

FREQUENTLY ASKED QUESTIONS

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ADVISORY GROUP

Q: Is it required that the Advisory Group have a Medical Director?

A: No, a Medical director is not required. The Advisory Group must consist of, at minimum, a healthcare professional(s), person(s) affected by diabetes and a community member. Members can fulfill multiple roles.

If a program is single discipline, the healthcare professional should be of a different discipline from the single discipline instructional staff.

(Persons affected by diabetes are persons who have diabetes, or have relatives/significant others with diabetes)

(Community members should be persons active in the community and have knowledge of the community at large: clergy, politicians, business owners, etc.)

Q: How often must the Advisory Group meet?

A: The established advisory group must provide input, at least annually, regarding planning of DSME operations and providing oversight for ensuring quality services are provided by the DSME program. The evidence for Advisory Group input can be documented meeting minutes, documentation of communications by phone, fax, email; review and approval of Annual Review and Plan, surveys, etc. of Advisory Group members.

Q: What topics are to be covered during Advisory Group meetings or what should the Advisory Group provide the program feedback on?

A: The Advisory Group does not have a required set of topics to discuss at meetings or provide the program feedback on. The group is responsible for overseeing the quality of the program. Therefore any topics pertaining to program development and quality improvement can be presented to the group for discussion and feedback. ADA has developed a template for Annual Program Review and Planning which includes some of the pertinent topics required for annual review by the program. This can serve as guidance for some or all of the topics presented for discussion to the Advisory Group.

[Annual program review template](#) (PDF)

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APPLICATION/SITE TYPES

Q: What is the difference between an Expansion site and a Multi-site?

A: Distinctions between multi-sites and expansion sites:

	<u>Multi-site</u>	<u>Expansion Site</u>
Curriculum	Can be different from primary site	Must be same as at parent site
Staff	Can be different from primary site	Must come from same pool of staff as at parent site
CQI	Can be different from primary site	Must be same as at parent site
Policies & Procedures	Can be different from primary site	Must be same as at parent site
Forms	Can be different from primary site	Must be same as at parent site
Certificate	Gets separate cert/can bill separately	Uses copy of originating site cert/billing from parent site only
Website	Listed separately	Unlisted

Q: I’ve just completed an expansion application and the instructors’ information does not print out. Is this normal and do I have to send in their credentials and CEUs?

A: This is absolutely normal. The expansion application does not include instructional staff information since the educators must come from the pool of staff at the parent site. The parent site can only be the primary site or an already established multi-site, previously approved. Therefore, we do not need to see their credentials or CEUs.

Q: We would like to add another site to our program. Do we have to wait until we renew or can it be done now?

A: Additional Site(s) can be added at any time during your current Recognition cycle. Multi-sites get added to the primary site. Expansions can be added to either the primary site or to an already existing multi-site (parent site).

There is a \$100 fee per additional site (multi- or expansion) application. Once approved, expansions can be converted to multi-sites and vice versa, during the same Recognition period, without an additional fee. However, converting from an expansion to a multi-site requires an application. Recognition for an added site expires when the primary site's Recognition expires.

Q: Can we have both single discipline sites and multi-discipline sites as part of a primary program with multi-sites?

A: Yes under the umbrella of one program with multi-sites, there can be multi-discipline sites and single discipline sites. Each site must meet its staffing specific requirements for CEUs and the coordinator will be considered the program to be multi-discipline as long as at least one of the sites is multi-discipline.

Q: We missed our renewal date. What are our options now?

A: You can still use the renewal application to re-apply for Recognition. You will still use your same program ID # and may use a reporting period of up to 12 months prior to the online application submission date. All other renewal requirements apply. If it has been more than 12 months since your Recognition has expired or your program has been closed, please call the ERP office for information on additional requirements.

Q: We are interested in applying for Recognition for the first time. Where can we get information as to what the requirements are?

A: There are two documents that we recommend you read for information on preparing to apply for ADA Recognition.

1. The "2007 National Standards" for Diabetes Self Management Education which can be found on the main page of our website. All programs applying for ADA Recognition must meet these standards.
2. ADA "Recognition Requirements" which can be accessed via the "Applying for Recognition" link, on the right rail of the main page of our website. This document outlines how ADA determines that the standards are met.

The ERP website is www.diabetes.org/erp. You may have additional questions after you have read these documents. If so, please call us at 888-232-0822 or email us at erp@diabetes.org. When you are ready to submit an application, you must call the ERP office in order to get a program ID # and to be set up in the ERP Portal.

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CONTINUING EDUCATION REQUIREMENTS

Q. What continuing education topics are acceptable?

A: The hours of continuing education may be in any one or any combination of the following topics: diabetes specific, diabetes related, psychosocial, educational and program management.

