A Guide for Completing Your Application for AADE Accreditation

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This guide was developed to assist organizations across the U.S. to become accredited for Diabetes Self-Management Education and Support (DSMES) through the American Association of Diabetes Educators (AADE). The intent of this guide is to show what documentation is needed to complete the online AADE application. It is based on the 2017 National Standards for Diabetes Self-Management Education and Support (Standards) at http://care.diabetesjournals.org/content/40/10/1409, and on AADE's Interpretive Guidance table, https://www.diabeteseducator.org/docs/default-source/practice/deap/standards/2017-interpretive-guidance-nov-rev_final.pdf?sfvrsn=6. This guide was also reviewed by AADE. In 2017, diabetes self-management education and support were combined from DSME/S into DSMES, to reflect that education and support is an ongoing process and is applicable to a variety of healthcare models. **DSMES quality coordinators may choose to apply for AADE accreditation or American Diabetes Association (ADA) recognition, the only two certifications approved to make programs eligible for Medicare reimbursement.** You are strongly encouraged to use the Standards and Interpretive Guidance table alongside this as you prepare. Once you utilize this guide and pull in your supplementary items, you will be ready to efficiently complete the AADE application (online entry system) or the ADA application. If you need further help, AADE and the ADA also have examples of the supplementary items required to complete their respective applications on each of their websites: www.diabeteseducator.org/accreditation and www.diabetes.org/erp.

INSTRUCTIONS FOR USE AND COMPLETION:

The information to be individualized for the specific organization applying is highlighted in red font or is a fillable blank. In each of these highlighted sections, please enter your organization's name and other information as specified. These should include:

1. Name of your organization (Std 1) – Use the name you use or will use for Medicare Entity NPI. Once accredited, this is the name that will appear on your accreditation certificate, and it's important that the name on certificate and Medicare NPI match.
2. Organization chart, mission statement, goals, and letter of support from organization leadership in medium or large entities (Std 1)
3. A documented process for seeking outside input that includes a list of identified stakeholders (Std 2) (Also, outreach to stakeholders and their input must be documented annually.)
4. Demographic data for area served, documented resource allocation to meet population-specific needs, and documented actions taken to overcome access-related problems (Std 3)
5. Quality coordinator and instructional staff resumes and job descriptions (Std 4)
6. Documentation showing coordinator provides oversight of DSMES services (i.e., implements Standards, meets population needs, ensures ongoing evaluation, and reviews CQI plan at least annually) (Std 4)
7. Documentation that Quality Coordinator and professional instructors earned 15 CEs within previous 12 months of application or maintained current CDE or BC-ADM certification (Std 4)
8. DSMES team has a method to meet participants' needs if they fall outside the realm of diabetes educators' scope of practice (Std 5)
9. Documentation showing at least one team member is an RN, RD, or pharmacist with training and experience in DSMES or is a CDE or BC-ADM (Std 5)

10. For paraprofessionals, show previous training or experience in diabetes, chronic disease, community health, education, or support via a resume or certificate, and show 15 hours of continuing education (CE) specific to the role they serve. If training occurred within previous 12 months, this may take the place of the 15 CE. Show the paraprofessionals report to the quality coordinator or one of the professional team members. (Std 5)
11. Name of curriculum used for the DSMES service that is evidence-based, and plan to review and update annually as needed; curriculum cover page; and if you created your own curriculum, also include a representative chapter with references (Std 6)
12. Complete de-identified chart of one participant completing the services from beginning to end, including:
    a. Referral from primary care clinician managing person's diabetes
    b. Evidence of ongoing education planning and behavioral goal setting with follow-up, based on needs identified together between educator and patient (Std 7)
    c. Evidence that a patient assessment is done covering health status, psychosocial adjustment, learning level, and lifestyle practices (Std 7)
    d. Community-specific ongoing support options with participant preferences indicated (Std 8)
    e. At least one SMART behavioral goal with follow-up and measured achievement (Std 9)
    f. At least one clinical outcome measure (Std 9)
13. For all Medicare providers, there must be communication back to the referring provider including the education provided and the participant outcomes. (Std 9)
14. List of community resources for ongoing support (Std 8)
15. A procedure for collecting aggregate data on clinical, behavioral, and process outcomes (Std 10)
16. A quality improvement plan for at least one process, behavioral, and/or clinical outcome should be clearly identified at time of application. It is to be reviewed annually and modified depending on annual review of program (Std 10).

