Diabetes Self-Management Education and Training

Introduction

Diabetes is a chronic disease that affects 25.8 million people in the United States; 18.8 million have been diagnosed, while an estimated 7 million people remain undiagnosed. Currently the seventh leading cause of death in the nation, diabetes is a major factor in the development or cause of heart disease, stroke, kidney failure, non-traumatic lower-limb amputations, and blindness. In 2011, the total costs of diabetes reached $174 billion in the United States, which included $116 billion in direct medical costs and an additional $58 billion in indirect costs (e.g., disability, work loss, premature mortality). Medical expenses for people with diabetes are more than two times higher than for people without diabetes.1

To avoid serious health complications, people with diabetes must adequately manage their disease by maintaining a healthy lifestyle, monitoring blood glucose (A1C) levels, and receiving treatment.2 However, due to a variety of factors, including lack of access to diabetes management education and health services, many people are unable to adhere to these essential maintenance activities.3

Local health departments (LHDs) play an important role in mitigating the diabetes epidemic. Implementing comprehensive diabetes self-management education/training (DSME/T) programs is one strategy for LHDs. DSME/T is a “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.”4

The National Association of County and City Health Officials (NACCHO) is pleased to offer this fact sheet, which gives general descriptions of several DSME/T programs, compares their characteristics, and provides links to more information and resources.

Stanford Self-Management Programs

The Stanford University Patient Education Research Center has developed, tested, and evaluated self-management programs for people with chronic health conditions. The institution currently has two programs that address diabetes: Diabetes Self-Management Program (DSMP) and Chronic Disease Self-Management Program (CDSMP).5,6 The following are highlights from the two programs:

- CDSMP addresses all chronic diseases, including diabetes, while DSMP is specific to type 2 diabetes.
- Both CDSMP and DSMP have goals of improving health status, health behavior, and self-efficacy; reducing healthcare costs; and decreasing emergency room visits. DSMP has an added goal of improving A1C blood glucose levels.
- CDSMP and DSMP curricula focus on action planning and problem solving to manage lifestyle behaviors and emotionally cope with living with chronic disease.
- DSMP addresses diabetes disease process and treatment options; monitoring blood glucose and using results to improve control; preventing, detecting, and treating acute and chronic complications; goal setting and problem solving; and integrating psychosocial adjustment.
- DSMP addresses diabetes disease process and treatment options; monitoring blood glucose and using results to improve control; preventing, detecting, and treating acute and chronic complications; goal setting and problem solving; and integrating psychosocial adjustment.
- CDSMP aims to improve participants’ communication with physicians and increase self-efficacy.
- The measured outcomes of the DSMP include reduced A1C blood glucose levels, reduced health distress, and fewer symptoms of hypo/hyperglycemia.
- CDSMP’s measured and proven outcomes include decreases in fatigue, shortness of breath, pain, social activity limitation, illness intrusiveness, depression, and health distress; improved health behaviors specific to exercise and cognitive symptom management; improved healthcare use; reduced healthcare costs; fewer days spent in the hospital; and fewer inpatient and outpatient stays.7
• CDSMP and DSMP class sizes are limited to 16 participants.
• CDSMP and DSMP programs offer 15 hours of group educational training (2.5 hours per week for six weeks); for DSMP, five hours focus exclusively on diabetes content.
• Leaders are two lay people, at least one of whom must have a chronic condition (in the case of DSMP, type 2 diabetes).

