ADA and AADE. This table details definitions and required documents. (The IHS program was not compared because its requirements are specifically designed for the unique community it serves.)

Additionally, each organization uses similar terminology. These terms are defined in Table 3 (p. 78). For example, ADA and IHS use the term "recognition," whereas AADE uses the term "accreditation." Each

program is also uniquely identified by a related acronym—DEAP, ERP, or IDERP. Other terminology differences noted include measurement references to the interpretation of the standards, such as "indicators" (ADA and IHS) and "essential elements" (AADE). All use a yes-or-no checklist for standards being met or not met. Although their terminology differs, the three programs' content and concepts are all based on the NSDSME.[6]

Summary

There are not enough DSME programs available to meet the needs of the increasing number of people with diabetes; more educational programs are needed. Educators must be prepared to review their practices, explore ways to expand their services, and be willing to meet the needs of their patients in a variety of traditional and nontraditional ways, all while maintaining quality DSME with documented, measurable outcomes. Accreditation/recognition supports the provision of quality DSME, is essential for reimbursement, and offers public acknowledgment of accomplishment. Three organizations (ADA, AADE, and HIS) have been authorized by the U.S. Centers for Medicare and Medicaid Services to determine whether diabetes education programs meet required standards. Each of these organizations supports the NSDSME and the need for more quality DSME programs. More information about each organization can be found at the following Web sites:

- AADE: Information available online from: http://www.diabeteseducator.org/ProfessionalResources/accred
- ADA: Information available online from: http://professional.diabetes.org/recognition.aspx?cid=57941
- IHS: Information available online from: http://www.diabetes.ihs.gov/index.cfm?module=programsIDERP

Acknowledgments

The individuals listed are acknowledged for the provision of information, review, and preparation of content, which the author used and interpreted to develop this article.

- Tammy L. Brown, MPH, RD, BC-ADM, CDE, Director, Integrated Diabetes Education Recognition Program, Indian Health Service Division of Diabetes Treatment and Prevention, Albuquerque, N.M.
- Paulina Duker, MPH, RN, BC-ADM, CDE, Director, Education and Recognition Programs, American Diabetes Association, Alexandria, Va.
- Karen Fitzner, PhD, Chief Science and Practice Officer, American Association of Diabetes Educators, Chicago, Ill.
- Leslie E. Kolb, RN, BSN, MBA, Director, Diabetes Education Accreditation Program, American Association of Diabetes Educators, Chicago, Ill.
- JoAnne Lafley, MSN, RN, CDE, Reviewer, Integrated Diabetes Education Recognition Program, Indian Health Service, Albuquerque, N.M.
- Melinda Maryniuk, RD, MEd, LDN, CDE, Director, Joslin Diabetes Center, Boston, Mass.
- Lois Moss-Barnwell, MS, RD, LDN, CDE, Director, Diabetes Education Accreditation Program, American Association of Diabetes Educators, Chicago, Ill.
- Robin G. Thompson, MS, APRN, BC-ADM, CDE, Review Coordinator, Integrated Diabetes Education Recognition Program, Indian Health Service, Albuquerque, N.M.

References

[1]Ahmad U, Brooks M, Emerson S, Korykowski K, Orchard T, Piatt G, Siminerio L, Simmons D, Thomas J: Translating the chronic care model into community: results from a randomized controlled trial of a multifaceted diabetes care intervention. *Diabetes Care* 29:811– 827, 2006

[2]Siminerio L, Piatt G, Emerson S, Ruppert J, Saul M, Solano F, Stewart A, Zigbor J: Deploying the Chronic Care Model to implement and sustain diabetes self-management training programs. *Diabetes Educ* 32:253–260, 2006

[3]Norris S, Engelgau MM, Narayan V: Effectiveness of self-management training in type 2 diabetes: systematic review of randomized controlled trials. *Diabetes Care* 24:561–587, 2001

[4]Mulcahy K, Maryniuk M, Peeples M, Peyrot M, Tomky D, Weaver T, Yarborough P: Position statement: Standards for outcomes measurement of diabetes self-management education. *Diabetes Educ* 29:804–816, 2003

[5]Austin M: Importance of self-care behaviors in diabetes management: business briefing. *US Endocr Rev* September:16–21, 2005

