Recognizing Health Education Specialists Roles in Diabetes Prevention and Management

A Toolkit for Diabetes Self-Management Education

Society for Public Health Education (SOPHE)

SOPHE is a 501 (c)(3) professional organization founded in 1950 to provide global leadership to the profession of health education and health promotion and to promote the health of all people by: stimulating research on the theory and practice of health education; supporting high quality performance standards for the practice of health education and health promotion; advocating for policy and legislation surrounding health education and health promotion; and developing and promoting standards for professional preparation of health education professionals. SOPHE members include nearly 4,000 health education professionals and students at the national and chapter levels, and in 25 international countries. SOPHE members work in elementary/secondary schools, universities, voluntary organizations, health care settings, worksites, and all levels of government agencies. SOPHE is a leading organization committed to the field of health education and the advancement of the profession, and continues to work as a champion for using health education specialists in community settings to address diabetes disparities.

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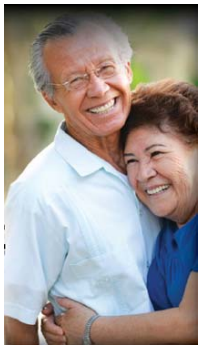


Introduction

Clinical and community prevention efforts should be mutually reinforcing and appropriate health care provided in clinical settings, recommending community-based prevention efforts, and providing environments that enhance health. According to the Institute of Medicine,

"It is unreasonable to expect that people will change their behavior when so many forces in the social, cultural, and physical environment conspire against such change."[1]

Because of diabetes, care must address a diverse community of people needing assistance with diabetes complications, and education, it is important for health education specialists to be diverse in their approach as well. This toolkit is not a comprehensive list of every diabetes education opportunity offered, but is to be used as a guide to highlight recent changes and can be used as a starting point. This toolkit has been designed to promote health education specialists in providing Diabetes Self-Management Education (DSME) in both clinical and community settings. Incorporating health education specialists within the community setting strengthens coverage for Americans and provides better opportunities for meeting healthcare needs, thus accelerating efforts to improving the nation's health overall.

[1] Institute of Medicine, Division of Health Promotion and Disease "Prevention. Promoting health: Intervention strategies from social and behavioral health research." *The National Academies Press,* 2001. Print.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
–Martin Luther King, Jr.

Health Disparities

In 1966, Martin Luther King said that "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." [2] The burden of illness, premature death, and disability disproportionately affects certain populations. Residents in mostly minority communities continue to have lower socioeconomic status, greater barriers to health-care access, and greater risks for, and burden of, disease compared with the general population living in the same country or state.[3] Health disparities are contributing the health crisis of increasing chronic diseases in America.

Chronic Diseases

According to the Centers for Disease Control and Prevention, chronic diseases are responsible for 70% of American deaths each year.[4] Americans living with chronic diseases account for 75% of the nation's health spending.[5] The World Health Organization has estimated that if the major risk factors for chronic diseases were eliminated, at least 80% of all heart disease, stroke, and type-2 diabetes would be prevented, and more than 40% of cancer cases would be prevented.[4] As the United States continues to move forward with health reform, there is a realization in the importance of having health education specialists plays a critical role in primary prevention and chronic disease management. This is especially true among chronic diseases such as diabetes.

[2] Hamilton, Nalo & Giscombé, Cheryl Woods. "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." *Human Capital Blog – Robert Wood Johnson Foundation,* 21 January 2013. Web. 22 May 2014. http://www.rwjf.org/en/blogs/human-capital-blog/2013/01/_of_all_the_formsof.html

[3] US Department of Health and Human Services. "CDC Health Disparities and Inequaliteis Report – United States, 3013." *Centers for Disease Control and Prevention,* 22 November 2013. Web. 14 May 2014. http://www.cdc.gov/mmwr/pdf/other/su6203.pdf

[4] National Center for Chronic Disease Prevention and Health Promotion. " The Power of Prevention – Chronic disease… the public health challenge of the 21st century." *Centers for Disease Control and Prevention,* 2009. Web. 14 May 2014. http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf

[5] Centers for Disease Control and Prevention. "Chronic Disease Prevention and Health Promotion." *Centers for Disease Control and Health Promotion,* 6 May 2014. Web. 14 May 2014. http://www.cdc.gov/chronicdisease/

Diabetes Disparities

While African Americans, Hispanic/Latino Americans, American Indians, Asian Americans, and Pacific Islander Americans have lower rates of type-1 diabetes, they are at greater risk for type-2 diabetes than Whites. Gestational diabetes affects African Americans, Hispanic/Latino Americans, and American Indians at greater rates than other groups. Additionally, poverty, lack of access to health care, cultural attitudes toward health care, and behaviors are all barriers to preventive services and diabetes management care in minority populations.[6]

Diabetes is the leading cause of new cases of blindness; non- traumatic, lower- limb amputations; and kidney failure among adults as well as a major cause of heart disease and stroke. People with diabetes can reduce diabetes complications by controlling blood glucose, blood pressure, blood lipids, and getting timely preventive care. Diabetes is associated with higher health care costs. For example, in 2001, 30% of *high- cost* Medicare beneficiaries (those in the top quartile of costs) had diabetes compared to 16% of *low- cost* beneficiaries (bottom 75%).[7]

In 2010, over 25 million people in the United States had diabetes. If current trends continue, 1 in 3 adults will have diabetes by the year 2050. The Centers for Medicare and Medicaid Services (CMS) estimate of healthcare expenditures for 2010 was $2.7 trillion.[8] Assuming the costs of care for people with diabetes held steady, people with diabetes account for 43% of the direct medical costs. [9]

[6] Centers for Disease Control and Prevention. "Groups Especially Affected by Diabetes." *Centers for Disease Control and Prevention,* 7 March 2014. Web. 12 May 2014. http://www.cdc.gov/diabetes/consumer/groups.htm

[7] National Association of Chronic Disease Directors. "Addressing a Major Complication of Diabetes to Reduce Health Care Costs." *Society for Public Health Education,* February 2012. 14 Web. May 2014. http://www.sophe.org/Sophe/PDF/NACDDDiabeteWhitePaper.pdf

[8] Centers for Medicare and Medicaid Services. "National Health Expenditure Projections 2011-2021." *Centers for Medicare and Medicaid Services,* 2011. Web. 13 May 2014. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf

[9] American Diabetes Association. "The Cost of Diabetes." *American Diabetes Association,* 18 April 2014. Web. 13 May 2014. http://www.diabetes.org/advocacy/news-events/cost-of-diabetes.html

What Can Be Done to Address the Problem?

