Indian Health Diabetes Best Practices:

Diabetes Self-Management Education

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Contents

What is diabetes self-management education?

Diabetes self-management education (DSME) helps individuals with diabetes acquire the knowledge, skills, attitudes, and behaviors they need to make the best decisions about their daily diabetes management. It is an integral component of diabetes care.

Why is diabetes self-management education important?

DSME is key to diabetes treatment and prevention. It affects all levels of diabetes treatment and prevention: primary, secondary, and tertiary levels. DSME also:

- Improves clinical and behavioral outcomes, such as lower A1c and improved quality of life.
- Provides individuals with the knowledge, skills, and resources necessary to make informed decisions on managing their diabetes throughout their lifetime.
- Informs individuals, families, and communities about the benefits of adopting healthy lifestyles.

Best practices for diabetes self-management education

The best practice for DSME describes the best methods for:

- Assessing the educational needs of people with diabetes.
- Assessing the resources available for quality DSME.
- Providing diabetes education to people with diabetes.
- Providing diabetes education to the community.
- Evaluating DSME activities.

Table 1 summarizes the best practices for DSME.

Table 1. Best practices for diabetes self-management education.

Provider Recommendations	Best Practices
1. Assess the **educational needs** of people with diabetes	***Why?*** Health care providers are better able to focus resources and maximize health benefits when they assess the DSME needs of people with diabetes. Providers can use assessments to develop individualized education plans, which can improve diabetes outcomes (AADE, 2005). ***How?*** – Consider the following topics in an education assessment for individuals with diabetes: • Health and medical history. • Nutrition history and practices. • Physical activity and exercise behaviors. • Prescription and over-the-counter medications, and complementary and alternative therapies and practices. • Factors that influence learning, such as education and literacy levels, perceived learning needs, motivation to learn, and health beliefs. • Diabetes self-management behaviors, including experience with self-adjustment of treatment plans. • Previous DSME, actual knowledge, and skills. • Physical factors, including age, mobility, visual acuity, hearing, manual dexterity, alertness, attention span, and ability to concentrate, special needs or limitations that require accommodations or adaptive support, and use of alternative skills. • Psychosocial concerns, factors, or issues including family and social support. • Current mental health status. • History of substance use including alcohol, tobacco, and recreational drugs. • Occupation, vocation, education level, financial status, and social, cultural, and religious practices. • Access to and use of health care resources. – Use this information to develop an individualized education plan.

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Table 1. Best practices for diabetes self-management education. (continued)

Provider Recommendations	Best Practices
2. Assess the **resources** available for quality DSME	***Why?*** DSME benefits the entire community by promoting healthy behaviors and lifestyles and by creating a supportive environment for people with diabetes or at risk of developing diabetes. Diabetes education resources and programs, like the Indian Health Service (IHS) Integrated Diabetes Education Program (IDERP), can help you build a quality diabetes education program and will enhance your diabetes education activities. ***How?*** – Learn more about the IHS IDERP: • The IHS IDERP offers a three-stage process for building quality diabetes education programs based on the *National Standards for Diabetes Self-Management Education*. • Please refer to the *IHS IDERP Standards, Review Criteria, and Application Manual* and *IHS IDERP Sample Materials for Developing Quality Diabetes Education Programs* (available online at: www.ihs.gov/MedicalPrograms/diabetes/recognition/recog_index.asp). • Use the *IHS IDERP Standards, Review Criteria, and Application Manual* to assess your existing diabetes education program. • Use the *IHS IDERP Standards, Review Criteria, and Application Manual* as a guide to develop quality diabetes self-management education programs (even if you choose not to apply for program recognition). • Use the IHS IDERP framework for providing diabetes education and documenting program outcomes. • Attend an IHS IDERP workshop. – Seek technical assistance through the IHS Division of Diabetes Treatment and Prevention. – Designate a coordinator with skills in program planning, implementation, and evaluation. – Consider establishing a diabetes team and advisory board. They can help: • Guide the development of quality DSME. • Decide if applying for IHS IDERP recognition would be right for your program and community.