[6]Funnell M, Brown T, Childs B, Haas L, Hosey G, Jensen B, Maryniuk M, Peyrot M, Piette J, Reader D, Siminerio L, Weinger K, Weiss M: National standards for diabetes self-management education. *Diabetes Care* 30:1630–1637, 2007

[7]National Diabetes Advisory Board: National standards and review criteria for diabetes patient education programs: quality assurance for diabetes patient education. *Diabetes Educ* 12:286–291, 1986

[8]Mensing C, Boucher J, Cypress M, Weinger K, Mulcahy K, Barta P, Hosey G, Kopher W, Lasichak A, Lamb B, Mangan M, Norman J, Tnaja J, Yauk L, Wisdom K, Adams C: National standards for diabetes self-management education. *Diabetes Care* 23:682–689, 2000

[9]Brown SA: Interventions to promote diabetes self-management: state of the science. *Diabetes Educ* 25 (Suppl. 6):52–61, 1999

[10]Norris SL, Lau J, Smith SJ, Schmid CH, Engelgau MM: Self-management education for adults with type 2 diabetes: a meta-analysis on the effect on glycemic control. *Diabetes Care* 25:1159–1171, 2002

[11]Norris SL: Self-management education in type 2 diabetes. *Pract Diabetol* 22:713, 2003

[12]Gary TL, Genkinger JM, Guallar E, Peyrot M, Brancati FL: Meta-analysis of randomized educational and behavioral interventions in type 2 diabetes. *Diabetes Educ* 29:488–501, 2003

[13]Deakin T, McShane CE, Cade JE, et al. Review: group based education in self-management strategies improves outcomes in type 2 diabetes mellitus. *Cochrane Database Syst Rev* CD003417, 2005

[14]Renders CM, Valik GD, Griffin SJ, Wagner EH, Eijk Van JT, Assendelft WJJ: Interventions to improve the management of diabetes in primary care, outpatient, and community settings: a systematic review. *Diabetes Care* 24:1821–1833, 2001

[15]Funnell MM, Anderson RM: Patient empowerment: a look back, a look ahead. *Diabetes Educ* 29:454–464, 2003

[16]Roter DL, Hall JA, Merisca R, Nordstrom B, Cretin D, Svarstad B: Effectiveness of interventions to improve patient compliance: a meta-analysis. *Med Care* 36:1138–1161, 1998

[17]Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J: Self-management approaches for people with chronic conditions: a review. *Patient Educ Couns* 48:177–187, 2002

[18]Skinner TC, Cradock S, Arundel F, Graham W: Lifestyle and behavior: four theories and a philosophy; self-management education for individuals newly diagnosed with type 2 diabetes. *Diabetes Spectrum* 16:75–80, 2003

[19]Brown SA, Hannis CL: Culturally competent diabetes education for Mexican Americans: the Starr County Study. *Diabetes Educ* 25:226–236, 1999

[20]Anderson RM, Funnell MM, Nwankwo R, Gillard ML, Oh M, Fitzgerald JT: Evaluating a problem based empowerment program for African Americans with diabetes: results of a randomized controlled trial. *Ethn Dis* 15:671–678, 2005

[21]Sarkisian CA, Brown AF, Norris CK, Wintz RL, Mangione CM: A systematic review of diabetes self-care interventions for older, African American or Latino adults. *Diabetes Educ* 28:467–479, 2003

[22]Chodosh J, Morton SC, Mojica W, Maglione M, Suttorp MJ, Hilton L, Rhodes S, Shekelle P: Meta-analysis: chronic disease self-management programs for older adults. *Ann Intern Med* 143:427–438, 2005

[23]Anderson-Loftin W, Barnett S, Bunn P, Sullivan P, Hussey J, Tavakoli A: Soul food light: culturally competent diabetes education. *Diabetes Educ* 31:555–563, 2005

[24]Mensing CR, Norris SL: Group education in diabetes: effectiveness and implementation. *Diabetes Spectrum* 16:96–103, 2003

[25]Rickheim PL, Weaver TK, Flader JL, Kendall DM: Assessment of group vs individual education: a randomized study. *Diabetes Care* 25:269–274, 2002

[26]Brown SA, Blozis SA, Kouzekanani K, Garcia AA, Winchell M, Hanis CL: Dosage effects of diabetes self-management education for Mexican Americans. *Diabetes Care* 28:27–32, 2005