Remember, information must be individualized for the applying organization. Documents need to be uploaded separately for each standard in the online application, or all the documents can be emailed to deap@aadenet.org.

Information not submitted at the time of the application will slow the application process. The information will be required before the application process can proceed. After the documentation is reviewed and payment submitted, there will be a telephone interview for questions, concerns, and next steps.

Name of Organization

Note: Name of organization should match the billing entity's NPI name. This is the name that will go on accreditation certificate that allows for Medicare billing.

Diabetes Self-Management Education (DSME)

STANDARD 1

The provider(s) of DSMES services will define and document a mission statement and goals. The DSMES services are incorporated within the organization – large, small, or independently operated.

Letter of Support on organizational letterhead and signed by someone above the program or owner of the organization

Insert here.

Organizational Structure

Insert organization chart showing where DSMES fits into larger organization, lines of communication, and all

Mission Statement

Name of Organization is dedicated to provide quality, accessible, and comprehensive healthcare services to the insert service area.

The Diabetes Education Program at Name of Organization is dedicated to providing self-management education for participants with diabetes mellitus who are residents of the insert service area. Name of Organization is committed to the concepts of participant education based on the Diabetes Education Accreditation Program by the American Association of Diabetes Educators (AADE), as well as the agency's healthcare values of quality, affordable, accessible, and comprehensive care.

To this end, the professional growth and development of the members of this Diabetes Education Program is strongly encouraged, as well as collaboration with all of the various disciplines composing the healthcare team.

DSME Program Goals

This section must be individualized for your organization.

The DSMES Program will empower patients to effectively manage their diabetes through education, diet, and exercise to prevent acute and chronic complications and promote quality of life.

Change the information below specific to your organization.

1. Empower patients to self-manage their diabetes, as evidenced by 100% of the diabetes population at Name of Organization having a documented self-management goal and being committed to following up with patients on their goals.
2. Evaluate clinical outcomes via Continuous Quality Improvement (CQI) on frequency and value of pre/post A1C testing.
3. Maintain effective staff as measured by continued attainment of CE in diabetes-related topics.
4. Strive to attain financial health of the DSMES service by actively pursuing Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) reimbursement.

STANDARD 2

Name of Organization DSMES Service

The provider(s) of DSMES services will seek ongoing input from valued stakeholders and experts to promote program quality and enhance participant utilization.

Purpose: The purpose of seeking stakeholder input in the ongoing planning process is to gather information and foster ideas that will improve the utilization, quality, measurable outcomes, and sustainability of the DSMES services. A formal advisory board is not required, but DSMES providers must engage key stakeholders to elicit ongoing input (by phone, email, or face-to-face), at least annually, on services and outcomes.

A documented process for seeking outside input that includes a list of identified stakeholders

The program's outreach to these stakeholders and the input from them must be documented annually.

Example: The DSME Oversight Committe will meet quarterly. The oversight committee will consist of:

Name, Program Coordinator

Name, Instructional Staff

Billing Representative

Name, Referring Physician

Names, Two Consumers with Diabetes

Name, local minority health coalition representati - Other disciplines will be invited as needed. The quality coordinator serves as the chair of the DSME Oversight Committee and provides programmatic management to instructional staff. The entire oversight committee will address committee tasks and community concerns. The quality coordinator will maintain minutes of these meetings. The minutes will show what was presented to stakeholders and what their input was. The quality coordinator will review the Continuous Quality Improvement (CQI) project with stakeholders and this will be recorded in the minutes.

STANDARD 3

The provider(s) of DSMES services will evaluate the communities they serve to determine the resources, design, and delivery methods that will align with the population's need for DSMES services, diabetes education to that population, and what resources can provide ongoing support for that population.

Evaluation of Population Served:

In order to design services that align with the characteristics and needs of the community served, the provider of DSMES services must document and review available demographic data from a published source for their area and update as needed. Understanding the population's demographic characteristics, including ethnic/ cultural background, sex, age, levels of formal education, literacy, and numeracy, as well as perception of diabetes risk and associated complications, is necessary.