Of the approximately 500,000 professionals that constitute the public health workforce, roughly 85% are employed by a government agency. They work in the 3,000 the local health departments, 56 state and tribal agencies, and various other federal agencies such as the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the Agency for Healthcare Research and Quality (AHRQ). The remaining 15% of the public health workforce works in nonprofit organizations, academia and research, hospitals, medical groups, and private companies. The Affordable Care Act (ACA) has been designed with investments into public health infrastructure and boosting the number of public health workers in the workforce. Community-based programming also benefits from these investments. Programs receive better support for their prevention efforts, health education activities, and training of health workers. The ACA also allows investment in projected health workforce needs. These projected needs are not just on the federal level – they trickle down to the regional, state, and local levels as well.[10] It is necessary to have affordable, comprehensive training options for Certified Diabetes Educators (CDE) at low cost using community-based adult learning methods.

With the rollout of the ACA, the healthcare landscape is rapidly changing. Because public health focuses on population-level health as opposed to individual, clinical health, it is unique in comparison to other areas of healthcare. Since the mid-1970s, there have been question surrounding the validity and need for a health education specialist. Today, we are questioning how to better incorporate health education specialists into the primary care team. With new funding for prevention and health promotion, new and innovative opportunities are becoming possible for health education specialists to broaden their impact and participate in the various new models of service delivery.[10]

[10] American Public Health Association, "The Affordable Care Act's Public Health Workforce Provisions: Opportunities and Challenges." *American Public Health Association,* June 2011. Web. 14 May 2014. http://www.apha.org/NR/rdonlyres/461D56BE-4A46-4C9F-9BA4-9535FE370DB7/0/APHAWorkforce2011_updated.pdf

The ACA creates opportunities for health education specialists to have a more defined role in healthcare delivery. Through the Prevention and Public Health Fund, the ACA provides invaluable resources to support community-based strategies in preventing chronic diseases as well as improving public health. Diabetes education is a cost effective management strategy. An investment of $10 per person in proven community-based disease prevention programs could yield a net savings of more than $16 billion annually within five years, a Return on Investment (ROI) of $5.6 for every $1 invested. A 5% reduction in the obesity rate could yield more than $600 billion in savings in health care over the next 20 years. [11]

Every new health plan, since 2010, has included coverage of evidence-based, effective preventive services, such as screenings for type 2 diabetes, immunizations, and mammograms, without co-pays. Since January 1, 2011, seniors on Medicare have received many preventive services, with no co-payments including annual wellness visits, cervical cancer screening, diabetes screening, mammograms and important immunizations such as for the flu and pneumonia.[12]

[11] De Biasi, Anne. "Sustainable Funding for Community Prevention." *Health Education Advocate,* 22 February 2014. Web. 14 May 2014. http://healtheducationadvocate.org/wp-content/uploads/2014/03/BringingItAllTogetherADV2014KR.pdf

[12] US Department of Health and Human Services. "Medicare Preventive Services." *HHS.gov/HealthCare,* 1 May 2014. Web. 14 May 2014. http://www.hhs.gov/healthcare/prevention/seniors/medicare-preventive-services.html

Diabetes Self-Management Education (DSME)

DSME is the collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions. It is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator. The intervention aims to achieve optimal health status, better quality of life and reduce the need for costly health care.

Diabetes education focuses on seven self-care behaviors that are essential for improved health status and greater quality of life. The AADE7™ Self-Care Behaviors are:

- Healthy eating
- Being active
- Monitoring
- Taking medication
- Problem solving
- Healthy coping
- Reducing risks [13]

In the September/October 2003 issue of The Diabetes Educator (TDE 29[5]) AADE published its Position Statement on Standards for Outcomes Measurement of Diabetes Self-Management Education. The Standards elaborate the five areas shown in Figure 1: DSME Outcomes Standards and listed below:

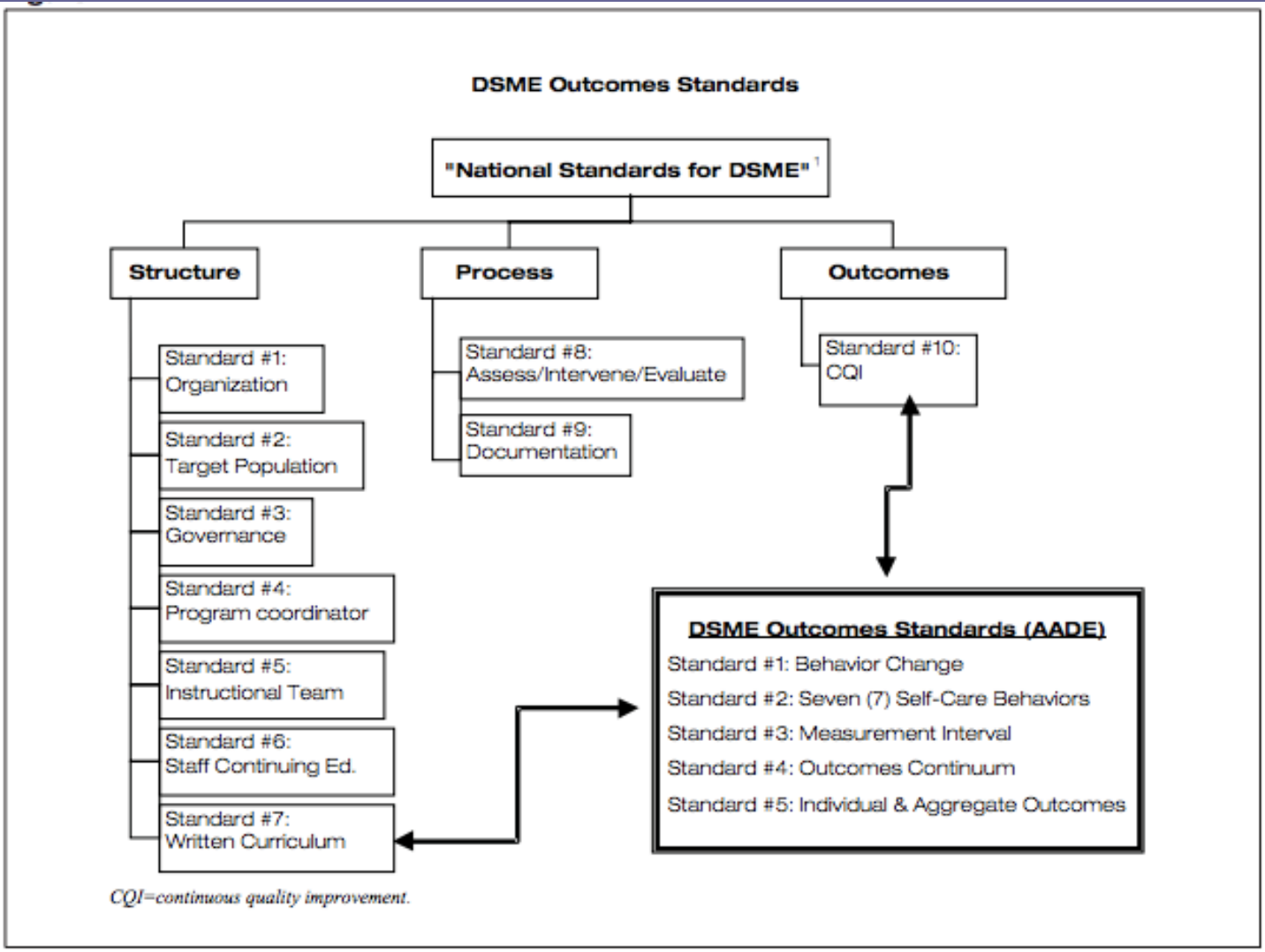
- Behavior change is the unique outcome measurement for diabetes self-management education.
- Seven diabetes self-care behavior measures determine the effectiveness of diabetes self-management education at individual, participant, and population levels.
- Diabetes self-care behaviors should be evaluated at baseline and then at regular intervals after the education program.
- The continuum of outcomes, including learning, behavioral, clinical, and health status, should be assessed to demonstrate the interrelationship between DSME/T and behavior change in the care of individuals with diabetes (see Figure 2: Outcomes Continuum).
- Individual patient outcomes are used to guide the intervention and improve care for that patient. Aggregate population outcomes are used to guide programmatic services and for continuous quality improvement activities for the DSME/T and the population it serves. [14]

[13] American Association of Diabetes Educators. "AADE7 Self-Care Behaviors." *American Association of Diabetes Educators,* 2009. Web. 22 May 2014. http://www.diabeteseducator.org/ProfessionalResources/AADE7/

[14] Mensing, Carolé, et. al., "The Diabetes Educator Career Path: Revised Levels of Practice." *American Association of Diabetes Educators,* Publication date unknown. Web. 13 May 2014. http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/general/Narrative.pdf

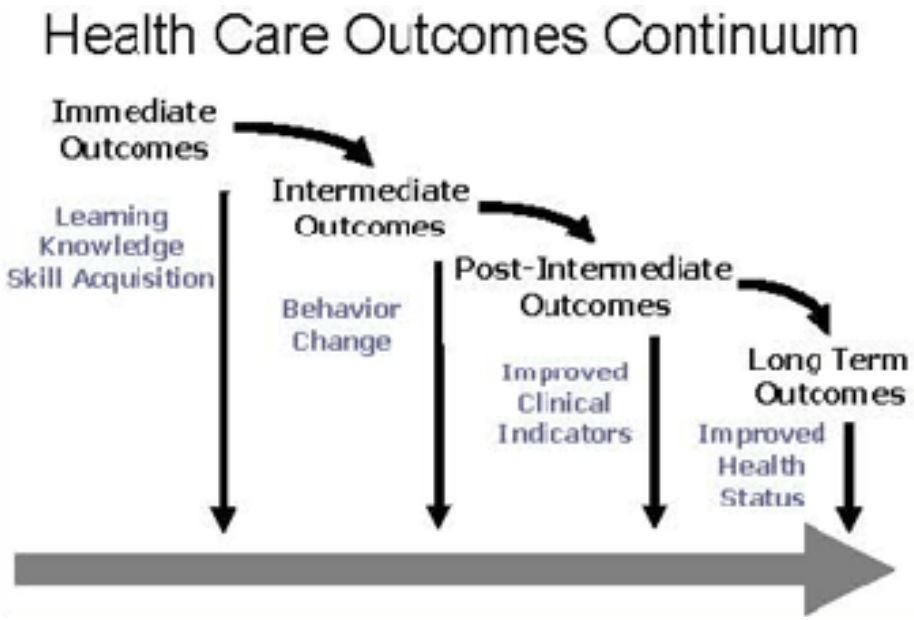
Diabetes Self-Management Education

Figure 1: DSME Outcomes Standards



Mensing, Carolé, et. al., "The Diabetes Educator Career Path: Revised Levels of Practice." *American Association of Diabetes Educators,* Publication date unknown. Web. 13 May 2014. http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/general/Narrative.pdf

Figure 2: Outcomes Continuum



American Association of Diabetes Educators. "AADE7 Self-Care Behaviors." *American Association of Diabetes Educators,* 2009. Web. 22 May 2014. http://www.diabeteseducator.org/ProfessionalResources/AADE7/

Health education specialists may play a critical role in providing diabetes self-management education.