[27]Polonsky WH, Earles J, Smith S, Pease DJ, Macmillan M, Christensen R, Taylor T, Dickert J, Jackson RA: Integrating medical management with diabetes self-management training: a randomized control trial of the Diabetes Outpatient Intensive Treatment Program. *Diabetes Care* 26:3048–3053, 2003

[28]Bodenheimer T, MacGregor K, Sharifi C: *Helping Patients Manage Their Chronic Conditions*. Oakland, Calif., California Healthcare Foundation, 2005

[29]American Diabetes Association: Recognition programs [article online]. Available from http://www.diabetes.org/recognition.ASPX?cid=57941&typ=15. Accessed 11 December 2009

[30]IHS Diabetes Division of Diabetes Treatment and Prevention: Integrated diabetes recognition program: fully accredited programs [article online]. Available from http://ihs.gov/index.cfm?module=programsIDERP. Accessed 11 December 2009

[31]American Association of Diabetes Educators: Diabetes education accreditation program [article online]. Available from htpp://www.diabeteseducator.org/Professional Resources/accred. Accessed 11 December 2009

Carolé Mensing, RN, MA, CDE, is the manager for clinical and education programs at the Joslin Diabetes Center in Boston, Mass.

Table 1. Overview Comparison of Three Organizations' Accreditation/Recognition Requirements

Item	AADE	ADA	IHS
Title	• Diabetes Education Accreditation Program (DEAP)	• Education Recognition Program (ERP): 7th Edition	• Integrated Diabetes Education Recognition Program (IDERP)
Guiding Standards	• National Standards for Diabetes Self-Management Education (2007)	• National Standards for Diabetes Self-Management Education (2007)	• National Standards for Diabetes Self-Management Education (2007)
Number of Programs	• 82 accredited programs • 250 sites (as of December 2009)	• 2,038 primary recognized programs • 3,451 sites, including all multi- and expansion sites • (as of October 2009)	• 42 recognized IHS/tribal/urban Indian programs • (as of November 2009)
Cost	• 1–10 sites: $800 • 11–20 sites: $1,200 • > 20 sites: contact AADE • Same fee structure for re-accreditation	• First site: $1,100 • Additional sites: $100 each • Same fee structure for renewal	• No fees

continued on p. 69

Table 1. Overview Comparison of Three Organizations' Accreditation/Recognition Requirements, *continued from p. 68*

Item	AADE	ADA	IHS
Initial Application	• Online application with stop/start option (does not have to be completed in one sitting); paper application also available • Submit supporting documents within 2 weeks • Complete a telephone interview or onsite audit with AADE DEAP staff or DEAP auditor(s) after fee, application, and supporting materials are received	• Online application for all application types: original, renewal, adding sites (must be completed in one sitting) • Submit supporting documents within 2 weeks	• Spring and fall application periods (March and September) • Submit written letter of interest and completed checklist • Prepare and submit written IDERP application and support documentation
Application Support Documentation	• Program description, including mission, goals, and organization chart • Job descriptions for each of the positions within the entity's organization • Resumes of coordinator and instructors • Proof of licenses and/or certification and acceptable continuing education (CE) credits related to diabetes for coordinator and all instructors • Performance measurement plan/continuous quality improvement (CQI) process • Copy of one de-identified chart • Copy of one complete section from the curriculum or the curriculum outline • Advisory group composition • Sample education materials (English and non-English as appropriate)	• Proof of professional licenses/certifications for instructional staff • Proof of CE credits for non-certified instructional staff • Audit items: ❍ CV and job description of coordinator only ❍ CQI plan with description of project ❍ De-identified participant chart ❍ Randomly assigned section of curriculum ❍ Documented evidence of advisory or oversight group input (e.g., minutes)	• Minutes from one team meeting • Minutes or other documented communication from advisory group members • Letters of support from sponsoring organization and tribal entities or urban board of directors • Program description • Annual program plan, including mission statement, goals, and objectives • Organization chart • Coordinator profile • Instructor profile (for instructors providing 10% or more of DSME instruction) • Table of contents and lesson plan/teaching guide for curriculums not approved by IHS • Individual assessment and education plan forms, templates, or other methods of documentation • Policy and procedure for participant-defined self-management behavior and metabolic outcome evaluation • Annual program evaluation • DSME program profile
Initial Application Process	Three steps: ❍ Online application (paper application also available) ❍ Support documentation (all; must be sent within 2 weeks) ❍ Telephone interview or randomly selected onsite audit	Two steps ❍ Online application ❍ Support documentation (all, including all audit items, must be sent within 2 weeks of application submission)	Two steps ❍ Letter of intent ❍ Application and supporting documentation

continued on p. 70

Table 1. Overview Comparison of Three Organizations' Accreditation/Recognition Requirements, *continued from p. 69*

