



North Carolina Diabetes Advisory Council

2017 Updates to National Standards for Diabetes Self Management Education & Support (DSMES)

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What are the National Standards for DSMES and why do they matter

- The Standards define timely EB practice and research, quality DSMES services that meet or exceed Medicare DSMT requirements
- Delineate commonalities among effective and evidence-based person centric DSMES strategies.
- Do not guarantee Medicare reimbursement
- Applicable to solo practices, multicenter, care-coordination, and population health programs as well as technology enabled care models
- Should be integrated into newer care models such as Accountable Care Organizations (ACO), Patient Centered Medical Home (PCMH), virtual visits, value based payment models



What are the National Standards for DSMES and why do they matter

Used in the Recognition Process for ADA and DEAP by the American Diabetes Association and American Association of Diabetes Educators , and as guide for non-accredited or non-recognized providers of diabetes education.

Reviewed every 5 years (2012-2017) by the ADA, AADE, key experts and stakeholders from the diabetes care & education community; inclusive of multidisciplinary health professionals , public health, clinicians working in underserved populations, rural areas, virtual, pharmacy, and insurers, large urban hospitals and specialty practices and individual practices.

Model of care goal –Minimal Disruption: Maximize participant outcomes with minimal work required by PWD.

Given the rapidly evolving health care environment, this to simplify rather than complicate. Diabetes management task force recognizes that these may need to be evaluated, revised and updated more frequently going forward .

DSMES Factoids

- **Given the diabetes and prediabetes burden:**
 - **In 2012, less than 7% of persons with diabetes were enrolled in DSMES in the first year of diagnosis**
 - **Less than 5 % of Medicare beneficiaries use their DSMES benefits**
 - **Persons with diabetes visit their provider 4 times/yr. on average with an average apt time of 20 minutes = persons with diabetes spend less than 1% of their life with their health care team accessing services**
 - **The Standards provide a platform to fill the gap with needed education , training, ongoing support, and follow-up across the lifespan; completing the feedback loop so successful self care management can be achieved and maintained.**

2017 Changes

Major changes focus on

- Language
- Increased emphasis on quality
- Acknowledging new care models, including technology enabled self management

Language

- DSME and DSMES were two separate entities in past revisions. Now, they are combined as one concept: Diabetes Management Education & Support (DSMES), reflective of the need for ongoing support across the lifespan

Standards to focus on diversity of interventions

- **Use of “ services “ rather than program** to reflect diversity in the personal individualization are participant directed and all encompassing where programs often are unable to offer this flexibility. **DSMES is highly individualized, and non-scripted, should simplify not increase complexity.**
- **Persons receiving DSMES are now called participants rather than patients.** Removes suggestion that the participant engaged in this is “ sick” as most PWD are not ill.
- **Program Coordinator was changed to Quality Coordinator** to emphasize the outcomes of DSMES. Coordinator role is to ensure DSMES services help participants achieve better outcomes. Aligns with quality outcome metrics in care payment models.
- **Standard 4 & 10 reflect reimbursement shift focus from fee for service to pay for performance,** incorporating outcomes metrics.

New Models of Care

- **Providers of DSMES services need to be able to incorporate new care models in practice as they become available**Moving away from PowerPoint presentations towards interactive, group, dynamic participation models:
 - Discussion, engagement, telehealth & telemedicine have made strides in improving outcomes and participant retention.
 - The change in verbiage of the standards reflects the current flexibility of all DSMES providers and opens opportunities as new models evolve.
 - “ Ever changing: How participants wish to engage in DSMES”.

