National Standards for Diabetes Self-Management Education and Support: Trusting the Process (Standards 5-8)

LINDSEY K. WAHOWIAK

Education without continued learning and ongoing support does not serve people with diabetes.

This is the third article on the 2017 National Standards for Diabetes Self-Management Education and Support (DSMES). The first 2 articles outlined the "whats" and "whos" of providing DSMES. This installment outlines the "hows," the process of providing the tools people with diabetes can use to achieve better health outcomes, which is encompassed in Standards 5 through 8.

As we've noted previously, DSMES is not a "one and done" event.[1] It's a lifetime of revisiting, refiguring, learning, and relearning as the management of diabetes is lifelong and ever changing. In Standards 5 through 8, the Task Force challenged with updating the Standards outlines how providers of DSMES can best serve participants in their services—both in person and remotely.

Standard 5: DSMES Team

At least one of the team members responsible for facilitating DSMES services will be a registered nurse, registered dietitian nutritionist, or pharmacist with training and experience pertinent to DSMES or be another health care professional holding certification as a diabetes educator (CDE) or Board Certification in Advanced Diabetes Management (BC-ADM). Other health care workers or diabetes paraprofessionals may contribute to DSMES services with appropriate training in DSMES and with supervision and support by at least one of the team members listed previously.

This Standard's name changed from 2012's "Instructional staff," reflecting how providers of DSMES do more than just provide teaching. As noted in previous parts of this series, the 2017 Standards merged diabetes self-management education and diabetes self-management support

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into one entity. In doing so, the Task Force recognized that education without continued learning and ongoing support does not serve people with diabetes. It requires engaging with more people and building a comprehensive team. "A well-made diabetes education program offering DSMES services relies on quality team members to help serve many of the needs of our people with diabetes," said Lori Blanton, MS, CHES, CDE, a Task Force member who worked on Standard 5.

Members of the DSMES team can include registered nurses, registered dietitian nutritionists, pharmacists, and members of health care disciplines that hold a certification as a CDE or BC-ADM to lead the DSMES services, including clinical assessments.[2-5] Paraprofessionals with additional training in DSMES can contribute to the DSMES team and may include diabetes paraprofessionals, medical assistants, community health workers, and peer educators.

Blanton also noted that growing DSMES teams might consider diversifying their staff. She highlighted NCBDE's "unique qualifications" pathway for people who wish to become CDEs but do not have the traditional clinical background. "People with diabetes are a diverse group, and we must have diverse disciplines supporting them to achieve their diabetes-related goals," she added.

Standard 6: Curriculum

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

Standard 6 is the Standard that went through the fewest changes from 2012 to 2017, but it is no less important in guiding how providers of DSMES best serve participants. The American Association of Diabetes Educators (AADE) and American Diabetes Association (ADA) both have evidenced-based curriculum listed as a requirement for becoming recognized center. A comprehensive curriculum provides a lot—which a participant in DSMES services may get all at once or piecemeal, based on when they need it.

"To . . . be the most impactful in diabetes and implementing self-management service, the service and the participant and the educator have to strive for the most information that can be appropriately discussed or presented," said Eric A. Orzeck, MD, FACP, FACE, CDE, a Task Force member who worked on Standard 6.

An evidence-based curriculum provides the strong base required for quality service.[6,7] It also means that as the evidence is updated, so too must the curriculum be—even if the Standard itself hasn't changed much, the curricula it covers have.

And just as a curriculum is not static within a service, it shouldn't be among participants in DSMES, said Andrew S. Rhinehart, MD, BC-ADM, CDE, FACP, one of the Task Force members working on Standard 6. "The most important aspect of the curriculum is realizing that not every patient needs every part of the curriculum," he said. "You're not

