Information Summary and Recommendations

Diabetes Educator

Sunrise Review

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THE SUNRISE REVIEW PROCESS

A sunrise review evaluates a proposal to change the laws regulating health professions in Washington. The legislature's intent, as stated in chapter 18.120 RCW, permits all qualified people to provide health services unless there is an overwhelming need for the state to protect the interests of the public by restricting entry into the profession. Changes to the scope of practice should benefit the public.

The Sunrise Act, RCW 18.120.010, says a health care profession should be regulated or scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable, isn't isolated, and isn't dependent upon weak argument;
- The public needs and can reasonably benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means that are more cost effective.

If the legislature identifies a need and finds it necessary to regulate a health profession not previously regulated, it should select the least restrictive alternative method of regulation, consistent with the public interest. Five types of regulation may be considered as set forth in RCW 18.120.010(3):

1. *Stricter civil actions and criminal prosecutions.* To be used when existing common law, statutory civil actions and criminal prohibitions are not sufficient to eradicate existing harm.
2. *Inspection requirements*. A process enabling an appropriate state agency to enforce violations by injunctive relief in court, including, but not limited to, regulation of the business activity providing the service rather than the employees of the business, when a service being performed for people involves a hazard to the public health, safety or welfare.
3. *Registration.* A process by which the state maintains an official roster of names and addresses of the practitioners in a given profession. The roster contains the location, nature and operation of the health care activity practices and, if required, a description of the service provided. A registered person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
4. *Certification*. A voluntary process by which the state grants recognition to a person who has met certain qualifications. Non-certified people may perform the same tasks, but may not use "certified" in the title.[1] A certified person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.
5. *Licensure.* A method of regulation by which the state grants permission to engage in a health care profession only to people who meet predetermined qualifications. Licensure protects the scope of practice and the title. A licensed person is subject to the Uniform Disciplinary Act, Chapter 18.130 RCW.

[1] Although the law defines certification as voluntary, many health care professions have a mandatory certification requirement such as nursing assistants – certified, home care aides, and pharmacy technicians.

EXECUTIVE SUMMARY

Background and Proposal

Diabetes has reached epidemic proportions in Washington. In 2010, an estimated 517,304 residents of the state had diabetes according to the Washington Association of Diabetes Educators (WADE). That number is expected to grow to 670,492 people by 2015. Health complications from the disease include cardiovascular disease, kidney failure, blindness, and foot and leg amputations. Diabetes self-management training (DSMT) [2] reduces complications from the disease and attending health care costs. The specific practice of diabetes education is not regulated in Washington although it is included within the scope of many existing health care professions.

In June 2013, the chair of the House Health Care and Wellness Committee asked the department to conduct a sunrise review of a proposal to license diabetes educators as a new and distinct profession. Health care practitioners who meet certain qualifications would be eligible for the new license as diabetes educators. The bill is intended to protect both title and scope of practice. A board would be formed to regulate the practice of the new profession.

The proposal was submitted by WADE, which states that regulation is necessary to protect the public. The group believes that all health care providers need sufficient additional diabetes knowledge to provide safe, competent care to people with or at risk of diabetes, and that licensure ensures that only qualified professionals will deliver diabetes education.

Recommendations

The department recognizes the magnitude of the diabetes epidemic, the value of highly qualified individuals providing diabetes self-management education and its effectiveness toward protecting patient health and controlling health care costs. However, the department doesn't support licensure for diabetes educators. The agency cannot support creating a barrier for the public to access diabetes education from their current health care providers, governmental and non-profit programs, and other community providers.

The proposal doesn't meet the sunrise criteria for the reasons below:

1. The applicant hasn't identified a clear and easily recognizable threat to public health and safety from the unregulated practice of diabetes education as a separate and distinct profession.
2. The proposal will result in unintended harm to particular populations. By limiting the number of health care professionals who can provide diabetes education, barriers to access will be created, particularly among those who rely on community health centers and rural clinics for services.

[2] Diabetes self-management education (DSME), diabetes self-management training (DSMT) or diabetes self-management education/training (DSME/T) are used interchangeably throughout the literature to refer to the general process of a diabetes educator preparing the patient for effective self-management of their own disease.