Item	AADE	ADA	IHS
Renewal Application	• Same three steps as initial application • Submit re-accreditation application • Submit support documentation • 10% (of re-accreditation applications) randomly selected for onsite audit	• Same two steps as initial application • Support documentation: ❍ Licenses and certificates of instructors ❍ Proof of CE credits for noncertified staff ❍ Only one of five possible audit items sent with initial application (randomly determined by computer)	• Same two steps as initial application • Submit letter of intent • Submit application for continued recognition and supporting documentation
Timeline for Process	• No data collection period • No minimum number of patients in program • Copy of one de-identified chart representative of the target population and education process • Total application process: 4–6 weeks • Eligible to submit Medicare claims as of date of approval • Valid for 3 years (submitted to CMS for 4-year program recognition cycle) • Must complete status updates and annual status reports	• Must select a 3-month data period for application submission • Must have 10 patients participate in program during the selected data period (not necessarily completed; participants can be at any stage of the education process with at least some completed, since at least one chart has to be available to demonstrate complete education process) • Application is processed by ADA staff within 12 weeks • Approval is retroactive to date of online application submission (for billing eligibility) • Valid for 4 years • Must complete annual status report	• Minimum 6-month data period • No minimum number of participants in program • Application is reviewed within 6 weeks by a multidisciplinary volunteer review committee • Total process: up to 12 weeks (includes opportunity to submit additional documentation for clarification) • Valid for 3 years (submitted to CMS for 4-year program recognition cycle) • Annual report required
Support Services	• Support by telephone, email • DEAP e-community • Free online podcast and Web cast • Online tools and sample documents • Accredited programs posted on AADE web site	• Support by telephone, email • Monthly conference calls • Web casts (free) • Free online library of sample forms and other tools (e.g., CQI plan, curriculum format) • Recognized programs listed on ADA web site	• Technical assistance by telephone, email, or onsite visit • Web casts (free) • Online tools and sample documents • Network of IHS IDERP programs
Audit	• 5% of initial applications annually • 10% of currently accredited programs annually • 10% of programs seeking re-accreditation annually • 2 weeks' notice • Volunteer auditors (1–2 per audit site)	• 5% annually (up to 70/year) • 2 weeks' notice • Volunteer auditors (2 per audit site)	• Minimum of 10% of all recognized programs annually • 1 month's notice • Onsite audit • Multidisciplinary volunteer auditors (2 per audit site)

Table 2. Comparison of AADE and ADA Programs by Standard

AADE		ADA	
Standard 1. The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.			
Essential Elements	**Essential Elements Checklist/ Interpretive Guidance**	**Review Criteria**	**Indicators**
A. There is documentation that describes or depicts diabetes education as a distinct component within the organization's structure and articulates the program's mission and goals. B. Documentation and/or procedures that support quality education shall include at least the following: 1. Job descriptions of the program coordinator and instructional team that are congruent with program needs, including educational needs of target population 2. Diabetes education process and self-management support	• Documentation of organizational chart of DSME/DSMT program: YES/NO • Documentation of program mission and goals: YES/NO • Policies and procedures are available: YES/NO • Job descriptions for all positions relating to the DSME/DSMT program: YES/NO	A. The DSME entity will have documentation that addresses its organizational structure, mission, and goals and its relationship to the larger, sponsoring organization.	• There is written evidence of the following: ❍ The organizational structure ❍ The mission of the program ❍ Mission-related goals • There is evidence of organizational support and commitment to the DSME entity (e.g., letter of support or attendance of senior administrative personnel at advisory meeting).
Summary of differences: There are minor differences. AADE requires a written policy and procedure relating to the program and education process. ADA does not require written policies or procedures but does require a letter of support for the program.			