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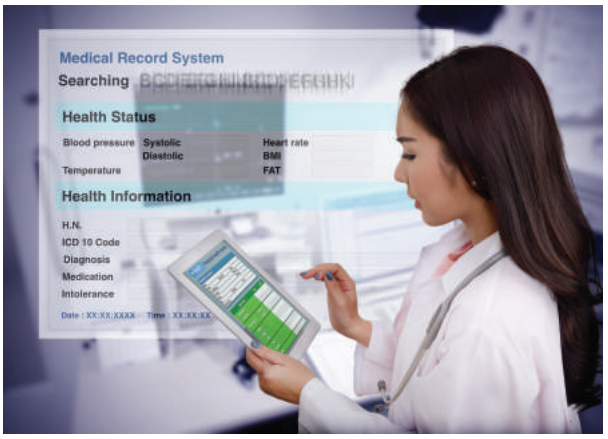

going to teach the things a patient doesn't need; individualize for each patient. As the patient's needs change over time, there may be a piece of the curriculum they do need to teach," such as insulin use, medication changes, or other updates.

Standard 7: Individualization

The diabetes self-management, education, and support needs of each participant will be assessed by one or more instructors. The participant and instructor(s) will then together develop an individualized education and support plan focused on behavior change.

As Standard 6 outlined how curricula can be adapted for each participant in DSMES, Standard 7 expounds further, noting how participants can and should be the leaders and decision makers regarding their own care. Standard 7 makes explicit that participants decide when their initial DSMES is complete (though we will see in Standard 8 how important ongoing support will be) and what they will do to manage their diabetes. The burden of diabetes management is real. Deborah A. Greenwood, PhD, RN, BC-ADM, CDE, FAADE, co-chair of the Task Force, noted that following every recommendation for diabetes management can add 2.5 hours to a person's day.[8]

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Standard 7 also highlights the use of electronic health records (EHRs) and patient-generated health data (PGHD) to help providers of DSMES better individualize services. Joni Beck, PharmD, BC-ADM, CDE, co-chair of the Task Force, said looking at data in real time can help providers of DSMES make individualized recommendations and can help participants in DSMES services as well. "For participants, they can fully engage in personal problem solving," she said. "They can learn from their information and then make subsequent behavior changes that hopefully improve outcomes."

Individualization can be done in group DSMES settings as well. Participants can use their own data, rather than watching traditional PowerPoint presentations, to stay more engaged in DSMES and gain better understanding, Beck added. "You can change the format of your teaching," she said. "If you teach patients to look at their health data, in whatever format that might be, hopefully it will not only teach them but empower them to make decisions based on the data that they're seeing."

To assist with using EHRs and PGHD effectively, Standard 7 recommends using validated tools to communicate with participants. These are used for assessment and ongoing evaluation. Examples of some validated tools are included in the Standards glossary.[1]

Electronic tools can also be used to help individualize DSMES services. But with all the tools available, providers of DSMES should make use

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of systems that utilize the technology-enabled self-management feedback loop: They engage in 2-way communication, include analysis of PGHD, allow for customized education, and offer individualized feedback.[9]

Standard 8: Ongoing Support

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.

Technology, such as verified tools, is a highlight of Standard 8, which reaffirms the need for continued DSMES, particularly at the 4 critical times: diagnosis, annually, when complicating factors occur, and during transitions of care.[10] Technology makes continued DSMES possible as participants can communicate with their DSMES team via portals or other online tools to make ongoing support easier.

Digital coaching, online support groups, and other tools also make peer support and ongoing services a possibility in remote places or places where diabetes educators are limited, said Jodi L. Pulizzi, RN, CDE, CHC, a Task Force member who worked on the Standard. "I think that there are so many more opportunities for support after somebody sees [an educator] in a clinic," she said. "If they do telephonic coaching, digital interactions—there's just so much more opportunity to follow up with that person. It makes it easier for people to receive the right education, at the right time, in the method they want to receive it. Ongoing coaching doesn't end within a 10-hour window of a year."

Online support groups[11] and wearable and remote devices, such as wireless glucose meters or fitness trackers, have also made ongoing support a round-the-clock possibility, said Jing Wang, PhD, MPH, RN, FAAN, a Task Force member working on the Standard. "Resources can be within the program and also outside the program," she said. "It doesn't have to be all within the program. In this version [of the Standards], it can be 24/7. They can be in touch with peers, [who] may have similar conditions but they may never know each other [except] in an online community."

Puluzzi and Wang both noted that for ongoing support to be effective, the full diabetes care team should be involved. Either the DSMES participant or their educator can initiate that conversation with health care providers.