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Table 1. Best practices for diabetes self-management education. (continued)

Provider Recommendations	Best Practices
3. Provide **diabetes education to *people with diabetes***	***Why?*** DSME is as an interactive, collaborative, ongoing process involving the person with diabetes, health care providers, and educators (ADA, 1999). DSME helps people with diabetes acquire knowledge, skills, attitudes, and behaviors needed to make the best decisions about their daily diabetes management and improve their quality of life. For health care providers and educators, DSME helps them develop individualized patient treatments and incorporate psychosocial and lifestyle issues into the treatment plan (AADE, 2005). ***How?*** – Include the following in the education process (ADA, 1999): • Assessing the individual's specific education needs. • Identifying the individual's specific self-management goals. • Directing education and behavioral interventions at helping the individual achieve identified self-management goals. • Evaluating the individual's attainment of the identified self-management goals. – Provide diabetes education using an IHS-approved (or equivalent) curriculum, such as the *Balancing Your Life and Diabetes Curriculum*. The curriculum should include written and measurable learning objectives, content outline, instruction methods, materials, and evaluation methods. Content should include: • Diabetes disease process and treatment options. • Appropriate nutrition management. • Physical activity. • Medications. • Monitoring and using results to improve management. • Preventing, detecting, and treating acute and chronic complications. • Goal setting to promote health. • Problem solving for daily living. • Psychosocial aspects of diabetes. • Preconception care, management during pregnancy, and gestational diabetes management (if applicable). Assess the needs of the person with diabetes to determine which content areas should be delivered.

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Table 1. Best practices for diabetes self-management education. (continued)

Provider Recommendations	Best Practices
4. Provide **diabetes self-management education in the *community***	***Why?*** DSME activities for people with diabetes, as well as for the community, can help increase awareness of DSME and engage the community in promoting healthier lifestyles. This can foster a supportive environment for people with or at risk for diabetes (AADE, 2005). ***How?*** – Look for opportunities to share DSME information in the community. – Participate in community activities and events, such as health fairs, sporting events, pow wows, and talking circles. – Provide culturally appropriate and community-specific diabetes education materials.
5. **Evaluate** DSME activities	***Why?*** Evaluation is necessary to monitor, manage, and improve education activities. Use a continuous quality improvement process to evaluate the effectiveness of the education experience and determine opportunities for improvement. ***How?*** – Use the *IHS IDERP Standards, Review Criteria, and Application Manual* to evaluate the DSME program. – Evaluate the patients' progress in meeting their individual goals at each education encounter. – Evaluate clinical variables to compare patients who received DSME with those who did not. – Use surveys to evaluate individual and community satisfaction with the DSME program. – Conduct quarterly continuous quality improvement (CQI), an effective evaluation method for the development, implementation, maintenance, and enhancement of quality DSME programs. – Refer to the Centers for Disease Control and Prevention Evaluation Working Group website for further information on evaluation methods: (www.cdc.gov/eval/index.htm).

Best practices for health care organizations

A health care organization that wants to improve DSME must be motivated and prepared for change throughout the entire organization. The organization's leadership must identify DSME as important work. They must also develop clear improvement goals, policies, and effective improvement strategies. This will encourage the entire organization to make changes that will help improve DSME activities.

Table 2 describes the best practices for health care organizations.

Table 2. Best practices for health care organizations.

Organization Recommendations	Best Practices
System and programmatic changes	***Why?*** Supportive health care systems can help improve the delivery of appropriate diabetes education. ***How?*** The health care system can implement the following activities to help enhance DSME programs: – Support DSME programs through written commitments, mission statements, goals, and specific objectives. – Establish a DSME program management advisory body that meets regularly to plan and review education processes, review patient outcomes, and address community concerns. – Designate a coordinator with skills in planning, implementing, and evaluating the DSME program. – Establish a DSME team that includes health professionals. – Provide appropriate resources for effective diabetes education, including a teaching environment that provides: • Privacy, safety, and accessibility. • Teaching space, materials, furniture, lighting, storage, and ventilation. • An adequate number of trained staff to address the needs of the patient population.