Health Education Specialists

Health education specialists are, as Tennessee senator, Bill Frist (R) states, "the workers on the ground [who] see the needs and the gaps in care."[15] The U.S. Department of Labor Bureau of Labor Statistics (BLS) defines health educators (SOC 21-1091.00) as those who promote, maintain, and improve individual and community health by assisting individuals and communities to adopt healthy behaviors, collect and analyze data to identify community needs prior to planning, implementing, monitoring, and evaluating programs designed to encourage healthy lifestyles, policies and environments. They may also serve as a resource to assist individuals, other professionals, or the community, and may administer fiscal resources for health education programs. [16]

The health education profession developed its first set of evidence-based competencies in 1998 and a certification system under the National Commission for Health Education Credentialing (NCHEC). Since then, SOPHE has worked with NCHEC on two comprehensive research projects to update the competencies addressing health educators' contemporary roles in individual- and population-based health. Health education specialists bring valuable, complementary skills to the health care and public health teams in addressing diabetes prevention and control.[17]

NCHEC is the official certification body for health education specialists, which is based on a rigorous exam. The Certified Health Education Specialist (CHES) examination is a competency-based tool used to measure possession, application and interpretation of knowledge in the Seven Areas of Responsibility for Health Educators, delineated by *A Competency-Based Framework for Health Education Specialists 2010*. Eligibility to take the CHES examination is based on exclusive academic qualifications. The Master Certified Health Education Specialist (MCHES) exam eligibility includes both academic and work experience requirements. Professionals who pass either exam and are credentialed as CHES/MCHES must complete 75 hours of approved continuing education over 5 years to maintain their certification.

[15] Frist, Bill. "The Case for Global Health Diplomacy." *Health Affairs Blog,* 14 April 2014. Web. 13 May 2014. http://healthaffairs.org/blog/2014/04/14/the-case-for-global-health-diplomacy/

[16] US Bureau of Labor Statistics. "What Health Educators and Community Health Workers Do." *Occupational Outlook Handbook,* 8 January 2014. Web. 13 May 2014. http://www.bls.gov/ooh/community-and-social-service/health-educators.htm#tab-2

[17] Society for Public Health Education. "Affordable Care Act: Opportunities and Challenges for Health Education Specialists." *Society for Public Health Education,* April 2013. Web. 14 May 2014. http://www.sophe.org/Sophe/PDF/ACA-Opportunities-and-Challenges-for-Health-Educators-FINAL.pdf

Health Education Specialists (cont'd)

The core areas of responsibility of CHES and MCHES are:

I. Assess Needs, Assets and Capacity for Health Education
II. Plan Health Education
III. Implement Health Education
IV. Conduct Evaluation and Research Related to Health Education
V. Administer and Manage Health Education
VI. Serve as a Health Education Resource Person
VII. Communicate and Advocate for Health and Health Education [18]

It is important to note that health education competencies are designed to be generic in nature and apply regardless of the work setting, group versus individual setting, and subject matter. These core competencies are then integrated specifically to a subject-specific material. The health education responsibilities and competencies are skills that can be applied to a variety of health content areas, including diabetes.[12]

[18] National Commission for Health Education Credentialing, Inc. "Responsibilities and Competencies for Health Education Specialists." *National Commission for Health Education Credentialing, Inc.,* 2010. Web. 14 May 2014. http://www.nchec.org/credentialing/responsibilities/

Diabetes Educators

Diabetes educators are involved in direct patient care, education of other healthcare professionals, research, social reform and advocacy. Many diabetes educators obtain certification in the specialty and are credentialed as a certified diabetes educator (CDE) or board certified advanced diabetes manager (BC-ADM) and, in some cases, both. An educational background in healthcare, considerable experience working with diabetes patients, and a comprehensive knowledge base enable a qualified healthcare professional to take a certification examination. It has long been AADE's position that diabetes educators should work toward certification in the specialty. In the U.S., the National Certification Board for Diabetes Educators (NCBDE)[19] sets the criteria for CDE certification whereas the American Association of Diabetes Educators (AADE) establishes the criteria for the BC-ADM credential.[20] Other countries often have their own standards, processes, and names for the credentialed educator. Curiously, recent surveys suggest that while certification is valued by the educator, it may no longer be required for employment (Tobin, 2008; Zrebiec, 2009). This disturbing trend suggests that employers may fail to understand the complexities of Diabetes Self-Management Education and Support (DSMES) and the critical role of the credentialed diabetes educator in the delivery of comprehensive care. Equally troubling is the notion that primary care providers may not fully appreciate the contribution of diabetes educators in facilitating self-care management, a trend suggested by referral patterns (AADE, 2009a; AADE 2009b; Martin et al., 2008; Martin et al., 2013; Peyrot et al., 2009).[14]

[19] National Certification Board for Diabetes Educators. "Welcome to the National Certification Board for Diabetes Educators." *National Certification Board for Diabetes Educators,* 2014. Web. 14 May 2014. http://www.ncbde.org

[20] American Association of Diabetes Educators. "American Association of Diabetes Educators." *American Association of Diabetes Educators,* 2014. 14 May 2014. http://www.diabeteseducator.org

Diabetes Educators (cont'd)

Certified Diabetes Educators

A Certified Diabetes Educator® (CDE®) is a health professional who possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention and management. The CDE® educates and supports people affected by diabetes to understand and manage the condition. The CDE® promotes self-management to achieve individualized behavioral and treatment goals that optimize health outcomes.[21]

Opportunities as Certified Diabetes Educators (CDE)