The program serves all ages, genders, and races of clients who have diabetes (type 1, type 2, and gestational diabetes). Name of Organization serves insert service area of organization with a high prevalence of diabetes and obesity (per statewide data), where limited DSMES is available to meet the needs of health disparities, as well as communities with higher demographics of African Americans. The unique educational needs of populations (literacy, cultural beliefs, and financial barriers to accessing care) are assessed and considered.

Resources:
An annual review of barriers and resources will be conducted to assure the needs of the program are met.

Operational Support: Support through Name of Organization includes office supplies, scheduling staff, educational support for instructional staff, and marketing.

Personnel: The instructional staff is responsible for assuring national Standards for DSMES are being met. A plan for orientation is defined by the program coordinator. The program coordinator will assure that the instructional staff receives the 15 hours of diabetes specific CE annually.

Budget: Name of Organization fiscally supports the DSMES program through its administration. The program coordinator monitors revenue/cost reports.

Equipment: Each site has access to current Name of Organization equipment as needed. Name of Organization supports additional equipment as needed. Existing staff persons are located in Name of Organization facilities. Name of Organization has adequate classroom space, desks, and chairs are available for use. Computer access is available for all staff.

Curriculum: The program is using Name of Curriculum for its DSMES curriculum, and instructional staff are encouraged to personalize the educational plan according to the individual client's needs. Examples of published curricula are Michigan's Life with Diabetes, Conversation Maps, AADE7 curriculum, Self-Management Resource Center's (formerly Stanford's) DSMP, and Diabetes Empowerment Education Program (DEEP, Univ of IL at Chicago). If you use your own original curriculum, references must be listed in it to show it is evidence-based.

Teaching Materials/Handouts: The program uses the Name of Curriculum workbook, which was written by insert author of curriculum.

Ongoing Support: Name of Organization DSMES offers a monthly support group for those DSMES participants who have completed the program. Other support will be supplied through community resources such as the YMCA, hospital-based fitness programs, and weight management programs. *This information must be individualized by the organization to list resources specific to their communities.*

Access to DSMES: The program will be offered through the Name of Organization offices in insert individualized area of service Transportation within these rural counties is very limited. The decision was made to provide the DSMES program in the communities where the participants reside.

STANDARD 4

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.

Insert coordinator's resume.

Quality coordinator's resume must show experience with chronic disease management, behavior change, and clinical services management. He/She must be able to aggregate data and communicate outcomes to stakeholders. This person may do this role only for DSMES services, but is also allowed to be part of the DSMES instructor team.

Insert coordinator's job description.

Job description should include overseeing all DSMES team members, ensuring services are evidence-based, implementing the Standards, ensuring service incorporates population needs, ensuring ongoing evaluation, and that the CQI plan is reviewed at least annually.

Insert coordinator's CDE or BC-ADM certificate or documentation of CE hours and current license/registration.

Must include documentation of 15 CE credits completed during the 12 months prior to applying, or show maintenance of CDE or BC-ADM. To maintain accreditation thereafter, annual completion of 15 CEs or annual maintenance of CDE or BC-ADM must be recorded annually and submitted upon four-year accreditation renewal.

STANDARD 5

At least one of the team members responsible for facilitating DSMES services will be an RN, RD, or pharmacist with training and experience pertinent to DSMES, or be another healthcare professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other healthcare workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed above.

Insert proof of credentials for all instructional staff, including licensure and/or registration proof.

Insert resumes for all paraprofessional instructors.

Insert proof of 15 hours in in the past 12 months of diabetes specific CE hours for healthcare professionals who a

Paraprofessional team members need CE specific to the role they serve within the team and clear documentation of that training. Training obtained within the required timeframe may also fulfill the CE requirement for paraprofessionals.

Insert proof of paraprofessionals' annual 15 CE hours and/or training specific to the role(s) they serve.

Insert proof that paraprofessionals report directly to quality coordinator or one of the professional DSMES team

Write a policy that identifies a mechanism for ensuring participant needs are met if needs are outside instructor's scope of practice and expertise, such as appropriate referrals or consultation with other colleagues. Example: "If the instructional staff cannot meet the client's needs due to limitation of their professional scope of practice or their expertise limitations, that instructional staff is responsible to refer to or consult with appropriate colleagues to meet that client's needs."