Essential elements of best practice diabetes self-management education programs

High quality DSME involves implementing six essential elements* in your health care organization. These elements are:

- Community resources and policies.
- Health care organization leadership.
- Patient self-management support.
- Delivery system design: Services, programs, systems, and procedures.
- Decision support: Information and training for providers.
- Clinical information systems: Collecting and tracking information.

Table 3, starting on the next page, summarizes how these elements apply to basic, intermediate, and comprehensive DSME programs. Much of the information presented in Table 3 describes the standards and criteria for IHS IDERP accreditation. Please refer to the Appendix and to the *IHS IDERP Standards, Review Criteria, and Application Manual* for more information on IHS IDERP standards and criteria.

*Adapted from the Chronic Care Model, which was developed by the MacColl Institute for Healthcare Innovation at the Group Health Cooperative. For more information on the Chronic Care Model, visit their website at www.improvingchroniccare.org.

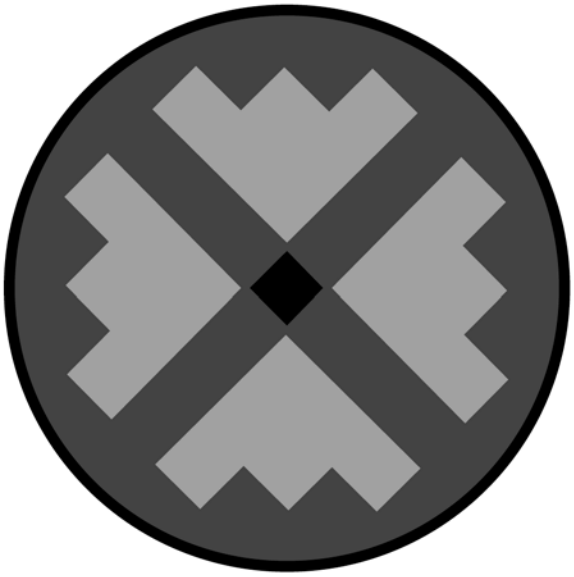

Table 3. Essential elements of basic, intermediate, and comprehensive best practice diabetes self-management education programs.

Basic Diabetes Self-Management Education Program	Intermediate Diabetes Self-Management Education Program Basic program *plus*:	Comprehensive Diabetes Self-Management Education Program Basic and intermediate programs *plus*:
Community resources and policies		
– Conduct a community assessment to determine the need for a DSME program. – Identify a list of community resources for DSME activities. – Consider forming partnerships with community programs that focus on at-risk populations that could benefit from DSME.	– Train field health personnel in diabetes self-management knowledge and skills. – Encourage community participation in DSME program development and planning. – Assess barriers and challenges to the community's access to DSME programs, and develop strategies to improve access.	– Coordinate diabetes self-management activities with available community services and agencies. – Define and document consumer and community access to the program. – Form partnerships with community programs that focus on at-risk populations and DSME. – Establish processes to obtain community and consumer input on DSME, including curricula and annual program plans.
Organization leadership		
– Obtain informal support and commitments from the clinic and tribal administration for space and resources for DSME.	– Obtain formal support and commitments from the clinic and tribal administration for DSME. – Begin discussions to place the DSME program within the appropriate organizational structure. – Begin discussions about how to continuously assess resources that will meet community needs.	– Include DSME as a recognized program in the organizational structure of the facility. – Allocate appropriate resources to support the DSME program. – Include DSME outcome measures in the organization's CQI plan. – Increase DSME training opportunities for health care staff, tribal leaders, and community programs.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice diabetes self-management education programs. (continued)

Basic Diabetes Self-Management Education Program	Intermediate Diabetes Self-Management Education Program Basic program *plus*:	Comprehensive Diabetes Self-Management Education Program Basic and intermediate programs *plus*:
Patient self-management support		
– Provide educational materials on diabetes risk, prevention, and self-management options. – Assess the specific education needs and self-management goals of each patient with diabetes. – Refer patients to appropriate DSME programs and providers. – Follow-up and monitor patients. – Identify the need for interpreters.	– Design or select a DSME curriculum and materials that meet: (1) the ten required content areas of the *National Standards for Diabetes Self-Management Education*; and (2) the needs of the target population. – Develop an individualized needs assessment process. – Use interpreters, as needed, in the DSME program.	– Review curricula and education materials annually for scientific accuracy and cultural relevancy. – Field test education materials when necessary. – Select education interventions and materials based on individualized needs assessments, education plans, and reassessments. – Encourage support groups for DSME participants.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice diabetes self-management education programs. (continued)