Starting January 1, 2014, NCBDE Board approved SOPHE's request to recognize MCHES credentials to be eligible to take the CDE exam. Individuals must meet the MCHES eligibility criteria and must still fulfill NCBDE's remaining eligibility criteria. Individuals holding the MCHES credential must meet the Discipline requirement, and prior to applying for certification, candidates must accrue:

1. A minimum of two (2) years, to the day of application, of practice experience as an MCHES;
2. A minimum of 1,000 hours of DSME practice experience in the four years prior to the date of the CDE® certification application, 400 hours of which must be in the year immediately prior to application; and,
3. A minimum of 15 clock hours of approved continuing education applicable to diabetes, and provided by one of NCBDE's recognized continuing education providers, within two years of the date of application.[22]

In 2010, NCBDE, AADE, and the American Diabetes Association (ADA) created the Diabetes Educator Mentorship Program as an avenue that promotes careers leading to a CDE designation. Now MCHES credential holders are able to earn the 1,000 hours of DSME through various offered mentorship strategies.[23] To find a mentor in your area, visit http://www.ncbde.org/certification_info/mentorship-program/mentor-listing/.

[21] National Certification Board for Diabetes Educators. "What is a CDE?" *National Certification Board for Diabetes Educators,* 2014. Web. 14 May 2014. http://www.ncbde.org/certification_info/what-is-a-cde/
[22] Harrington, Carolyn C., RD, LDN, CDE. "Ltr to Auld Re-MCHES." Letter to Elaine Auld, MPH. *National Certification Board for Diabetes Educators*, 1 Mar. 2013. Web. 22 May 2014. file:///Users/bethy/Downloads/ltr%20to%20auld%20re-mches%20credential%200227013%20_3_%20(1).pdf
[23] National Certification Board for Diabetes Educators. "Mentorship Program." *National Certification Board for Diabetes Educators,* 2014. Web. 22 May 2014. http://www.ncbde.org/certification_info/mentorship-program/

The National Certified Board of Diabetes Educators (NCBDE) Mentoring Program

In 2010, the NCBDE, the ADA, and the AADE created the Diabetes Educator Mentorship Program that began in 2011. This program has been designed to promote careers that will lead to Certified Diabetes Educator designation, thus improving access to DSME. The National Certification Board for Diabetes Educators makes it easy to find a CDE in your area. To find a CDE currently working in your area, visit http://www.ncbde.org/find-a-cde/.

The program works to partner healthcare professionals interested in gaining experience in providing DSME with experienced CDE-credentialed diabetes educators. The goal is to assist these professionals with meeting the current hours of experience practice requirement for CDE certification. To be eligible for certification, NCBDE requires the following:
To *meet the discipline licensure requirement*, one must be a clinical psychologist, registered nurse (RN), occupational therapist, optometrist, pharmacists, physical therapist, physician (MD or DO), or podiatrist holding a current, active, unrestricted license from the US or its territories. One can also be a dietitian or dietician nutritionist holding active registration with the Commission on Dietetics Registration, a physician assistant (PA) holding active registration with the National Commission on Certification on Physician Assistants, an exercise specialist holding active certification as an American College of Sports Medicine (ACSM) Registered Clinical Exercise Specialists, or an exercise physiologist holding an active certification as an ACSM Registered Clinical Exercise Physiologist, a health educator holding active certification as a Master Certified Clinical Exercise Specialist from the National Commission for Health Education Credentialing. One can also be a health professional with a master's degree or higher in social work from a US college or university accredited by a nationally recognized regional accrediting body. If you do not meet any of these licensure requirements, you can file for the NCBDE Unique Qualifications Eligibility Pathway
http://www.ncbde.org/assets/1/7/UQPathwayAppCanonsPacket092513fillableFinal.pdf.

After meeting the discipline requirement and before applying for the examination, a minimum of 15 clock ours of continuing education activities that are applicable to diabetes within the two years prior to applying for certification, must be met. These continuing education hours can be provided by the following providers:

- American Association of Diabetes Educators (AADE) https://www.diabeteseducator.org/ProfessionalResources/products/
- American Diabetes Association (ADA) http://professional.diabetes.org/HomeContinuingEducationAndMeetings.aspx?hsid=5
- Academy of Nutrition and Dietetics (Academy) http://www.eatright.org/cpd/
- International Diabetes Federation (IDF) http://www.idf.org/
- Accreditation Council for Pharmacy Education (ACPE) Accredited or Approved Providers https://www.acpe-accredit.org/shared_info/providersSecure.asp
- Accreditation Council for Continuing Medical Education (ACCME) Accredited or Approved Providers http://www.accme.org/
- American Academy of Family Physicians (AAFP) http://www.aafp.org/cme.html
- American Academy of Optometry (AAO) http://www.aaopt.org/meetings-continuing-education
- American Academy of Physician Assistants (AAPA) http://www.aapa.org/cme/
- American Association of Clinical Endocrinologists (AACE) https://www.aace.com/education
- American Association of Nurse Practitioners (AANP) http://www.aanp.org/education/continuing-education-ce
- American College of Endocrinology (ACE) https://www.aace.com/college
- American College of Sports Medicine (ACSM) http://www.acsm.org/find-continuing-education
- American Medical Association (AMA) http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education.page?
- American Nurses Association (ANA) http://ananursece.healthstream.com/
- American Nurses Credentialing Center (ANCC) Accredited or Approved Providers http://www.nursecredentialing.org/
- American Occupational Therapy Association (AOTA) http://www.aota.org/Education-Careers/Continuing-Education.aspx
- American Physical Therapy Association (APTA) http://www.apta.org/CoursesConferences.aspx?navID=10737422670
- American Psychological Association (APA) http://www.apa.org/education/ce/
- Council on Continuing Medical Education (CCME-AOA) Approved Sponsors [American Osteopathic Association (AOA)] http://www.osteopathic.org/inside-aoa/development/continuing-medical-education/Pages/default.aspx
- Council on Podiatric Medical Education (CPME-APMA) Approved Sponsors http://www.cpme.org/education/content.cfm?ItemNumber=2422
- Commission on Dietetic Registration (CDR) Accredited or Approved Providers https://www.cdrnet.org/

- National Association of Clinical Nurse Specialists (NACNS) http://www.nacns.org/html/cont-ed.php
- National Association of Social Workers (NASW) http://www.socialworkers.org/pdev/default.asp
- National Commission for Health Education Credentialing (NCHEC) Designated Providers http://www.nchec.org/ce/getcredit/ [24]

Continuing education activities that are provided through an accredited academic institution in the U.S. or its territories granting degrees to professional practice are also accepted. The exam is offered twice a year (spring and fall) to approved candidates. There are multiple testing centers across the country, and the exams are proctored.