3. The proposed legislation will likely prevent or discourage doctors, nurses, and other qualified health care professionals from providing diabetes education to their patients as fully as they may have otherwise done.
4. The proposal would place a second burden of state licensure, renewal fees, and education requirements on already licensed health care professionals operating within their scope of practice.
5. The proposed legislation would result in expanding the scope of practice beyond the current level of training and experience of some health care practitioners.
6. There are processes already in place for the public to file complaints against practioners who provide substandard care or commit unprofessional conduct. Licensing for diabetes educators for the purpose of providing oversight and discipline would be a costly and unnecessary duplication of regulation.
7. The public can already reasonably expect to receive quality team-based diabetes education services from health care professionals working within their scope of practice. With ongoing support from the community, including not-for-profit diabetes and chronic disease education programs, the public can be effectively protected in a cost beneficial manner.

In addition to failing to meet the sunrise criteria, the proposed bill contains numerous factors, errors, and contradictions that would make it difficult to implement because it:

1. Does not place this new profession in the Uniform Disciplinary Act (UDA), chapter 18.130 RCW.
2. Appears to both exclude and include certain professions.
3. Requires non-diabetes educators to work under the supervision of a diabetes educator when providing DSMT. Because of contradictory language within the bill draft, considerable confusion exists about whether or not highly trained and independent practitioners such as physicians would be required to work under a diabetes educator when providing DSMT.
4. Defines unprofessional conduct differently than the UDA and has very narrow sanctions.
5. Allows for automatic licensure if the applicant has national certification without regard for other factors such as the applicant's disciplinary or criminal history.

The applicant has stated intent and understanding that are different than the language of the proposed bill. However, our mandate is to review the bill provided to the department. The department recognizes that the lack of a specific state credential may prevent someone from being compensated for services by insurance or some government programs; however, this potential outcome isn't part of the sunrise review criteria.

SUMMARY OF INFORMATION

Proposal and Bill Draft

The bill draft submitted for review, identified as H-1847.3/13 3rd draft, was sent to the department on June 13, 2013. The request was made by Representative Eileen Cody, Chair of the House Health and Wellness Committee.

The draft bill includes an intent section, definitions, title protection and scope of practice, creation of a licensure board, requirements for licensure, definition of unprofessional conduct and disciplinary measures, and conditions for automatic qualification for licensure.

The proposal applies a licensure requirement to any individual who develops plans of care and conducts self-management training for persons with or at risk of diabetes. To become a diabetes educator the individual must meet education and supervised experience requirements established in the proposal or meet the criteria for automatic qualification.

Background

Diabetes has reached epidemic proportions. In 2010, approximately 8.9 percent of the population of Washington had been diagnosed with diabetes at some time in their life. Another 1.1 percent had been diagnosed with pre-diabetes or borderline diabetes.[3] The estimated number of people with the disease at that time stood at 517,304, according to WADE. WADE expects that number to grow to 670,492 people by 2015. According to many sources, all people who consume a standard American diet are at risk of diabetes.

Diabetes is a complex disease that, if not managed properly, often results in serious complications including blindness, kidney failure, leg amputations, heart disease, and stroke. Diabetes self-management training plays a critical role in preparing a patient to take control of his or her own health by reducing the risk of complications through effective management of blood glucose levels. An individual with diabetes or at risk of diabetes must carefully manage his or her diet, exercise, medication, and stress on a daily basis to reduce the risks of more serious health complications. Effective self-management improves health outcomes and reduces health care costs.[4]

Diabetes self-management training includes a comprehensive set of activities including patient assessment, goal setting with the patient, developing a plan with the patient for self-management, assisting with implementation of the plan, evaluating outcomes, and documenting the training and education.[5] Self-management training is usually conducted by a variety of health care professionals working together as a team. Diabetes education, as a professional practice, is not regulated in Washington as a specific profession, but is included within the scope of many health care professions.

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[3] Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, http://apps.nccd.cdc.gov/brfss.