Insert the policy.

STANDARD 6

A curriculum reflecting current evidence and practice guideline, with criteria for evaluating outcomes, will serve as the framework for the provision of DSMES. The needs of the individual participant will determine which elements of the curriculum are required.

Assessed needs of the individual with diabetes will determine which of the content areas listed below are to be provided. The information below must be individualized for your organization but needs to cover the participants in the program and meet the AADE 7 Self-Care Behaviors™ and eight American Diabetes Association content areas.

- Diabetes pathophysiology and treatment options
- Healthy eating
- Physical activity
- Medication usage
- Monitoring, including pattern management and using patient-generated health data (PGHD)
- Preventing, detecting, and treating acute (hypo/hyper, DKA, sick days, severe weather or crisis supply management) and chronic (immunizations, eye/foot/dental exams, and kidney function testing as indicated) complications
- Healthy coping with psychosocial issues and concerns
- Problem-solving

A client workbook, Name of Curriculum and the eight (8) content areas, was developed by Name of Curriculum source and is utilized with clients who have type 1 and type 2 diabetes. The curriculum is based on the AADE7 Self-Care Behaviors™. The workbook is provided to each client and is used for all educational encounters. Clients are encouraged to make notes in the workbooks, take the workbooks home at the end of each session, return with the workbooks at each session, and consider the workbooks as a resource post-education. The program believes that learning is an active, not passive, process. The clients participate in learning through discussion, skills practice, demonstration, role-playing, and other active educational techniques. Literacy and educational levels are important variables in the educational process. Name of Curriculum uses a variety of written and visual educational materials for different reading levels. Ethnic and culturally appropriate materials are available to be used as indicated to promote acceptance and adherence to diabetes care. The client's age, socioeconomic level, educational level, psychological adjustment, and prior diabetes education experiences are considered when choosing appropriate educational methods.

The instructional staff continually evaluates the effectiveness of the curriculum and client workbook. Input from the instructional staff is requested by the program coordinator periodically to improve the curriculum and client workbook. A formal review of the curriculum and workbook is conducted annually by the insert the title of the person/people responsible and updated to reflect the latest ADA Standards of Medical Care in Diabetes and to better meet the changing needs of our target population. If using a pre-published, evidence-based curriculum, you need only include a copy of the cover page. If your curriculum is not published, submit entire curriculum with references.

STANDARD 7

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

Note: To meet this standard, a de-identified chart of one patient completing through follow-up must be submitted. For full list of de-identified chart requirements, see Education Record (Chart) Review form at https://www.diabeteseducator.org/practice/diabetes-education-accreditation-program-(deap)/applying-for-accreditation

In order to individualize and guide a participant's course of instruction, it is necessary to evaluate the participant's educational status and needs, and the factors affecting these. The process used in the Name of Organization DSMES addresses the following:

1. Each participant is assessed for their diabetes knowledge and skills related to the eight (8) content areas during a 1:1 assessment with a member of the professional staff prior to the educational process. This assessment includes:
    a. Health status: medical history, physical limitations, diabetes-related hospitalizations, and ER visits
    b. Psychosocial adjustment: emotions related to diabetes, social support, readiness to change, and financial means
    c. Learning level: diabetes knowledge and health literacy and numeracy
    d. Lifestyle practices: diabetes self-management skills, cultural and religious beliefs, and health attitudes

This assessment is documented on the Name of Organization Diabetes Needs Assessment and retained in the participant's permanent educational record, which will be included in the Name of Organization Electronic Health Record (EHR).

Note: If the organization does not use an EHR for the DSMES service, insert: "The forms for the program will be scanned and placed into the organization's EHR at the end of the class series." This statement must be included if such a situation exists in place of the above sentence.