American Diabetes Association (ADA) Diabetes Recognition Programs

Another option that addresses diabetes disparities is for organizations to become recognized Diabetes Self-Management Education programs. Diabetes Self-Management Education has been associated with improvement in diabetes knowledge, self-care behavior, and clinical outcomes. The American Diabetes Association (ADA) *Standards of Medical Care in Diabetes 2011* states that health management plans for people with diabetes "should recognize diabetes self-management education (DSME) and ongoing diabetes support as an integral component of care." DSME is associated with improved diabetes knowledge, improved self□care behavior, better clinical outcomes such as lower HbA1c and lower self□reported weight, and reduced hospitalizations, emergency room visits and medications costs.[7]

[24] National Certification Board for Diabetes Educators. "Recognized Provider List." *National Certification Board for Diabetes Educators,* 2014. Web. 14 May 2014. http://www.ncbde.org/currently_certified/recognized-provider-list/

To become certified through ADA, you must have the following:

- Annual Quality Improvement Project
- Approved Curriculum
- Advisory Committee Meeting and meeting minutes
- All areas of Chronicle completed, communication with provider documented and DSMS plan completed.
- Behavior goals must be set at every patient contact and reviewed at every patient subsequent visit. Documentation in Chronicle.
- Program Coordinator must have a job description and CV
- Cost
- Chronicle Application
- Materials Needed
    - Check number
    - Minimum of 1 patient seen in last 3-6 months.
    - 2 outcome measures for all patients
    - Letter of support from sponsoring organization
    - Copies of licenses, registrations, CDE credentials and certificates indicating 15-20 hours of CEUs
    - Possible Audit Items [25]

As of May 2014, you must provide $1100 for initial site and $100 for each additional site after that. For current fees, visit http://professional.diabetes.org/HomeDiabetesEducationAndRecognition.aspx?hsid=4. Recognition must be within the lasts 4 years. All data is pulled from the site; documented evidence of Sponsoring Organizational support (PDF) (e.g. letter signed by official of the sponsoring organization responsible for the diabetes education program).

A potential CDE must have copies of active licenses, registrations (CDR cards only required for RDs), certificates for other credentials (e.g. CDE, BC-ADM, etc.), as well as certificates for official verification of accrued continuing education credits as applicable to the coordinator and all active instructional staff on the application. Non –certified instructional staff (non-CDE or BC-ADM) must provide 15 hours of qualifying CEUs for multi-discipline programs and 20 hours for single-discipline programs.

[25] American Diabetes Association. "Education Recognition Requirements." *American Diabetes Association,* 2012. Web. 14 May 2014. http://professional.diabetes.org/admin/UserFiles/2012%20ERP/education-recognition-requirements-2012.pdf

Paper Audit Items: (Note all five required for new or original applicants; one randomly assigned for renewing/additional site applicants)

- Documentation of Advisory Group activity within 12 months of application submission date http://professional.diabetes.org/UserFiles/ERP/Annual%20Program%20Review%20-%2005-11-09.pdf
- Program Coordinator's job description http://professional.diabetes.org/UserFiles/ERP/Sample%20Program%20Coordinator%20Job%20Description.pdf and resume or CV http://professional.diabetes.org/UserFiles/ERP/Resume%20Template.pdf
- A full section of one assigned content area of the curriculum http://professional.diabetes.org/UserFiles/ERP/A%20Written%20Complete%20Curriculum.pdf
- A description of a formal CQI plan/process, using a CQI project http://professional.diabetes.org/UserFiles/ERP/Continuous%20Quality%20Improvement%20Process.pdf
- A copy of one de-identified participant chart demonstrating the complete education process http://professional.diabetes.org/UserFiles/ERP/Example%20of%20a%20Complete%20Patient%20Education%20Record.pdf [26]

American Association of Diabetes Educators (AADE) Diabetes Education Accreditation Program

The AADE provides a program that addresses providing DSME to community members. The *AADE Diabetes Education Accreditation Program* [27] is a multidisciplinary association of healthcare professionals dedicated to integrating self□management as a key outcome in the care of people with diabetes and related chronic conditions, constantly working toward the vision of optimal health and wellness for all people with diabetes and related chronic conditions. AADE certified members are primarily diabetes educators and focus on helping people with diabetes achieve behavior change goals, which, in turn, lead to better clinical outcomes.

Board certification in Advanced Diabetes Management (BC-ADM) indicates achievement of standards set by professionals in your area of practice and it demonstrates commitment to competence in within your profession. Board certification is the process by which AADE validates, based on predetermined standards, an individual's knowledge, skills, and abilities in the area of advanced diabetes management.[18]

[26] Rinker, Joanne. "How to Get Your Diabetes Self-Management Program Recognized by the ADA." *American Diabetes Association,* 2014. PowerPoint. 14 May 2014.
[27] American Association of Diabetes Educators. "AADE Diabetes Education Accreditation Program." *American Association of Diabetes Educators,* 2014. Web. 26 May 2014. http://www.diabeteseducator.org/ProfessionalResources/accred/

The AADE follows the NCBDE guidelines for becoming a CDE, but to become BC-ADM certified, candidates must complete a different process. The BC-ADM certification validates a healthcare professional's specialized knowledge and expertise in the management of people with diabetes. Practicing within their discipline's scope of practice, healthcare professionals who hold the BC-ADM certification credential adjust medications, treat and monitor acute and chronic complications, provide medical nutrition therapy, help patients plan exercise regimens, counsel patients to manage behaviors and psychosocial issues, participate in research and mentor. The depth of knowledge and competence in advanced clinical practice and diabetes skills affords an increased complexity of decision making which contributes to better patient care.