Basic Diabetes Self-Management Education Program	Intermediate Diabetes Self-Management Education Program Basic program *plus*:	Comprehensive Diabetes Self-Management Education Program Basic and intermediate programs *plus*:
Delivery system design: Services, programs, systems, and procedures		
– Identify a program coordinator. – Create an advisory body for the DSME program. – Identify the target population to receive DSME. – Begin to define the DSME program's structure, including a program description, a mission statement, and goals.	– Establish a DSME team that includes a minimum of a primary care provider, registered nurse, and registered dietitian. This team should meet regularly to discuss, track, and document DSME program issues. – Identify instructional staff that includes a minimum of a registered nurse and registered dietitian. – Identify the roles and responsibilities of the team members. – Identify tasks for developing an education program that meets the *National Standards for Diabetes Self-Management Education*. – Develop a program manual that includes, at minimum, a general description of the DSME program, policies, a mission statement, goals, the annual plan, the organizational chart, the education organization structure, and forms. – Support collaboration among DSME staff.	– Have the program coordinator oversee the planning, implementation, and evaluation of the DSME program, and act as the liaison among team, departments, programs, and the community. – Consider including the following as additional DSME team members: fitness specialists, behaviorists, and pharmacists. – Conduct ongoing communication among team members on program policies, goals, and other issues. – Define how a consumer gains access to program services. – Clearly define approval mechanisms for policy and program changes. – Document advisory body review and input on program evaluation and modifications.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice diabetes self-management education programs. (continued)

Basic Diabetes Self-Management Education Program	Intermediate Diabetes Self-Management Education Program Basic program *plus*:	Comprehensive Diabetes Self-Management Education Program Basic and intermediate programs *plus*:
Decision support: Information and training for providers		
– Ensure that DSME program coordinators and instructors are familiar with DSME for American Indians and Alaska Natives.	– Ensure that DSME program coordinators and instructors have knowledge in chronic disease management and program management. – Train providers to identify an individual's specific self-management goals. – Train providers in DSME and behavioral interventions. – Ensure that instructors can demonstrate the use of evidence-based guidelines in DSME activities, such as the *National Standards for Diabetes Self-Management Education* and *IHS Standards of Care for Diabetes*. – Ensure that instructors and coders are familiar with diabetes education codes.	– Have the DSME program coordinator document a minimum of 12 hours of continuing education in diabetes education principles and/or leadership or management every two years. – Have the DSME program instructors maintain a minimum of 12 hours of continuing education in diabetes management, behavioral interventions, teaching and learning skills, and counseling skills every two years. – On a regular basis, provide training and orient interpreters on their role in the program. – Incorporate current and up-to-date evidence-based guidelines into diabetes care and education, such as the *National Standards for Diabetes Self-Management Education* and *IHS Standards of Care for Diabetes Care*.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice diabetes self-management education programs. (continued)

Basic Diabetes Self-Management Education Program	Intermediate Diabetes Self-Management Education Program Basic program *plus*:	Comprehensive Diabetes Self-Management Education Program Basic and intermediate programs *plus*:
Clinical information systems: Collecting and tracking information		
– Develop a diabetes registry. – Encourage the consistent use of DSME forms as part of the medical record. – Document DSME using the IHS Patient Education Codes. – Participate in annual diabetes audits. – Assess community satisfaction with diabetes education activities.	– Document the teaching process in the medical record (e.g., assessments, education plans, interventions, and evaluations of individualized education experiences). – Identify behavioral and clinical indicators for the target population. – Identify DSME program goals and outcomes. – Establish a process for evaluating DSME participant satisfaction.	– Document data, such as the population served and types of services, to evaluate program impact and outcomes. – Document behavioral and clinical indicators and program goals. – Document education processes and use of diabetes education codes in the patient medical record. – Conduct pre/post program measures. – Measure DSME participant satisfaction. – Use audit data to evaluate variables of interest and compare patients who receive DSME with those who did not. – Use data to determine if the *National Standards for Diabetes Self-Management Education* and *IHS Standards of Care for Diabetes* are met. – Assess progress toward or meeting of DSME program goals on an annual basis. – Document actions that were taken as a result of program evaluations (as part of organizational CQI process).