continued on p. 72

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 71*

Standard 2. The DSME entity shall appoint an advisory group to promote program quality. The group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
A. A policy that identifies the structure and process, for the program's advisory group, will be maintained. 1. This policy will address the advisory group's role in promoting quality DSME/DSMT programming.	• Advisory Group Policy: YES/NO • Advisory Group Function: YES/NO AADE suggests the advisory group includes a primary care provider, educator, community member with diabetes, etc. The group actively reviews and makes recommendations on the DSME/DSMT annual program plan and evaluation. The group will vary according to program size, location and scope, and complexity of services provided.	A. An advisory group is appointed that is representative of the diabetes community and includes people affected by diabetes, health professionals, community members, and other stakeholders. B. Activities of the advisory group, reflecting its role as quality overseer, are documented at least annually.	• A document exists (e.g., policy) that identifies members of the advisory group. At a minimum, the advisory group must include: ❍ Health professional(s) ❍ People affected by diabetes ❍ Community member(s) • For single discipline-staffed programs, the health professional member(s) of the advisory group must belong to a second discipline (different from the discipline of the program staff; members can fulfill multiple roles). • There shall be documentation of the activities of the committee, at least annually, that demonstrates how it contributed to the quality of the DSME entity. Members of the committee may contribute either as part of the group meetings and/or be consulted on an individual basis (e.g., ballot, surveys, phone consults, emails).

Summary of differences: AADE requires a policy (document) to be in place to guide the advisory group. ADA requires membership documentation according to the standards and requires that for a program taught by a single discipline, at least a member of the other disciplines serve on the advisory group.

Standard 3. The DSME entity will determine the diabetes education needs of the target populations and identify resources necessary to meet these needs.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
A. There shall be documentation of: 1. A needs assessment for the target population 2. The availability of resources to meet these educational needs	• An identifiable process was used to assess the needs of the target population: YES/NO • Unique needs of target population are specified: YES/NO • Allocation of resources are specified: YES/NO	The target population/service community is identified, and its needs are assessed and/or reassessed periodically.	• Documentation exists that reflects an assessment, at least annually, of the target population or service community and program resources and identification of resources to address specific needs of the target population. This document must include: ❍ Target population/service community assessment (e.g., access, demographics, cultural influences, barriers to education) ❍ Assessment of program resources relative to services provided for the target population/service community (e.g., physical space, staffing, equipment). ❍ A plan to address the identified needs (e.g., identification of referral sources for additional services, plan for options for class times).

Summary of differences: There are no differences.

continued on p. 73

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 72*

Standard 4. A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self-management education. Thecoordinator will have academic or experiential preparation in chronic disease care and education and in program management.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
A. A completed job application/resume of the program coordinator that identifies experience and/or education in program management and the care of individuals with chronic disease, congruent with the job description, is kept on file. B. The coordinator's position description will indicate that the coordinator is responsible for oversight of the planning, implementation, and evaluation of the DSME/DSMT program (see Standard 1). C. Coordinators are to follow the continuing education requirements of their professions (a minimum of 15 hours of continuing education required annually).	• Coordinator's resume reflects academic, continuing education, and/or experiential preparation: YES/NO • Position description describes program oversight by coordinator: YES/NO CDE or CE documentation is required and CE is ongoing throughout the year.	A. The DSME entity has a designated coordinator. B. The coordinator is academically or experientially prepared in areas of chronic disease care, patient education, and/or program management. C. The coordinator oversees the planning, implementation, and evaluation of the DSME.	• There is documentation of one program coordinator. • CV or resume of the coordinator reflects appropriate qualifications. • 15 hours/year of continuing education are required (if individual does not have a CDE or BC-ADM certification). Topics should include but are not limited to chronic disease care, patient education, and program management. • Job description (or other document such as performance appraisal tool) reflects requirements for chronic disease care, patient education, and/or program management and verifies the coordinator's responsibilities in planning, implementing, and evaluating the DSME.