Individualization is Critical to increasing enrollment in DSMES services

- EBR is clear - **continuing education & support is critical for improved outcomes especially during times of transition of care.**
- **Technology enabled self-care management models (TES) can break these barriers by removing issues such as location , transportation, family, etc.**
- **TES needs all 4 components to be effective and improve outcomes – including the feedback loop:**
 - 2 way communication
 - Use of participant generated health data
 - Individualized education
 - Individualized Participant feedback to modify plan of care

Reimbursement

- The Standards drive ADA/AADE recognition.
- There are many tools, solutions and services not reimbursed for DSMES currently.
- Reimbursement for Recognized programs is paltry at best and complicated.
- RN CDE's still are not recognized as direct Medicare providers.
- Standards highlight the EBR that supports best outcomes for participants and urge payers to reimburse for services that work for the greatest diversity of participants.
- At present, **Livongo is the one TES achieved AADE Recognition, and One Drop has achieved ADA recognition. Neither are covered by CMS at this time.**

STANDARD 1- Internal Structure.

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Key Points:

Mission statement

Goals

Defined leadership

Lines of communication,

Evidence of organizational support

Changes:

Goals and outcomes must be reviewed annually.
Letter of administrative support at organizational level must be renewed annually.

STANDARD 2 - Stakeholder Input (formerly called external input). *The provider(s) of DSMES will seek ongoing input from valued stakeholders and experts to promote quality and enhance participant utilization.*

“Stakeholders” reflects those working INSIDE & OUTSIDE the organization that are vital to success and to meeting the needs of participants (referring providers, other health professionals, marketing department, health clubs, community groups, senior centers, local newspaper/ radio staff, organization social media, former participants.)

- Identify who is important in your success as a service and meeting the needs of identified populations based on social determinants of health. (see standard 3). The stakeholders provide input, information, foster ideas, and may help to improve utilization of services and help with quality, outcomes, and sustainability of the DSMES services.
- Must a PLANNED and DOCUMENTED STRATEGY for eliciting input from stakeholders. It does NOT have to be an in-person meeting, although it certainly can be. Using emails, phone calls, surveys, etc., are also ways of obtaining feedback from stakeholders. Be sure to document any feedback from your stakeholder group, regardless of how you interact with your stakeholders.

STANDARD 3 -Evaluation of Population Served (formerly called 'access')

The provider(s) of DSMES 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.

- Assess & understand the community served inclusive of both physical and virtual.
- Identify who is coming to education vs those your market is missing.
- Identify barriers that prevent access to DSMES and develop processes to overcome those barriers.
- Technology-enabled DSMES can increase access, so investigate:
 - Strategies to reach out to those not utilizing your services
 - Consider pursuing alternate methods of providing DSMES services to those in your service area who are not coming in-person



STANDARD 4: Quality Coordinator Overseeing DSMES Services (previously called 'Program Coordinator')



- *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.*
- There will be one qualified Quality Coordinator who manages all aspect of services. This person can be a part of the DSMES team, or this person can be a separate person serving in this role.
- The title change reflects the need to address quality at all levels of DSMES services, and aligns with new models of care and payment methods. The position description title does NOT have to be 'Quality Coordinator' but duties/responsibilities must align.

STANDARD 5 – DSMES Team (formerly called ‘instructional staff’)



- *At least one of the team members will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES, or can be another health care professional holding certification as a CDE or BC-ADM.*
- *Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training and supervision/support by at least one of the team members listed above.*
- Key elements include: professional educators must maintain current credentials, document appropriate CEs of diabetes-related content, paraprofessionals need continuing education specific to the role they serve on the team, and they also directly report to the quality coordinator or to the other qualified DSMES team members.
- **CHANGE:** ALL DSMES services must have a policy of referring services outside of the expertise and scope of DSMES providers. This includes single discipline programs AND all other multi-discipline programs, as you probably all refer to podiatrists, ophthalmologists, etc. This means ALL programs must have a policy for referring to other health professionals outside of their expertise.

STANDARD 6 – Curriculum

NEW topics in the ADA review criteria that need to be covered by the curriculum (most of the newer curricula all cover these topics including sick days, disaster planning, navigating the health system, e-health education, etc.). There are a number of 'approved' curricula: ADA's "Life with Diabetes," AADE's "Diabetes Education Curriculum: A Guide to Successful Self-Management," and the International Diabetes Center's "Type 2 Basics."