*Note: CDSMP and DSMP are not currently reimbursable under Medicare.*

In 2012–2013, NACCHO, with support from the Centers for Disease Control and Prevention’s Division of Diabetes Translation, Division of Population Health, and Office of State, Tribal, Local, and Territorial Support, supported 12 LHDs to develop or enhance their capacity to deliver effective CDSMP within local jurisdictions. By helping to expand the availability of the CDSMP to additional local jurisdictions, NACCHO seeks to increase LHDs’ use of evidence-based programs while enhancing the well-being and self-efficacy of people with chronic illnesses.8

### Nationally Recognized or Accredited DSME/T Programs

The American Association of Diabetes Educators (AADE) and the American Diabetes Association (ADA) provide nationally recognized/accredited DSME/T programs. DSME/T provided by AADE is accredited through the Diabetes Education Accreditation Program (DEAP),9 and DSME/T provided by ADA is recognized through the Education Recognition Program (ERP).10 AADE-accredited and ADA-recognized DSME/T curricula both meet the National Standards for Diabetes Self-Management Education (National Standards), guidelines designed to define quality diabetes self-management.11 Key organizations and federal agencies within the diabetes education community review and revise the National Standards every five years. The following are highlights from these programs:

- Participants in both programs may have prediabetes, type 1 diabetes, type 2 diabetes, gestational diabetes, or pregnancy complicated by diabetes.
- Both programs focus on lifestyle changes such as healthy eating, physical activity, blood glucose monitoring, proper use of medications, preventing and treating complications, reducing risks, healthy coping, and psychosocial strategies.
- Measured outcomes of these programs vary but include reduced cost of care, higher rates of alignment with best practice treatment measures, higher frequency of exposure to DSME/T associated with better outcomes (dose-response relationship), and increased glycemic control.
- AADE-accredited programs do not have a specified number of participants per group; ADA-recognized programs must have at least 10 participants per group.

- The programs are 10 hours total (one to two hours individual counseling and eight to nine hours in-group)
- The programs require that one instructor be a registered nurse, registered dietitian, or pharmacist. A Certified Diabetes Educator (CDE) is not required for the program, but all instructors (including CDES) must be experienced and skilled with continuing education hours each year.
- Medicare will cover costs for 10 hours of initial AADE-accredited and ADA-recognized DSME/T self-management training in the first 12-month period, and two additional hours in the following years.12

### U.S. Diabetes Conversation Map Program/Journey for Control

U.S. Diabetes Conversation Map Program/Journey for Control is an ADA-recognized structured, interactive education program that provides a friendly learning experience for patients through images, metaphors, and thought-provoking conversation topics.13 The program provides Conversation Map education tools, training services, and ongoing support at no cost to facilitators, and the program may bill for Medicare reimbursement. For each Conversation Map, the Facilitator Guide includes objectives, evaluation plans, and a complete curriculum that meets the National Standards.

During each Conversation Map educational session, the facilitator uses a visual, conversation questions, and discussion cards to encourage sharing among participants. The groups have three to 10 participants, but there are also tools for one-on-one sessions. The Conversation Map program uses action plans to help participants change their choices and behaviors. Facilitator trainings are held nationwide, and most trained facilitators are licensed healthcare professionals. Individuals with the following designations are eligible facilitators: Board Certified-Advanced Diabetes Management, Certified Diabetes Educator, Doctor of Osteopathy, Exercise Physiologist, Licensed Nurse (LPN, LVN), Medical Doctor, mental/behavioral health professional (LPC/LMHC/LCPC/LCP/PsyD), Nurse Practitioner, Occupational Therapist, Optometrist, Pharmacist (PharmD/RPh), Physical Therapist, Physicians Assistant, Podiatrist, Registered Dietitian, Registered Nurse, Social Worker (LCSW), and Certified Promotor/Community Health Worker in Texas.

### Key Differences among Stanford, AADE-Accredited, and ADA-Recognized Programs

The following are among the key differences between the Stanford University, AADE-accredited, and ADA-recognized programs:

- CDSMP and DSMP are not currently reimbursable under Medicare.
Fact Sheet: Diabetes Self-Management Education and Training

• Medicare does not provide reimbursement for Stanford’s Self-Management Programs (CDSMP and DSMP); however, Medicare does provide reimbursement for AADE-accredited and ADA-recognized DSME/T programs. Medicare will cover costs for 10 hours of initial self-management training in the first 12-month period, and two additional hours in the following years.