Building a DSMES Team

While the Standards define the steps to creating a strong and successful DSMES service, they do leave some things to the discretion of those running such programs. They don't define who ought to be involved in the DSMES team beyond the minimum outlined in Standard 5. So, who's providing?

Ideally, DSMES providers include everyone on a participant's diabetes care team—and that's true for DSMES programs that are large as well as those that are a 1- or 2-person shop. Those who work in small operations needn't worry that their participants will get care that is any less

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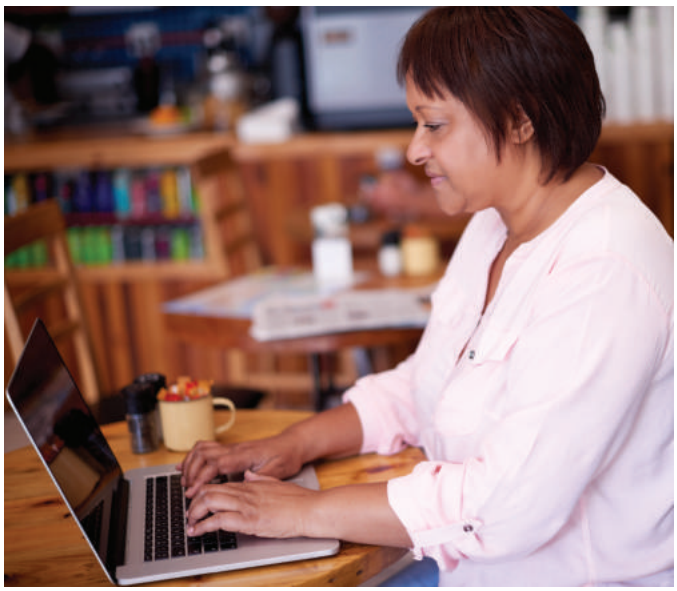

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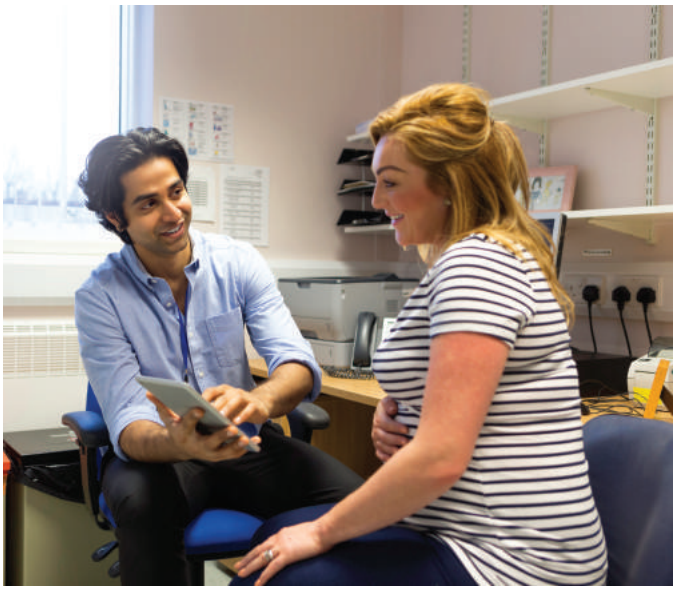

comprehensive than other services with larger staffs. They may, however, want to get creative.

If you're a single-discipline provider of DSMES, Beck said working closely with community stakeholders—the group of experts who offer insight to make services more comprehensive—will ensure DSMES is approached from a variety of disciplines. You can incorporate the expertise of your stakeholders into the support and education provided through the service. They're a community you can access as needed, added Greenwood. She also suggested AADE's Communities of Interest. In these online forums, providers can talk to others in the field who have faced similar problems or questions and share solutions.

Service providers can also look to participants' health care providers, such as their endocrinologists, primary care physicians, and others, to contribute to efforts of the DSMES team. Strong lines of communication are critical for ensuring that DSMES meets participants' needs, providing support for participants and for providers of DSMES as well! There is no one-size-fits-all version, but when communication is prioritized, participants are more likely to succeed. ■

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