As of May 2014, to become BC-ADM certified, a candidate must hold a current, active RN, RD, RPh, PA OR MD/DO license in a state or territory of the United States or the professional, legally-recognized equivalent in another country. You must hold a graduate degree from an accredited program and within 48 months prior to applying for this certification exam, complete a minimum of 500 clinical practice hours in advanced diabetes management. For complete information about eligibility please refer to the BC-ADM Handbook.[28, 29]

The National Diabetes Education Program (NDEP)

The Centers for Disease Control and Prevention as the National Institutes of Health have created the National Diabetes Education Program (NDEP), a joint project that conducts consumer education campaigns targeting people with diabetes, their families, and people at risk for diabetes.[17] NDEP works with partners to reduce the burden of diabetes and prediabetes by aiding in the implementation of approaches proven to delay or prevent the onset of type-2 diabetes and its complications.[30]

[28] American Association of Diabetes Educators. "Board Certified – Advanced Diabetes Management Certification." *American Association of Diabetes Educators,* 2014. Web. 14 May 2014. http://www.diabeteseducator.org/ProfessionalResources/Certification/BC-ADM/

[29] American Association of Diabetes Educators. "Candidtate Handbook for the American Association of Diabetes Educators (AADE) Board Certified Advanced Diabetes Management (BC-ADM) Examination. *American Association of Diabetes Educators,* November 2012. Web. 14 May 2014. http://castleworldwide.com/aade/AppSystem/6/Public/Resource/AADE_Candidate_Handbook.pdf

[30] Centers for Disease Control and Prevention. "About NDEP." *Centers for Disease Control and Prevention,* 8 May 2014. Web. 14 May 2014. http://www.cdc.gov/diabetes/ndep/about.htm | Centers for Disease Control and Prevention. "National Diabetes Education Program." *Centers for Disease Control and Prevention,* 8 May 2014. Web. 14 May 2014. http://www.cdc.gov/Diabetes/ndep/index.htm

NDEP has a strong history of working with partners on all its activities and continues to maintain strong networks of partners interested in diabetes education related to the following:

- African-Americans and people of African ancestry
- American Indians and Alaska Natives
- Asian-Americans, Native Hawaiians, and Pacific Islanders
- Hispanics/Latinos
- Children and adolescents
- Older adults (60 years or older)
- Businesses
- Health care providers
- Community Health Workers
- Podiatrists, pharmacists, optometrists, and dentists [31]

[31] Boren, S.A., et. al. "Costs and Benefits Associated With Diabetes Education: A Review of the Literature." *The Diabetes Educator,* 35(1). (2009). 72-96. Print.
[32] Centers for Disease Control and Prevention. "Partnerships." *Centers for Disease Control and Prevention,* 29 April 2014. Web. 14 May 2014. http://www.cdc.gov/diabetes/ndep/partnerships.htm

Why Become Accredited?

The ACA is driving change in our health care system. Delivery system reforms are aimed at making health care providers more accountable for quality and health outcomes. Financing reforms are shifting the reimbursement system from volume-based to value-based. A highly coordinated health care system will be critical for addressing our nation's chronic disease burden, which today accounts for roughly 75% of our health care spending. Evidence of effective community-based prevention programs is mounting, and studies show that investment in community-based prevention yields savings on a magnitude of more than 5 to 1.2. The Prevention and Public Health Fund has funded new and expanded evidence-based community-based prevention programs, building on years of experience and activities at the Centers for Disease Control and Prevention (CDC).[33]

Health education specialists – particularly those employed in community-based organizations – may consider becoming recognized for reimbursement eligibility. Uptake of various community-based prevention programs has been hampered by a lack of reimbursement for these activities. Public and private insurers have traditionally focused on reimbursing services provided by licensed clinical providers in a health care setting. The focus on population health is driving changes in the marketplace related to the need for a broader array of health professionals to provide preventive services. The Trust for America's Health Healthier America 2013 report recommended that the Centers for Medicare and Medicaid Services (CMS) "clarify states' ability to reimburse a broader array of health providers and pay for additional covered services" under Medicaid.[17]

A broader array of health professionals that could be reimbursed for providing preventive services to Medicaid beneficiaries include:

- Community Health Workers (CHW)
- Care Coordinators
- Education Counselors
- Home Visiting Staff
- Lactation Consulters
- Developmental screening
- Parenting Educators

[33] Nemours. "Medicaid Reimbursement for Community-Based Prevention Based on Convening Held October 31, 2013." *Centers for Medicare and Medicaid Services,* 16 December 2013. Web. 14 May 2014. medicaid_and_community_prevention_final_12.20.13 (1).

Opportunities in Community Settings for Diabetes Education

The Task Force on Community Preventive Services recommends communities to have gathering places for adults with type-2 diabetes to get self-management education.[18] Certified Diabetes Educators must first define a scope of practice and create a framework for standards and credentialing (ideally with regional coordination). Education, technical assistance, and capacity building for employers and sites on best practices and the role of CDEs must be provided. Overall, for a successful community diabetes education program, CDEs must create networks among both service providers and themselves.

Medicaid Reimbursement for Community Organizations

With the rollout of the ACA, the CMS had to change its Medicaid regulations to comply with the existing Medicaid statute. Medicaid reimbursements were previously only for preventive services provided by a licensed practitioner. Now, reimbursement for preventive services can be provided for non-licensed providers. Services that could potentially be reimbursed are:

- Care coordination and educational counseling
- Home visiting
- Group health education

Community-based prevention programs have not traditionally been reimbursed by health insurers, but the CMS clarified statute in the recently issued Essential Health Benefits rule. With the new changes, Medicaid will now allow preventive services recommended by licensed providers to be provided, at state option, by non-licensed providers. Reimbursement for preventive services by non-licensed providers offers a great opportunity for health education specialists.