Summary of differences: A slight difference is that AADE CE topic requirements are flexible based on target population needs, whereas ADA suggests topics.

continued on p. 74

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 73*

Standard 5. Diabetes self-management education will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participants' needs are met if those needs are outside the instructors' scope of practice and expertise.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
The program's instructors are qualified and include an RN, an RD, or a pharmacist. A. Resumes and proof of licenses, registration, and/or certification shall be maintained to verify that program staff is composed of instructor(s) who have obtained and maintained the required credentials. B. If community health workers (CHWs) are part of the DSME/DSMT program team, there is documentation of successful completion of a standardized training program for CHWs and additional and ongoing training related to diabetes self-management. Training includes scope of practice relative to role in DSME/DSMT. C. If CHWs are part of the DSME/DSMT program's team, there shall be documentation that they are directly supervised by the named diabetes educator(s) in the program. D. Proof of continuing education will be maintained to provide evidence that instructors maintain their qualifications according to the specific criteria below and consistent with their job description: 1. 15 hours of CE annually for all instructors 2. These hours must be from a nationally recognized accrediting group E. For programs, particularly those that have solo instructors, there shall be a policy that identifies a mechanism for ensuring that participant needs are met if those needs are outside of the instructors' scope of practice and expertise. F. There shall be documentation that: 1. Describes a process for ensuring that appropriate care coordination among the diabetes care team occurs 2. Team coordination/interaction occurs	• Instructors' current credentials: YES/NO • Instructors' current resume: YES/NO • 15 hours annual CE for all instructors: YES/NO • At least one of the instructors is an RN, RD, or pharmacist: YES/NO • CHW training, continuing education, and name of supervisor, if applicable: YES/NO • Mechanisms for ensuring participants' needs are met: YES/NO • Team coordination/ interaction is documented: YES/NO	A. The DSME instructor(s) must include at least one RN **OR** one RD **OR** one pharmacist. B. DSME instructor(s) must be qualified and provide diabetes education within each discipline's scope of practice. C. A mechanism must be in place to meet the needs of participants if they cannot be met within the scope of practice of the instructor(s).	• At least one RN or one RD or one pharmacist is involved as an instructor in the education of the participant. • Instructor(s) must have valid, discipline-specific licenses and/ or registrations. • Instructor(s) must be a CDE or have BC-ADM certification or accrue 20 hours/ year of continuing education credits if practicing in a single-discipline program. (CE topics must be diabetes specific, diabetes related, educational, or psychosocial and relevant to services provided or population[s] served.) • Instructors working in a multidisciplinary diabetes education setting (with other disciplines as part of the instructional staff) can have CDE or BC-ADM certification or accrue 15 hours/year of continuing education credits. • Guidelines (e.g., policy, procedure) must be in place for determining when patient needs are outside of the scope of practice of a single-discipline program. • Communication to referring providers must include education not provided due to content being beyond the scope of practice of the specific discipline providing education.

continued on p. 75

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 74*

Standard 5, *continued*

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
Summary of differences: ADA has more specific criteria for programs that are taught by only one discipline; such programs must have 20 hours of CE, guidelines (such as a policy) in place for what to do if patient needs are outside of their discipline, and communication with the referring provider if needs were not met. AADE states that mechanisms must be in place for ensuring that patient needs are met related to the scope of practice. It also requires documenting of reporting and supervisory relationship of CHWs and of which staff have nontechnical, nonclinical roles. AADE requires detail on CHW training, CE, and name of instructor. ADA does not require additional documentation about training or CEs for CHWs. AADE requires proof of continuing education credits for all instructors including those with CDE or BC-ADM. ADA requires written documentation and copies of continuing education credits for non-CDE staff. There is a difference between ADA and AADE with respect to the timing of continuing education credit acquisition. AADE requires 15 hours annually, which can be for a calendar year, and ADA requires all continuing education credits to be earned within 12 months prior to the online application date.			
Standard 6: A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME program. Assessed needs of the individual with pre-diabetes or diabetes will determine which of the content areas listed below are to be provided.			
Essential Elements	**Essential Elements Checklist/ Interpretive Guidance**	**Review Criteria**	**Indicators**
Program uses a current written curriculum. A. A written curriculum that meets the patients' needs will be maintained and updated as needed to reflect current evidence and practice guidelines. B. The curriculum: 1. Uses principles and concepts of the AADE7 self-care behavior framework, including the self-care behaviors: a. Healthy eating b. Being active c. Monitoring d. Taking medications e. Healthy coping f. Problem solving g. Reducing risks 2. Includes content about the diabetes disease process/ pathophysiology 3. Is tailored for the target population 4. Uses primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods	• A written curriculum tailored to meet the needs of the target population: YES/NO • Adopts principles of AADE7 and includes disease content: YES/NO • Curriculum is kept updated reflecting current evidence and practice guidelines and is culturally appropriate: YES/NO • Curriculum maximizes use of interactive training methods: YES/NO	A. A written curriculum, with learning objectives and criteria for specifying methods of delivery and evaluating successful learning outcomes, is the framework for the DSME. B. There is periodic review and revision of the curriculum and/or course materials to reflect current evidence.	• Validate that the education process is guided by a reference curriculum with learning objectives, methods of delivery, and criteria for evaluating learning for the populations served (including pre-diabetes, type 1 diabetes, type 2 diabetes, gestational diabetes, or pregnancy complicated by diabetes) in the following nine content area: ❍ 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 promote health and behavior change (risk reduction) • There is documentation at least annually of review and revisions as needed of the curriculum and/or course materials by DSME instructor(s) and/or advisory group. (For programs staffed from a single discipline, the advisory group must review curriculum and/or course materials at least annually).