2. Each participant will have an individual education plan, documented on the Coordinated Plan of Care This form was developed to meet the participant's individual needs as determined by the Diabetes Needs Assessment . The participant actively participates in defining their education plan. The Coordinated Plan of Care is retained in the participant's permanent educational record within the EHR.
3. Each participant completes the program's behavioral contract . The behaviors the participant is currently doing are documented on the insert the behavior contract title here , which is based on the AADE-7 Self-Care Behaviors™. This contract is reviewed by the instructional staff during the educational encounters. At the conclusion of the educational encounters, the participant chooses individual goals that need to be addressed during the next three months prior to the follow-up visit with the instructional staff.
4. The instructional staff documents class attendance and determines whether the client met the learning goals at the end of each class session on the Continuation/Coordination Shee , and this form is retained in the participant's permanent record within the EHR.
5. Communication with the referring healthcare provider is documented through a letter sent to the provider using a communication relay within the EHR. This communication is sent immediately after

the participant assessment and includes a summary of the information obtained in the assessment process. The educational process is also defined at this time.

6. At the completion of the final educational encounter, the participant will be asked to complete an anonymous program evaluation of the encounters received. This evaluation will request that the participants define their skills and behaviors based on the AADE-7 Self-Care Behaviors™. The evaluation also includes a Customer Satisfaction Survey. Results of these evaluations are entered into a database to allow for program monitoring and evaluation.
7. Communication is sent to the referring provider immediately upon completion of the educational encounters. It includes a summary of the educational process and the participant's plan to address the AADE-7 Self-Care Behaviors™, as well as any concerns noted by the instructional staff. All communication with the referring provider is retained in the participant's permanent educational record within the EHR.
8. In conjunction with the final educational encounter, the instructional staff will explain the follow-up visit process, the need to have a repeat A1C level, and the opportunity to attend the DSMES Support Group meetings.

All forms are multi-disciplinary. Collaboration with the referring provider and the instructional staff is crucial to assure the participant's needs are met. A multi-disciplinary approach to education (where possible) and the educational team discusses the unique individual needs of the participant as identified in the

Diabetes Needs Assessment

Insert: De-Identified Chart (complete with assessment and documentation showing ongoing education and beha

Note: No participant is required to complete a pre-set DSMES structure; rather, when a participant has fulfilled their individual education plan, their initial DSMES intervention is complete. While it's key to define completion for each patient, documentation of complete/not complete is not required. If the DSMES service has a process for recording completion, the policy/process would be submitted under Standard 7.

STANDARD 8

The participant will be made aware of options and resources available for ongoing support of their initial education, and will select the option(s) that will best maintain their self-management needs.

Note also: DSMES providers need to identify community resources that may benefit their participants and support their ongoing efforts to maintain their achievements reached during active participation in the DSMES services. The community resource ongoing support list must be reviewed periodically to keep it up-to-date. Examples of community resources include the local YMCA, activity-related classes at a senior center, a local support group, grocery store tours at the local grocer, local food shelf, a walking group or local walking trails, community center swimming pool, church group, dental school for discounted or free cleanings, local mental health services, etc. You can also include more broadly available resources, such as online diabetes communities (Tudiabetes.org, etc.) and specific diabetes magazines (Diabetes Forecast, etc).

At the conclusion of the education process, an ongoing support plan is developed with each participant.

Individualize the information below for your organization.

Name of Organization Diabetes Education Service offers a monthly support group for those DSMES

participants who have completed the program. Other support will be supplied through community resources such as the YMCA, our hospital-based fitness program, and local Weight Watchers' program.

STANDARD 9

The provider(s) of DSMES will monitor whether participants are achieving their personal diabetes self-management goals and other outcome(s) to evaluate the effectiveness of the educational intervention(s), using appropriate measurement techniques.

The follow-up plan of care is documented in the participant's educational record and communicated to the referring healthcare provider via a written progress report, which also lists the educational topics the client received as well as individual concerns/comments and participant outcomes achieved. The behavioral goals chosen by the client are communicated at this time.

At three to four months post-education, a follow-up visit via telephone or in person will be completed by the instructional staff. Those participants completing at least two of the three educational sessic will have follow-up visits and will be defined as completing the DSMES service. The participant will be asked the information on the Educational Encounter Documentation form. The information obtained on participant-chosen behavioral goals and the most recent clinical outcomes will be entered into a database. The definition of goal met will be if the client determines that they have met the goal at least 50% of the time since completing the DSMES. **Your organization chooses what number or percent means goal achieved and indicate as Met/ Not Met**. Based on a 1-10 self-rating system in the AADE-7 Software, AADE states, "These change rate numbers are for your use only and how your particular program is defining the numbers. Because each program is unique, there is no set number that means 'achieved' to the system.")