Learning process must be engaging to participants...just reviewing power point slides and lecturing doesn't 'cut it'

STANDARD 7– Individualization

The DSMES needs will be identified and led by the participant with assessment and support by one or more of the DSMES team members. Together, the participant and DSMES team member(s) will develop and individualized the DSMES plan.

Key elements include being person-centered, focus on the priorities and values of the person.



Assessment: a collaborative process that assesses disease, treatment burden, peer and social support with reassessment at the four key times (diagnosis, yearly, when there is a change in treatment, and when there is a change in life/living situation). Document the assessment, education plan, intervention and outcomes.



No participant is required to complete a certain set or # of DSMES classes/sessions/programs. When the participant achieves their goal, they determine that their initial DSMES intervention is complete. **HIGHLIGHTED: DSMES is an ongoing, lifelong process!!!**

STANDARD 7– Individualization (cont.)

The DSMES needs will be identified and led by the participant with assessment and support by one or more of the DSMES team members. Together, the participant and DSMES team member(s) will develop and individualized the DSMES plan.

Emphasizes -interactive teaching style (not static lecture), with goal setting and action planning, shared decision-making, teach backs, motivational interviewing, cognitive behavioral therapy (CBT), and problem-solving using data (patient self-generated data) to change behavior.

Team members will use clear health communication principles, avoid jargon, be culturally relevant, and use validated assessment tools to evaluate progress.

Technology-enabled DSMES (texts, apps, social media) may empower participants and improves A1C, but use caution with Medicare: not currently reimbursable. However, when used to meet Medicare criteria, telehealth (real time audio/visual) may be used to serve certain patients.

STANDARD 8 :Ongoing support.

The participant will be made aware of option and resources available for ongoing support of their initial DSMES, and will select the option that best supports their self-management needs. Support services include those that help implement and sustain the ongoing skills, knowledge, and behavior changes needed to manage their diabetes.

These support services could be within your organization or outside of DSMES services. The diabetes online community (DOC) is a resource where people can learn from others facing similar situations and is available 24/7.

CHANGE: You no longer have to send this piece to the referring provider, but you must document it.

STANDARD 9:Participant Progress

- You must be able to identify individual participant progress, as well as your overall participant population progress, and provide population outcomes report on attainment of goals.