continued on p. 76

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 76*

Summary of differences: AADE supports a behavior-change focus curriculum package that includes assessment, implementation, evaluation of outcomes demonstrated in the AADE7, and self-care behaviors appropriate for patient and target population. AADE requires updates utilizing current evidence and practice guidelines. ADA specifies annual review.

Standard 7. 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.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
The program includes individualized patient assessments and educational plans. A. There will be documentation to identify that pertinent assessment data were obtained in a collaborative, ongoing manner between the participant and instructor. B. The AADE7 self-care behavior framework will serve as the foundation for the assessment and include the following elements: 1. Relevant medical history 2. Present health status and health service or resource utilization 3. Risk factors 4. Diabetes knowledge and skills 5. Cultural influences 6. Health beliefs and attitudes 7. Health behaviors and goals 8. Support systems 9. Barriers to learning 10. Socioeconomic factors C. There will be a written policy that describes the diabetes education process (assessment, planning, intervention, and evaluation), and there will be documentation of the following for each patient: 1. Educational plan 2. Educational interventions provided a. If interventions not provided according to the plan, there shall be documentation about plan revision 3. Achievement of learning objectives D. Staff providing service will be identifiable in a way that can be authenticated E. There shall be documentation to identify that an educational goals and learning objectives and the plan for educational content and methods were collaboratively developed between the participant and instructors	• Collaborative participant assessment: YES/NO • Education process policy: YES/NO • Plan of care based on assessment and meets the individual's needs: YES/NO • Integration of AADE7: YES/NO • Intervention per plan provided and outcomes evaluated: YES/NO • Collaborative development of education goal, objectives, and plan: YES/NO	A. Participants receive a comprehensive assessment, including baseline diabetes self-management knowledge and skills and readiness for behavior change. B. Participants have an education plan based on their individual assessment. C. There is evaluation of the education plan after the educational intervention. D. The education process is documented in the permanent record.	• An assessment of the participant is performed in the following domains: clinical (diabetes and other pertinent clinical history), cognitive (diabetes self-management skills, functional health literacy) and psychosocial and self-care behaviors (support systems, lifestyle practices, and behavior-change potential) in preparation for education. Parts of the complete assessment may be deferred if applicable and the rationale for deferment documented. • There is evidence of ongoing education planning and behavioral goal setting based on the assessed needs of the participant. • The DSME has a process for evaluating the educational intervention to determine success of the education plan, including evaluation of behavioral goal achievement. • Documentation includes other evidence of the education process: referral from provider, assessments, education plan, with dates of implementation/interventions, outcomes, and plans for follow-up as indicated.

Summary of differences: There are no significant differences. AADE requests de-identified chart, review for collaborative goal setting, and an educational process policy to ensure that a consistent process is in place. Both require documentation. ADA emphasizes demonstration of the educational process.

continued on p. 77

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 76*

Standard 8. A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self-management support will be communicated to the referring provider.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
A. There will be a written policy and documentation that identifies that a personalized follow-up plan to ensure ongoing self-management support was developed in collaboration with the participant. B. There shall be documentation that identifies that the patient's outcomes and goals, and the plan for diabetes self-management support, are communicated to the referring physician (or qualified nonphysician practitioner).	• Communication of educational services to physician/qualified nonphysician practitioner: YES/NO • Policy for personalized process and ongoing self-management support strategies: YES/NO	A. Participants will have a plan for post-education self-management support for ongoing diabetes self-care beyond the formal self-management education process.	• There must be evidence of a personalized follow-up plan for diabetes self-management support (e.g., return to referring provider, referral to support groups, referral to community programs, etc.). • There must be evidence of communication of the follow-up plan with the referring provider.