Procedure for follow-up visits: Individualize this section.

1. The diabetes educator will conduct the follow-up visit at three-four (3-4) months post completion of DSMES program to track clinical goals and behavioral goals for each client.
2. Three attempts by phone are to be completed and documented before closing the participant's permanent educational record.
3. All follow-up results will be reported monthly to the instructor designate to collect data for the annual status report.

Individualize for your organization.

Note: First time applicants must have the measures and a process identified as described in the example below. First time applicants must also have followed at least one patient through the process, including follow-up, and have their data recorded in the CQI form as part of the application. The CQI form is embedded in the online application. After accreditation is achieved, CQI data must be collected and submitted annually.

The measures and process will need to be individualized for your organization.

The Name of Organization DSMES team is tracking:

- Achievement of behavioral goals as defined by the individual client on the behavioral contract based on the AADE-7.
- Clinical Outcome – change in A1C , pre-education to post-education

Process for assessing level of behavioral goals met, educational goals, and clinical outcomes:

1. During the educational process, the instructional staff reviews, with each participant, their attainment of educational goals, established during the initial assessment, and the client-defined behavioral goals. Each participant completes the program's behavioral contract. The behaviors the participant is currently doing

are documented on the Behavioral Goal Sheet , which is based on the AADE-7 Self-Care Behaviors. This contract is reviewed by the instructional staff during the educational encounters. At the conclusion of the educational encounters, the participant chooses individual goal(s) that need to be addressed during the next three months prior to the follow-up visit with the instructional staff. The goal(s) chosen must be "SMART" – specific, measureable, achievable, relevant, and time-bound.

2. The instructional staff is familiar with community resources as emotional, social, or medical concerns become apparent.
3. At the time of the follow-up visit the instructional staff reviews the client-defined goals, and they collaborate with the client on determining the level of attainment for each goal. This is a self-reported level of attainment.
4. The instructional staff also reviews the educational elements of the DSMES with participants to assess any concerns and/or knowledge deficits.
5. Based on this re-assessment, the instructional staff will reinforce/review content as needed.
6. The post-education A1C level is recorded and assessed as compared to the pre-education A1C level.
7. Utilization of the healthcare system, the diabetes support plan, psychosocial needs, and other successes or concerns are discussed.

The post-education assessment forms the basis for identifying unmet educational needs and provides a method of providing additional education for the identified deficits. Participants are offered additional post-education as a review of DSMES educational components. The instructional staff reminds the client that they may access this educational review at any time they identify a need and are encouraged to contact the staff for additional information.

STANDARD 10

The DSMES quality coordinator will measure the impact and effectiveness of the DSMES services and identify areas for improvement by conducting a systematic evaluation of process and outcome data.

The information below is based on AADE's Interpretive Guidance. #1 and #2 describe documents the quality coordinator/DSMES team needs to produce and submit with Standard 10 of the application. Formal quality improvement strategies can lead to improved diabetes outcomes.

1. DSMES providers need a **procedure** in place to collect, aggregate, analyze, and report to stakeholders **clinical and process outcomes and behavioral** goal achievement. Examples of outcomes to measure are: a) process measures: improving number of referrals, no show rate, participant evaluation of the education, percent attending follow-up; b) clinical measures: A1C, % body weight lost, ER visits; and c) behavioral measures: participant satisfaction, behavior goal achievement. The quality coordinator must show evidence of their procedure at time of application.

    - Example procedure for aggregating DSMES clinical and behavioral outcome measures:
        - The pre- and post-education A1C results and the level of attainment of the client-defined behavioral goals (based on the elements of the AADE-7) are entered into a data analysis system.
        - At the end of the educational year, the data are analyzed. Comparisons are made on the change in pre- to post-education A1C results and in the level of attainment of the individual client-defined behavioral goals.
        - Annually, this data is analyzed and is reported in the Annual Status and Performance Measurement Report for AADE.