Evaluating your diabetes self-management education program

Evaluation is important because it helps you see what is working and what is not working in your DSME program. It will show you if adjustments or changes need to be made to improve your program. Evaluation also provides you with information that you can use to share your successes with patients, providers, tribal leaders, administrators, the community, funders, and other stakeholders.

Consider including the following data in your evaluation:

- Diabetes audit data for individuals and for the population of patients with diabetes.
- Clinical Reporting System (CRS) data, such as data for the Government Performance and Results Act (GPRA) and Indian Health Performance Evaluation System (IHPES).
- Other local measures, such as performance improvement and other outcome data.

Sustaining your diabetes self-management education program

Often, for diabetes goals to be reached, programs must be in place for more than a few years. Here are some helpful tips for sustaining your program:

- Secure long-term funding (i.e., non-grant funds) to meet your diabetes program's needs.
- Ensure that DSME is included in the health care organization's long-term strategic plan.
- Orient new staff to DSME and go their responsibilities.
- Provide ongoing training for staff members.
- Train and involve community members in providing DSME.
- Explore reimbursement opportunities for innovative DSME.
- Formally recognize accomplishments through incentives and awards.
- Include diabetes audit reports as an ongoing meeting agenda item.

Contacting others for help

Contacting other people involved in DSME programs is important because they can help you get started. Your peers at other health care organizations can share their expertise, materials, and ideas, and can also tell you what has worked for them and what has not worked. This can help you avoid reinventing the wheel. Here are some tips on how to connect with others:

- Ask your Area Diabetes Consultant for the names of people who may be able to help you.
- Contact the IHS Division of Diabetes Treatment and Prevention for ideas. They may be able to point you in the right direction.
- Refer to the IHS Division of Diabetes Treatment and Prevention website (www.ihs.gov/medicalprograms/diabetes) for:
  - A list of IHS-accredited diabetes education programs.
  - Resources for the IHS IDERP program, including the *IHS IDERP Standards, Review Criteria and Application Manual*.
  - Sample materials for developing quality DSME programs.
- Flip through issues of *Health for Native Life Magazine*. The magazine profiles many diabetes programs throughout Indian Country. The articles may give you ideas for activities to try and people to contact.

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APPENDIX

Standards and Review Criteria for the IHS Integrated Diabetes Education Recognition Program

The IHS Integrated Diabetes Education Recognition Program (IDERP) offers a three-stage process for building quality diabetes education programs based on the *National Standards for Diabetes Self-Management Education*:

- Programs at Level 1, or the developmental stage, are beginning to work on developing quality diabetes education programs.
- Programs at Level 2, or the educational stage, have quality diabetes education services in place.
- Programs at Level 3, or the integrated stage, offer the best in diabetes care and education practices by integrating community-wide prevention programs, diabetes clinical systems, and educational programs for people with diabetes and their families.

Table 4, which begins on the following page, lists the ten standards and their associated criteria for IHS IDERP accreditation. For further information on the IHS IDERP standards and criteria, as well as the application process, please refer to the *IHS IDERP Standards, Review Criteria, and Application Manual* (available online at: www.ihs.gov/MedicalPrograms/diabetes/recognition/iderp_app1.asp).

Table 4. IHS IDERP standards and review criteria.