- i. **Diabetes specific** is any program or session topic or any program objective or course outline that specifically addresses diabetes.
- ii. **Diabetes related** is any program or session topic or any program objective or course outline that clearly states issues related to diabetes, but does not specifically use the word, “diabetes.” These topics can be, but are not limited to the following: nutrition, exercise, retinopathy, nephropathy, neuropathy, cardiovascular disease, stroke, lipids, obesity, metabolic syndrome, etc.
- iii. **Psychosocial** is any program or session topic or any program objective or course outline that addresses , psychological, behavioral or social content related to diabetes, self management or chronic disease.
- iv. **Educational** is any program or session topic or any program objective or course outline that pertains to teaching strategies, knowledge assessment, learning principles, education, training or instructional methods. .
- v. **Program Management** is any program or session topic or any program objective or course outline pertaining to the operations of the DSME, including business operations, performance improvement, case and disease management.

Include a copy of the official program brochure with objectives or a copy of the official course outline only if it is NOT clear from the title that it fits into one of the above categories.

Q: Our Registered Dietitians get logs of their continuing education from CDR. Can I send this in as proof of CEUs?

A: We do not accept logs or transcripts of CEUs. For all members of the Instructional Staff who are not a CDE or BC-ADM, you must submit copies of official verification for the required number of Continuing Education hours. The official verification documentation of completion of CE hours (Certificates of Attendance/Completion) must include:

- the educator’s name,
- the title of the CE offering,
- the date the CE hours were awarded (the date must be within the 12 months prior to the online application date),
- the number of CE hours, and
- the name of the Continuing Education Credentialing Body (e.g. ADA, AADE, ANCC, ACCME, CDR, etc.).

In addition, the following are not accepted:

- Academic hours (college credits) will not be accepted unless the college or university is approved by a recognized credentialing body as a provider of continuing

education and is willing to convert credits to Continuing Education hours and supply verification of conversion on official letterhead.

- BLS and ACLS courses do not qualify for CE credits.
- Poster sessions do not earn credit unless objectives are provided at the poster session and they are submitted with the Support Package documents.
- Credit is not given for exhibit hours.

Q: We are a single discipline program. How many CEUs are required for our anniversary year and for the renewal application?

A: For a single discipline program, the program coordinator and the educator(s) must have 20 hours of CEUs for both time periods.

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CURRICULUM

Q: We teach GDM's in our program. Do we need to have a separate curriculum for them? Do we count them as participants?

A: No, you do not need a separate curriculum for gestational participants. Your core curriculum should contain all nine content areas as outlined in the National Standards and should be applicable to all types of diabetes. Content specific to or not applicable to gestational patients may be noted as such in a separate guide or as an addendum to your core curriculum for your instructors. You count GDMs as participants if they go through the complete education process (see Education Records)

Q: We were assigned the nutrition section of our curriculum as the paper audit item for our application. Can I just send in copies of our slides?

A: Your slides would most likely just reflect the content. A complete curriculum also includes learning objectives, methods of teaching and methods used to evaluate whether learning has taken place.

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DISCIPLINE- SINGLE VS. MULTI

Q: We have two educators, but they are both RNs. Are we a single or multi-discipline program?

A: You would be a single discipline program. A site is single-discipline if there is only one instructor or there are 2 or more instructors, but they are all of the same discipline, i.e. all RN's or all RD's, etc. A multi-discipline site must have at least 2 different disciplines.

A program is considered to be multi-discipline if at least one of its sites is multi-discipline. A single discipline program must have a policy in place that addresses how the education needs of a patient will be met if they are outside the scope of practice and/or expertise of the single discipline.

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EDUCATION RECORDS

Q: If we were to be audited, what documentation would ERP expect to see in the charts?

A: All participant education records must document the required items as listed below.

1) Referral from the provider responsible for the diabetes management of the patient.

2) Comprehensive assessment – A comprehensive assessment must be done with each participant. This assessment must include the participant’s diabetes knowledge, self-management skills, diabetes and health-related behaviors, behavioral change potential and other relevant information, including medical history. The assessment can be ongoing; parts of it may be deferred and documented as such with rationale for the deferment.

A self-assessment or knowledge pre-test may not serve as the sole means of assessing and documenting the participant's knowledge, skill level and behaviors.

3) Education plan based on the assessed needs of the participant with participant selected behavioral objectives – The education record should document a plan which includes topic areas determined to be needed by the participant and at least one patient identified behavioral objective (with educator assistance as needed.) The behavioral objective documentation should include the specific behavior that the participant is interested in changing, how the participant will change that behavior. .