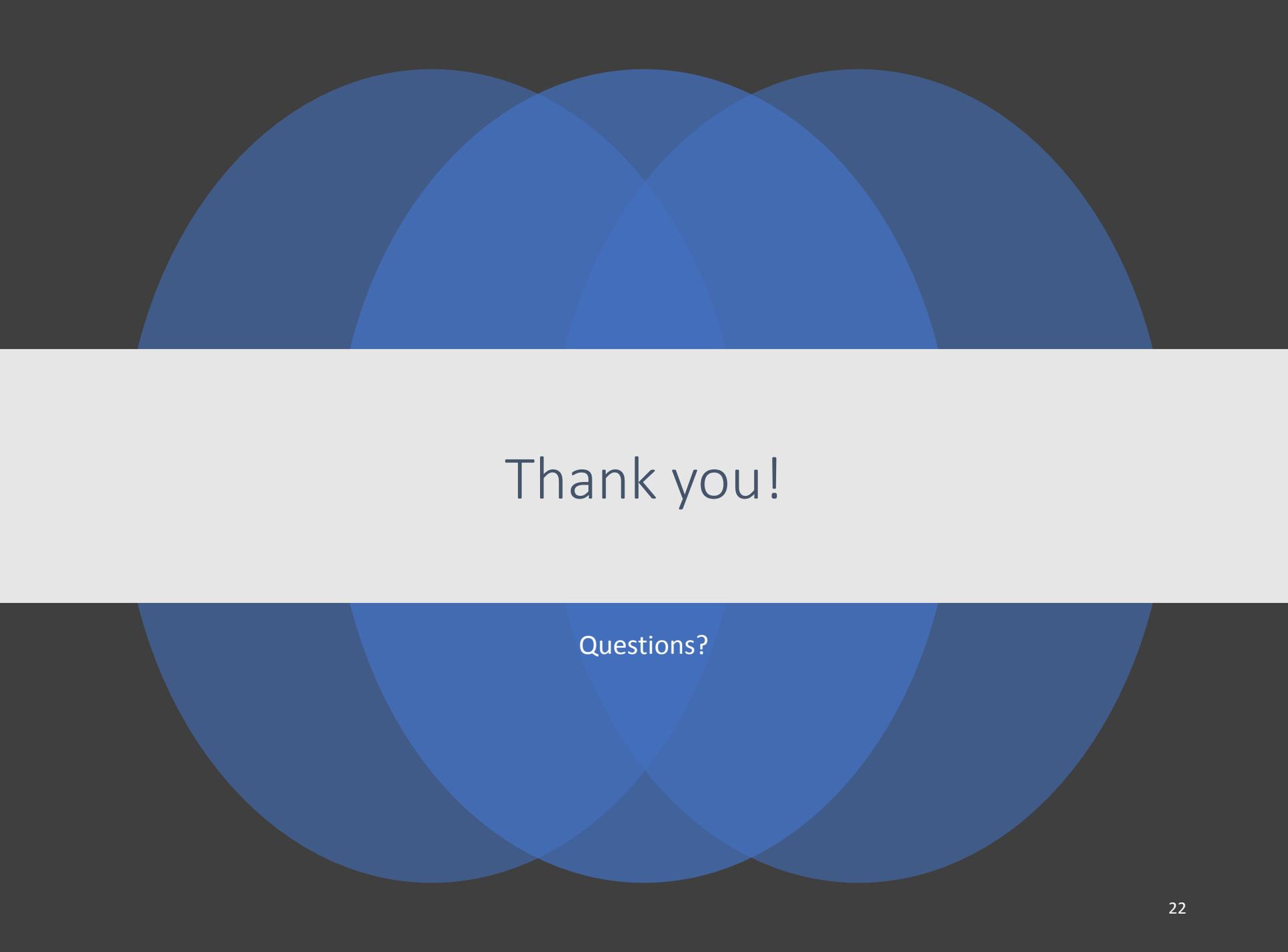


STANDARD 10: Quality Improvement

- **MUST** have a **PLAN** to conduct evaluation of process and outcomes data, and measure the impact and effectiveness of the DSMES services via a CQI plan.
- Suggested to address quality initiatives for pay-for-performance models of reimbursement...quality and outcomes versus 'productivity'.
- The Institute for Health Care Improvement has 3 important questions that should be addressed in an improvement process:
 - What are you trying to accomplish?
 - How will you know a change is an improvement?
 - What modifications will result in an improvement?
- A variety of methods can be used for CQI: Plan/Do/Study/Act, Six Sigma, LEAN, Re-AIM, Workflow mapping, etc.
- Outcome measures indicate the RESULT of a process, whereas process measures provide information about what CAUSED those results. Process measures target those processes that impact the most important outcomes. Make it *meaningful!*
- Behavioral measures – participant's report on self-management activities, psychosocial behaviors, etc.
- Clinical measures – A1C, weight, BP, etc.
- Operational measures – participant satisfaction, no show rates, marketing efforts
- Process measures – referrals, etc.

In Summary:

- DSMES - *support* is included in DSME
- *Service* instead of program
- *Participant* instead of patient
- *Quality Coordinator* instead of Program Coordinator
- Standards 4 and 10 – stronger focus on quality
- Title changes:
 - External input is now called *Stakeholder Input*
 - Access is now called *Evaluation of Population Served*
 - Program Coordinator is now called *Quality Coordinator* overseeing DSMES services
 - Instructional Staff is now called *DSMES Team*
 - Patient is now called *participant*
- These changes in the National Standards are now being reflected in the **ADA Review Criteria** and **AADE Interpretive Guidance**. ALL DSMES services (formerly called ‘programs’) will have to have the National Standards incorporated into their program by May 2018. **New applications and renewal applications MUST use the 2017 standards and the accompanying recognition or accreditation application criteria by January 1, 2018.**



Thank you!

Questions?