Standard 1: The Indian health DSME entity documents an organizational structure, mission statement, and goals, and will recognize and support quality DSME as an integral component of diabetes care.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify team members and start meetings. – Establish a diabetes registry. – Consider the diabetes education program as part of the organizational structure. – Start developing a program manual, which at minimum should include a general description of the education program, policies, mission statement, goals and annual plan, organizational chart, team member roles and responsibilities, education program structure, and forms. – Document the team approach, administrative commitment and support, and tribal commitment and support in written statements.	– Document team meetings, which are held on a quarterly basis (at minimum). – Use the diabetes registry for annual planning. – Include the diabetes education program in the organizational chart. – Complete the content of the program manual, ensure that the appropriate personnel sign the manual, and establish a process to review and update the manual. – Document approval mechanisms for program and policy changes.	– Expand team membership to include clinical, educational, public health, and community representatives. – Establish a coordinated approach to diabetes management and education. – Document the integration of diabetes education and medical standards of care. – Expand the diabetes registry to include the general registry and complications. Develop other registries to track target populations (e.g., gestational diabetes, hypertension, and end-stage kidney disease registries). – Expand the program manual to describe educational and clinical components for diabetes prevention and management. – Include written statements in the program manual on: (1) the team and administration's commitment to the *National Standards for Diabetes Self-Management Education* and the *IHS Standards of Care for Diabetes*; and (2) tribal commitment to address diabetes prevention and management.

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Table 4. IHS IDERP standards and review criteria. (continued)

Standard 2: The Indian health DSME entity will determine its target population, assess educational needs, and identify the resources necessary to meet the self-management educational needs of the target populations.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify the tasks needed to develop the education program. – Identify the target population and its educational needs. – Complete the community assessment for diabetes education. – Identify the diabetes education program's goals and objectives. – Complete a diabetes education resource assessment.	– Annually evaluate progress toward meeting diabetes education program goals and objectives. – Identify and obtain resources sufficient to meet program goals and objectives. – Implement services that meet the needs of the target population. – Define and document consumer access to the education program.	– Consider diabetes prevention and control services at primary, secondary, and tertiary prevention levels. – Continue to meet the needs of the target population. – Expand goals and objectives to include community- and clinic-based diabetes prevention and management. – Base goals and objectives on expanded community assessments. – Include community- and clinic-based diabetes prevention and management in the program's goals and objectives. – Continue to identify and obtain resources for the program. – Further define and document access to programs and services.
Standard 3: An established system (e.g., committee, governing board, and advisory board) involving professional staff and stakeholders will participate annually in a planning and review process that includes data analysis and outcome measurements and addresses community concerns.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify an advisory body, which includes medical, educational, community, and consumer members. – Document advisory body communication.	– Establish a process to obtain community and other advisory member input into the educational program on at least an annual basis.	– Have the advisory body review and provide input annually to the education program on the curriculum, annual program plan, and audit results. – Provide evidence that policy recommendations have been forwarded to the administrative unit for approval.

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Table 4. IHS IDERP standards and review criteria. (continued)

Standard 4: The Indian health DSME entity will designate a coordinator with academic and/or experiential preparation in program management and the care of individuals with chronic disease. The coordinator will oversee planning, implementation, and evaluation of the Indian health diabetes education entity.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify a coordinator, who is a credentialed health professional and has the appropriate education and experience. – Document the coordinator's responsibilities and line of authority.	– Have the coordinator manage the educational team's efforts, including program planning, implementation, and evaluation. – Have the coordinator act as the diabetes education liaison among team members, departments or programs, and the community. – Ensure that the coordinator's position description and annual employee evaluation reflect his or her roles and responsibilities. – Have the coordinator document continuing education activities (minimum of 12 hours/two years) in diabetes, educational principles, or leadership and management.	– Have the coordinator act as the liaison between the multidisciplinary team and the programs and departments that provide comprehensive diabetes services. – Expand the coordinator's role to include managing the diabetes education program and being a leader or team member in clinical or community diabetes programming. – Have the coordinator lead or help with diabetes care and education outcome audits and diabetes surveillance system monitoring.
Standard 5: The Indian health DSME entity will involve ensuring that the individual with diabetes interacts with a multifaceted instructional team, which may include a behaviorist, exercise physiologist, ophthalmologist, optometrist, pharmacist, physician, podiatrist, registered dietitian, registered nurse, and other health care professionals and paraprofessionals.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify instructional team members. – Include, at minimum, a registered nurse and registered dietitian in the instructional team. – Document instructional staff, credentials, roles, and responsibilities in the program manual.	– Maintain diabetes education services for the target population. Base the services on identified needs. – Use a variety of teaching and learning methods. – Provide evidence of instructor review and approval of education materials, teaching methods, and activities.	– Provide multifaceted diabetes education that includes integration of traditional and western methods of teaching and learning activities.