4) Educational interventions which include date of intervention, content taught and name(s) of instructors – The instruction should be based on the assessed needs of the participants, education plan and behavioral objectives. The content areas taught should be documented, along with the date of instruction and identification of each instructor who taught the specific objective or content area.

5) Evaluation of progress towards behavioral goals and related health or quality of life outcomes, and/or achievement of learning objectives – After the educational intervention, the educator must assess and document whether the participant is making progress towards or has met the learning and behavioral objectives. . If the participant is unable to meet the outlined objectives the participant’s needs should be reassessed and new achievable objectives should be developed. The follow-up assessments and progress toward objectives, both learning and behavioral should be documented.

6) Communication with the referring provider. This communication should include a summary of the education process and a plan for Diabetes Self-Management Support (DSMS).

Note: Specific forms are not required for documentation of the education process. However, the program can ensure thorough and complete education process and documentation of it for all participants if identified education forms are used.

Q: What is the DSMS plan and how is it different from setting behavioral goals?

A: The Diabetes Self Management Support (DSMS) plan is a plan mutually agreed on by the program participant and the instructor(s) as a way to help the participant sustain outcomes gained from the education program and receive ongoing support for living with diabetes. DSMS plans may include plans by participants to join a gym, join a weight management group, attend healthy eating cooking classes, attend diabetes support group, join a mall walking group, use diabetes case management services provided by the participant's employer/insurer or access legitimate diabetes information websites via the Internet. This is different from a follow-up plan like a scheduled medical appointment or follow-up education visit that is part of a comprehensive education program. The DSMS plan focuses on accessible, community resources available to the patient for ongoing diabetes self-management outside of formal healthcare. However, in some communities and for some patients, the DSMS may be obtained only through the use of medical services since resources are limited or non-existent and some participants obtain ongoing support as part of primary care. It is recommended that you scan or assess your service area for available resources regularly and either develop or update a list of resources with which you can guide your patients in formulating the DSMS plan. Handing patients such a list, as has been traditionally done in education programs, does not constitute DSMS planning, but engaging patients to select specific resource(s) on the list or to identify their own plan to use on an ongoing basis constitutes a DSMS plan.

Q: If we get assigned “a copy of a de-identified patient chart” as a paper audit, does that patient have to have completed the program?

A: Yes. The patient needs to have completed “their” program. We need to see the entire education process from assessment, creation of an education plan based on the assessed needs and patient goals, an education record documenting the education interventions and evaluation of learning, setting of goals and follow-up with goal achievement evaluation, DSMS planning and communication to the referring provider.

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OUTCOMES TRACKING AND REPORTING

Q: What is expected for outcomes tracking and reporting in terms of target and actual degree of achievement?

A: Each recognized program must track at least one behavioral objective as an outcome and one other program outcome, for a minimum of two program outcomes. Behavioral outcomes are grouped generally under the seven self-care behaviors. Other outcomes include clinical outcomes like A1c, BP, lipids; quality of life outcomes like number of hypoglycemic events, diabetes-related hospitalizations, lost work days; and process outcomes like wait time for enrollment into DSMT classes, patient satisfaction, and physician satisfaction. Programs may report on as many outcomes tracked as they wish even though reporting is expected for at least one of each category.

Target achievement or benchmark is what degree of achievement is expected. This target is set based on knowledge of target population, national or regional standards and/or effort put forth by program staff towards achieving this benchmark in terms of resources and capabilities of the program. Actual degree of achievement is what is assessed at the time of follow-up and includes data on only the patients that have successfully completed follow-up and have had follow-up outcome evaluation. Target Outcomes can be reported in percentages from 1% to 100%. Actual outcomes can be reported from 0% to 100%.

Q: What is the time period for collecting data on outcomes?

A: Data collection on outcomes should be done on a continuous basis. On a renewal application, the reporting period is acceptable as a snapshot for outcomes data. However, aggregated outcomes, reported as a percentage, represent your population regardless of the period of time over which the outcomes are aggregated, therefore renewing programs may report outcomes collected over periods other than the reporting period; up to one year. Outcomes data reported on an Annual Status Report should represent current operations: an anniversary year

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PARTICIPANT TYPES

Q: What is the difference between comprehensive/initial participants and post-program?

A: Comprehensive/initial includes participants (all diabetes types) who were seen at your program for ANY PART(S) of the Recognized DSME process (assessment, educational interventions, post education evaluation/re-assessment and/or at least one follow-up contact for evaluation of achievement towards goals set). This includes participants seen on a 1:1 basis as well as in a group setting.