Summary of differences: There are no significant differences. AADE requires a written policy for personalized process and ongoing self-management support strategies to ensure that a consistent process is in place. ADA emphasizes that documentation of actual planning for support services must be in place, not just a policy.

Standard 9. The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.

A. The evaluation policy shall use the AADE7 self-care behavior framework (or equivalent), core outcome measures, and behavioral and clinical outcomes for each patient individually and in aggregate. Outcomes will be compared to quality indicators to assess the effectiveness of the patients' care plan and the education intervention. 1. Individualized and aggregate outcomes data include at a minimum, attainment of participant-defined behavior-change goals (intermediate outcomes) and at least one post-intermediate or long-term health outcome measure. 2. There shall be evidence that there was a critical analysis that determined the choice for the post-intermediate (clinical improvement) or long-term (health status improvement) outcome measure that will be or was tracked.	• Individual and aggregate achievement of behavior-change goals: YES/NO • Policy required that outcomes data include appropriate measures: YES/NO • Reason for choice of outcome measures: YES/NO • Effectiveness of intervention is based on data: YES/NO	A. Attainment of goals/outcomes shall be measured regularly in order to evaluate the effectiveness of the educational intervention.	• There is evidence of a collection and summary of participant goals used to evaluate the effectiveness of the DSME. • There is evidence of a collection and summary of other participant outcome (clinical or other) to evaluate the effectiveness of the DSME.

Summary of differences: ADA's indicators for this standard are concise; auditors would only look to see if there was a collection and summary of behavioral goals as well as one other outcome. AADE's requirement is to have a policy in place to ensure consistent care regardless of staff providing care. ADA emphasizes the importance of acknowledging the distinction between tracking outcomes and conducting a continuous quality improvement (CQI) process.

continued on p. 78

Table 2. Comparison of AADE and ADA Programs by Standard, *continued from p. 77*

Standard 10. The DSME entity will measure the effectiveness of the education program and determine opportunities for improvement using a written CQI plan that describes and documents a systematic review of the programs' process and outcome data.

Essential Elements	Essential Elements Checklist/ Interpretive Guidance	Review Criteria	Indicators
A. There is documentation that: 1. Opportunities for improvement, as indicated by data tracked, were identified 2. A process for improvement was implemented if feasible (or an explanation for why it was not) 3. CQI improvement activity shall be undertaken annually	• Systematic process for implementing a CQI process/plan: YES/NO • Program improvement, if applicable, is based on data deficiencies that have been analyzed: YES/NO • CQI results are shared with the advisory group annually: YES/NO	A. The DSME entity has a quality improvement process and plan in place for evaluating the education process and program outcomes. B. Quality improvement projects are developed and implemented according to the plan. C. Results are used to make improvements in the DSME.	• There is documentation of a CQI plan/process (e.g., written policy, annual program plan, CQI meeting minutes). • There is documentation of at least one project following the quality improvement plan. • There is evidence of application of the results of the quality improvement project to the DSME upon completion.

Summary of differences: There are no significant differences. AADE specifically advises that CQI results be shared with the advisory group. ADA emphasizes the plan, process, and application.

Table 3. Synonymous Terms Used by the DSME Recognition/Accreditation Programs of AADE, ADA, and IHS

	ADA Term	IHS Term	Definition
Accreditation	Recognition	Recognition	The process for identifying programs that meet the NSDSME
Re-accreditation	Renewal	Continued recognition	Process for reapplying to maintain recognition or accreditation status
Essential Elements	Review Criteria	Review Criteria	Document outlining standard-specific requirements for recognition or accreditation
Essential Elements Checklist	Indicators	Indicators	Specific or individual elements that must be present for a program to meet criteria for each standard
DSME/T	DSME	DSME	Diabetes self-management education, the ongoing service provided by a recognized or accredited program, involving a collaborative process between educators and people with diabetes, aiming at optimal health outcomes and improved quality of life for people with diabetes; Medicare classifies this service as diabetes self-management training (DSMT)
Change of Status/ Supplemental Application	Change of Information	Change of Status	Form for notifying accrediting body of changes in program
Annual Status and Performance Measurement	Annual Status Report	Annual Report	A report completed by each recognized or accredited program annually as proof of ongoing compliance with recognition criteria or accreditation guidelines