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Table 4. IHS IDERP standards and review criteria. (continued)

Standard 6: The Indian health DSME entity instructors will obtain regular continuing education in the areas of diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Document that instructors have or are updating knowledge and skills in diabetes in American Indian and Alaska Native communities. – Document that instructors have knowledge, skills, and abilities in behavioral interventions, teaching and learning, and counseling and communication.	– Document instructors' continuing education activities (minimum of 12 hours/two years) in diabetes management, behavioral interventions, teaching and learning skills, and counseling skills.	– Have team members participate in annual workshops and in-service programs on diabetes management, behavioral interventions, and teaching, learning, and counseling skills relevant to American Indian and Alaska Native communities.
Standard 7: A written curriculum, with criteria for successful learning outcomes, shall be available. Assessed needs of the individual will determine the content areas that are delivered.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Use an IHS-approved curriculum. – Identify and review the diabetes education curriculum. – Ensure that the curriculum: (1) meets community needs; (2) includes written measurable learning objectives, content outline, instructional methods, materials, and means of achieving objectives; and (3) the ten content areas of the *National Standards*.	– Annually review the curriculum and educational resources for scientific accuracy and cultural relevancy. – Field test new materials for relevancy and comprehension. – Orient interpreters on a regular basis.	– Document participation of the medical staff, public health staff, and the community in curriculum review and adaptation.

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Table 4. IHS IDERP standards and review criteria. (continued)

Standard 8: An individualized assessment, development of an educational plan, and periodic reassessment between participants and instructors will direct the selection of appropriate educational materials and interventions.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Develop an individualized needs assessment process. – Document relevant medical history, cultural influences, health beliefs and attitudes, diabetes knowledge and skills, readiness to learn, preferred learning method, family support, and financial limitations.	– Select education interventions and materials based on individualized needs assessments, education plans, and reassessments.	– Systematically address the ongoing diabetes care needs of the individual and family through case management or other organizational diabetes best practices.
Standard 9: There shall be documentation of the individual's assessment, education plan, intervention, evaluation, and follow-up in the permanent, confidential education record. Documentation also will provide evidence of collaboration among instructional staff, providers, and referral sources.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Identify diabetes education forms as part of the medical record. – Ensure instructors and coders are familiar with diabetes education codes (Resource and Patient Management System [RPMS] preferred).	– Document the teaching process (e.g., assessment, planning, implementation, and evaluation of the individualized educational experience) in the medical record. – Document collaboration among the educational team.	– Include information on the individual's diabetes education and clinical care in the medical record. – Orient and update team members on diabetes documentation and coding issues. – Document the services provided to the community.

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Table 4. IHS IDERP standards and review criteria. (continued)

Standard 10: The Indian health DSME entity will utilize a continuous quality improvement process to evaluate the effectiveness of the education experience provided, and determine opportunities for improvement.		
Level 1: Developmental stage	Level 2: Educational stage	Level 3: Integrated stage
– Document desired program outcomes. – Establish a process for evaluating consumer satisfaction.	– Document at least two clinical and one behavioral outcome indicators. – Design a program evaluation that allows for pre- and post-program measures. – Document appropriate advisory body review and input on outcomes, evaluation plan, and program modifications. – Document, at minimum, the population served, types of service, length of participation, setting, content, and age. – Document that action is taken as a result of program evaluation and consumer review and evaluation.	– Annually review medical records using the IHS Diabetes Care and Outcomes Audit or similar system. – Annually expand and modify educational indicators. – Establish an annual program evaluation or surveillance system for community-based programs. – Share continuous quality improvement data with the established advisory bodies, appropriate tribal leaders, community diabetes prevention systems, and the community. – Use program evaluation and outcome results in annual program planning.