Post Program participants are those who have completed their education plan (including the one follow-up contact) and returned to the program for additional education (skills update, additional training secondary to change in treatment plan/regimen, etc.)

Q: We see pre-diabetes patients in a large group lecture. Do we count these as participants?

A: You only count pre-diabetes patients if they go through the same education process as the rest of your patients; including assessment, creating an education plan, education, goal-setting, reassessment, follow-up on goals set and DSMS planning.

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PROGRAM COORDINATOR

Q: I will be retiring as the program coordinator in a few months and we are starting to look for a replacement. Must the coordinator be a clinical person? Does the coordinator have to be a CDE?

A: The Program Coordinator does not need to be a clinical person. They do need to have the following qualifications:

- The Program Coordinator must be able to oversee the planning, implementation, and evaluation of the DSME program at all sites.
- She/he must have academic or experiential preparation in areas of chronic disease care, patient education and/or program management.
- The coordinator does not have to be a CDE (or BC-ADM) but must have appropriate CEUs if not certified. A coordinator affiliated with a multi-disciplinary program (a program with at least one multidiscipline site) must have 15 CEUs per year. If affiliated with a single discipline program, the coordinator must have 20 CEUs per year

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REPORTING PERIOD

Q: We have already collected 3 months worth of data. We now see that the application calls for a program defined “Reporting Period.” Can we use the 3 months of data as our reporting period?

A: Yes, you can use the three months of data as your reporting period, as long as it fits the following criteria: Original applications can use a reporting period that starts no more than 6 months prior to the submission of the online application. Renewing programs can use a reporting period that starts up to 12 months prior to the online application submission. In either case, the reporting period cannot end more than 3 months prior to the date of the online application submission. Within these parameters, the length of the Reporting Period is at the discretion of the program coordinator.

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STAFF TYPES

Q: Is it correct that under the new guidelines we no longer need both a nurse and a dietitian to staff the recognized program in order to achieve or maintain recognition?

A: This is correct. Under the revised 2007 National Standards for Diabetes Self Management Education, the entire core curriculum may be taught by an instructor from one discipline: registered dietitian or registered nurse or pharmacist. In this case, the program or site is considered single discipline

Q: What is meant by auxiliary staff?

A: Auxiliary staff refers to staff that supports the recognized program regularly, whether paid or unpaid, in capacities such as administrative assistant, dietary technician, peer educator or community health worker.

Q: Who are considered to be qualified instructional staff?

A: Qualified Instructional Staff is defined as “experienced, skilled, in a CDE eligible health profession (a health professional who has the academic credentials to sit for the CDE exam*) who works with the client in the process of DSME”.

Although a multi-disciplinary staff is still encouraged, the required instructional staff is at least ***1 RD OR 1 RN OR 1 Pharmacist***. Other instructional staff members must be individuals with academic credentials for CDE-eligibility and may qualify as instructional staff only in addition to one of the above disciplines. (*Please contact NCBDE for CDE-eligibility requirements at www.ncbde.org or at 847-228-9795)

The options for other staff on the application are Exercise Physiologist, Physician, Physician’s Assistant, Podiatrist and Social Worker and other.

Q: I am the only educator in my program and need someone to fill in for me for vacations and other time off. Who can fulfill this role?

A: You may use Temporary Instructional Staff – These are individuals who fill in for a regular instructional staff member on a temporary basis, up to, but not more than, 4 consecutive months. If the temporary instructional staff member fits this definition, that instructional staff member does not have to be a CDE, BC-ADM or need to acquire the continuing education credits as dictated by the 8th edition application criteria. While some new staff may be hired as qualified instructional staff, others may need orientation and may be classified in the temporary staff category while on orientation. Temporary staff should not be included on the application, which means there has to be other qualified instructional staff in place.

Q: We have a podiatrist that would like to come in a present a half hour session on foot care. Is this allowed and does he have to acquire CEUs?

A: This type of an instructor would be considered a resource person. A resource person is someone who teaches less than 10% of your total program. The qualified instructional staff is still responsible for content taught by the resource staff and oversees the work of the

resource staff. Resource staff is not required to have CDE or BC-ADM certification or CEUs. They should also not be listed on the application.

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OTHER RESOURCES

Additional information may be found on our website at www.diabetes.org.

Recognition Requirements and templates for different types of application can be found in the “Applying for Recognition” link at:

<http://professional.diabetes.org/Recognition.aspx?typ=15&cid=84041>.

There are samples, examples and templates for various forms, records and paper audit items in the “Recognition Resources” link at:

<http://professional.diabetes.org/Recognition.aspx?typ=15&cid=84044>.

You can always contact your ERP Staff with questions at 888-232-0822 or at erp@diabetes.org.

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