Action Steps

Diabetes educators and health education specialists can be found in various settings including: hospitals, physician offices, private practices and clinics. In community settings, they can be found in schools, community programs, research programs, insurance companies, wellness programs, and even government agencies. The American Association of Diabetes (AADE) Educators provides a list of diabetes education programs in the United States.
https://www.diabeteseducator.org/ProfessionalResources/accred/Programs.html
AADE also provides a way to connect with CDEs in your area.
https://nf01.diabeteseducator.org/eweb/DynamicPage.aspx?Site=AADE&WebCode=AADEDiaEduDirectory

To address these and other issues, you can work in collaboration with other partners and stakeholders to accomplish the following external and internal actions:

External:

1. Educate Congress and the Administration at the national and state levels to include health education specialists in highlighting and translating public health evidence; collecting and analyzing data; publishing and disseminating results of research; implementing prevention strategies; conducting community outreach services; fostering coalition building and consensus on public health initiatives; providing leadership and training, and fostering safe and healthful environments.
2. Educate the Department of Health and Human Services and its agencies (including the National Institutes of Health, Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Food and Drug Administration, Agency for Healthcare Research and Quality, and Health Resources and Services Administration) to provide funding for research, identification, use of new technologies and dissemination of best practices for improving patient centered care, including the role of health education specialists.
3. Call for professional preparation schools and programs for health care providers, public health, allied health, health education, and health communication to strengthen professional preparation and training of health professionals about evidence-based strategies for patient-centered care, including the role of health education specialists as part of the team.
4. Educate public health and health care communities to organize and work with multi sectoral coalitions (i.e., consumers, government, businesses, and non-profit agencies) to help enroll uninsured consumers into health care plans by reducing individual and structural barriers to health literacy, promoting the dissemination of accurate health information, and involving and advocating for vulnerable populations and communities in their right to informed health decision-making. [16]

Internal:

1. Conduct a comprehensive community assessment to learn about existing diabetes education resources in your area, gaps in those resources, and the self-perceived needs of your target audience and begin organizing the human, material, and financial resources you will need for establishing a DSME program.[34]
2. Convene an expert panel to examine the latest research and best practices in patient-centered health care, ACA implementation, and the roles of health education specialists and other professionals in promoting patients and families as active participants in decision making and treatment. Publish the findings in one of SOPHE's journals – *Health Promotion Practice* (HPP) and *Health Education & Behavior* (HEB).
3. Provide continuing education for national and chapter members on ACA implementation and patient and consumer engagement as part of its national and chapter meetings and through distance education opportunities.
4. Work with allied health education organizations in the next health education job analysis to identify any additional knowledge and skills should be part of the core competencies of all health education specialists in the new and evolving era of health reform.
5. Advocate for the inclusion of health education specialists when identifying personnel for funding opportunities; job announcements; or pertinent federal/state/local legislation or regulations. SOPHE must also advocate for the use of health education specialists as opposed to lower cost and more narrowly trained classifications of employees.
6. Work with CMS to establish insurance codes for claiming reimbursement funds.
7. Expand outreach efforts, especially on the local and regional levels, to build relationships with and educate payers and health providers to assure the calculations of the bundled payments include the health educator as part of the team. [16]
8. Use the Assets-Based Community Development (ABCD) model to begin a grassroots community diabetes education program in your area.[35] For more information visit http://www.abcdinstitute.org/

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[34] Partnership for Prevention. "Establishing a Community-Based DSME Program for Adults with Type 2 Diabetes to Improve Glycemic Control – An Action Guide." *Partnership for Prevention,* April 2008. Web. 14 May 2014. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCsQFjAA&url=http%3A%2F%2Fwww.prevent.org%2FdownloadStart.aspx%3Fid%3D16&ei=Bph-U6SzEYamyAT26YGYCw&usg=AFQjCNELnp6oOjqesFUI-of59VQaiPXX7w&sig2=augBxRBKhFXtkWzmQc4akA&bvm=bv.67720277,d.aWw

[35] School of Education and Social Policy Northwestern University. "The Asset-Based Community Development Institute." *ABCD Institute,* 2009. Web. 30 May 2014. http://www.abcdinstitute.org/

Conclusion

Health equity can only be achieved when every person has the opportunity to "attain his or her full health potential" and no one is "disadvantaged from achieving this potential because of social position or other socially determined circumstances." [36] Evidence exists to show that communities that are more cohesive are more likely to maintain and sustain health, regardless of disadvantages faced. Cohesion is seen as a health asset – measured by strong and positive networks and their impact on a community's wellbeing.[37]

It is necessary for Certified Diabetes Educators and health education specialists to be a part of the communities they serve. If under careful guidance, diabetes education can have a great impact on more people if it is offered as a do-it-yourself option. Becoming a CDE not only helps to accelerate the impact of the ACA to a wider audience, but it also helps to further push the idea of DSME. This toolkit serves as a starting point for how you, a health education specialist, can be utilized in the communities as diabetes educator. SOPHE, its leadership, chapters, members, and organizational partners and allies offer this toolkit as a creative resource for health education specialists to begin. Diabetes educators and health education specialists improve the health care system and contribute to a healthier nation through Disease Self-Management Education.

[36] Centers for Disease Control and Prevention. "Health Equity." *Centers for Disease Control and Prevention,* 12 December 2013. Web. 14 May 2014. http://www.cdc.gov/chronicdisease/healthequity/

[37] Morgan, A., & Ziglio, E. "Revitalizing the Evidence Base for Public Health: An Assets Model." *IUHPE –Promotion & Education Supplement*; 2. (2007). 17-22.

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