Note: Once accredited, DSMES service needs to submit one aggregated behavioral outcome and one aggregated clinical outcome to AADE per year (in annual report).

- Example procedure to collect process measures on the DSMES service.
  - The participant completes the DSMES Evaluation and Customer Satisfaction Survey at the end of the educational interventions.
  - The Evaluation is designed to determine the level of comfort the participant feels with their ability to perform the AADE-7 behaviors and their comfort level with the skills learned during the series of educational interventions.
  - The Customer Satisfaction Survey is designed to determine the level of satisfaction with the content of the educational interventions, their satisfaction with the delivery of the information presented, and the opportunity to rate the helpfulness of the information presented.
  - Quarterly, the information from these two forms is entered into a data analysis system. This information is discussed at the quarterly Diabetes Oversight Committee meeting to provide continuous feedback for improvement of the DSMES program.
  - Annually, this information becomes part of the Continuous Quality Improvement (CQI) report and is entered into the Annual Status and Performance Report for AADE. The CQI projects are reviewed at least quarterly by the Diabetes Oversight Committee , and results are used to determine how the CQI projects should continue based on the results of the previous quarter.
  - Annually, the Annual Status and Performance Measurement Report for AADE is shared with the Name of Organization DSMES stakeholders.
  - If you have a separate program evaluation and/or customer satisfaction survey as all or part of your CQI project, you would insert it here.

program evaluation and/or customer satisfaction survey

2. The quality coordinator needs to document the DSMES team's Continuous Quality Improvement (CQI) project chosen for a process, clinical, and/or behavioral outcome. Once the team identifies areas for improvement on chosen outcome(s), the quality coordinator will set timelines for data collection, analysis, and presentation of results to your identified DSMES stakeholders (from Std 2).

Notes:

- Three fundamental questions should be answered by the CQI project: 1) What are we trying to accomplish? 2) How will we know a change is an improvement? 3) What changes can we make that will result in an improvement? A variety of methods can be used for quality improvement initiatives, such as the Plan Do Study Act model, Six Sigma, Lean, Re-AIM, and workflow mapping.
- Aggregated process and outcome data, as well as results of CQI projects, need to be regularly reported to stakeholders for continual evaluation and input into future CQI projects.
- After accreditation is achieved, all DSMES sites, including new ones, must be able to show implementation of the CQI plan by the six-month mark. Annually, DSMES providers will need to submit a report of their CQI project from the previous 12 months through their anniversary date and their CQI plan for the next 12 months. Once a CQI project, which could contain multiple improvement cycles, has resulted in achievement of the DSMES entity's target goal, another specific CQI project is chosen.

- Example of a CQI cycle using Plan-Do-Study-Act for participants' behavioral goals set for the AADE-7 behavior of Being Active:
  - **Identified problem:** Problem identified while monitoring attainment of behavior set goals at 3-6 month follow up contact with participant. The being active-exercise goal was being met <70% of the time. Goal would be to meet exercise goals >70% of the time.
  - **Plan:** Meeting exercise participant set behavior change goals (increasing physical activity) in at least 70% of participants who complete the program.
  - **Do:** Adjust exercise portion of group class to include more sample exercises including those for at home fitness as well as work fitness ideas, list of local exercise resources, and stressing why exercise can be that "magic bullet."
    - Set initial goal for exercise to be attainable, with rate of progression ideas given to participant. More concrete ideas given to participant in helping them to develop their specific goals. Increase goal attainment for three-six month follow-up.
    - Encourage participant to set exercise related/being active goal to help improve health status, quality of life, and longevity.
    - Look at exercise frequency, type, and duration when initial goals are set by participant.
    - Look at any barriers to exercise, and address those when goals are set and in follow-up.
    - Give list of exercise facilities/classes in the area.
    - Information recorded on and collected from the AADE-7 Self Care Behaviors sheet
  - **Study:** Monitor through follow up process at four weeks and again at three-six months to see percent of clients meeting their exercise/being active goal. Utilize the AADE-7 Self Care Behavior goal setting sheet to record data and a created spreadsheet to track data.
  - **Act:** Continue to improve strategies or create new ones as needed, to help with exercise related goal attainment in participants who complete the program.