• AADE-accredited and ADA-recognized DSME/T programs require fewer hours from participants than the Stanford programs, but the classes do cover diabetes-specific information taught by licensed healthcare professionals.

• DSMP and DSMP require leaders to be lay people with at least one leader having diabetes (for DSMP) or a chronic condition (for CDSMP); AADE-accredited and ADA-recognized DSME/T programs require leaders to be healthcare professionals with specifications on licensure and CEUs.

• DSMP participants mainly have type 2 diabetes; AADE-accredited and ADA-recognized DSME/T programs participants may have pre-diabetes, type 1 diabetes, type 2 diabetes, or gestational diabetes.

• CDSMP and DSMP meet only in a group setting; AADE-accredited and ADA-recognized DSME/T programs offer both group sessions and individual counseling sessions.

• Training costs for AADE-accredited and ADA-recognized DSME/T programs vary by program but tend to be less expensive than Stanford programs. (LHDs should consider any costs that are associated with the program or that will arise, such as the required continuing education hours and cost of initial licensure for leaders to be eligible to deliver DSME/T programs.)

• Cost of DSME/T accreditation/recognition ranges from $800 to $2,000, while training/certification through the Stanford programs (CDSMP and DSMP) ranges from $3,000 to $20,000.

Conclusion

As the prevalence of diabetes and pre-diabetes in the United States continues to rise, the provision of comprehensive DSME/T services is becoming increasingly essential, especially at the local level. Self-management programs, including Stanford’s CDSMP and DSMP, AADE-accredited DSME/T, and ADA-recognized DSME/T, have been shown to prevent or delay the complications of diabetes and enhance overall well-being of people with diabetes.

Enacted in March 2010, the Patient Protection and Affordable Care Act (ACA) presents opportunities for LHDs in the provision of direct services, including DSME/T. LHDs need to determine whether a clinical care role continues to makes sense for them in their communities and among the services provided by partners and others supported by the ACA. Such determinations should be made in coordination with local or regional stakeholders. LHDs can begin to think about developing new business models to bill or contract for services.14

With the rising rates of diabetes and demand for services, an expanded workforce is necessary to deliver DSME/T programs. Currently, Master Certified Health Education Specialist (MCHES) do not meet the qualifications for leaders in the Conversation Map program and other DSME/T programs. (Certified CHWs in Texas do meet the qualifications for the Conversation Map program.) However, in March 2013, the National Commission for Health Education Credentialing approved the Society for Public Health Education’s request to allow MCHES to be eligible to quality for the CDE exam. Beginning Jan. 1, 2014, professionals with MCHES credential will be eligible to apply to become a CDE.15

Acknowledgments

This document was made possible through support from the Centers for Disease Control and Prevention, Cooperative Agreement #SU38HM000449-05. NACCHO is grateful for this support. The views expressed within do not necessarily represent those of the sponsor.
TOOLS & RESOURCES
The Centers for Disease Control and Prevention funded NACCHO to create a toolkit with resources, templates, and tools for LHDs to use and develop capacity to bill third-party payers for immunization services. More than 150 resources have currently been collected from state billing guides, the Centers for Medicare and Medicaid Services, state and local health departments, insurance companies, and vendors of products such as electronic medical records and billing clearinghouses. While created primarily for immunization, the Billing Toolkit contains information relevant to other areas, including steps on establishing billing procedures for other clinical services. In 2013, NACCHO will launch a Billing for Clinical Services toolkit with resources grouped by services, including sexually transmitted diseases, HIV, tuberculosis, and diabetes. For tools and resources, visit www.naccho.org/toolbox/.

References

FOR MORE INFORMATION, PLEASE CONTACT:
Chronic Disease/Healthy Communities Team
202-783-5500
chronicdisease@naccho.org