[4] *Redesigning the Health Care Team*. National Diabetes Education Program. NIH Publication No. 17-7739. www.ndep.nih.gov

[5] The Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators, American Association of Diabetes Educators.

Voluntary National Certifications

Regulated health care professionals may work to gain the voluntary national certification of Certified Diabetes Educator® (CDE)® or Board Certified – Advanced Clinical Diabetes Management (BC-ADM). The applicant reports that approximately 60.1 percent of the 589 "quality diabetes educators" in Washington hold the title of CDE®[6]. These voluntary certifications do not confer title or scope of practice protection for diabetes educators.

The CDE® requires at least two years professional practice as a health care professional along with with 1,000 hours of training in DSMT. Eligible disciplines for the CDE® include clinical psychologist, registered nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician (M.D. or D.O.), or podiatrist. Dietitians, physician assistants, exercise specialists, and exercise physiologists have additional requirements. Social workers must have a master's degree from an accredited university. The number of practice hours required and the tight time frame to acquire them presents a barrier for many health care providers, particularly in rural areas, to gain the national voluntary certification of CDE® because 40 percent of the DSMT practice experience hours must be gained within a year of application.[7]

The BC-ADM can be awarded to physicians (medical doctor or doctor of osteopathy), pharmacists, registered nurses, dieticians, or physician assistants. Applicants must have a graduate degree from an accredited program and complete a minimum of 500 clinical practice hours in advanced diabetes management within 48 months prior to taking the certification examination.[8]

Recognition of Team Care

Because of the complexity of the disease and the many healthcare specialties that are drawn from when teaching the patient effective self-management, the team approach to diabetes self-management training is considered best practice. The National Diabetes Education Program, a program of the National Institutes of Health and the Centers for Disease Control and Prevention, holds team care as the model for effective and cost effective management. The program contends that self-management training team members should vary according to patient needs. The team may include primary care providers, registered nurses, registered dieticians, pharmacists, and other health care providers. Clinical care should be backed up by community partners including school nurses, social workers or psychologists, trained community-based fitness instructors, podiatric physicians, dental and eye care professionals, and telehealth services.

Medicaid and Medicare pay for DSMT through recognized clinics, not based on individuals providing DSMT services. States vary in their Medicaid requirements. Washington's

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[6] Applicant post-hearing response letter. American Association of Diabetes Educators and WADE. "Quality" is defined by the applicant as the diabetes educator having 250 or more diabetes practice hours within 2 years, along with a core body of knowledge. See letter, appendix C.

[7] National Certification Board for Diabetes Educators. 2013. http://www.ncbde.org/certification_info/professional-practice-experience/

[8] American Association of Diabetes Educators http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/accred/FAQs_BCADM_March_2013.pdf

Medicaid certified clinics require health care professionals to either have voluntary certification credentials or a prescribed minimum of diabetes continuing education hours. The Department of Health currently certifies approximately 130 DSMT clinics around the state for Medicaid reimbursement. Reimbursement under Medicare requires a higher standard. Programs must be accredited by the American Association of Diabetes Educators or the American Diabetes Association. By certifying clinics and not individual providers for DSMT services, Medicare and Medicaid programs underscore the provision of team-based services and provision of DSMT by many people in various professions.

Community Diabetes Education and Support

Governmental, non-governmental, and community organizations work together to provide diabetes education classes that either fill a gap in critical services, broadly educate people who are at risk of diabetes, or provide ongoing support to those who have already seen a diabetes educator. These programs may include health care professionals as well as lay educators. Most often these classes are of a general nature, providing information about healthy eating, the importance of exercise, and what medical tests are routinely given to patients with diabetes and why they are important. Data collected through these community education programs have demonstrated their potential impact.

The *YMCA Diabetes Prevention Program*, taught by lifestyle coaches and others, focuses on behavior change, including the importance of healthier eating, weight loss, physical activity, and managing stress. "The program is based on research which showed that by eating healthier, increasing physical activity, and losing a small amount of weight, a person with pre-diabetes can prevent or delay the onset of type 2 diabetes by 58 percent."[9] The YMCA program consists of 16 one-hour sessions.

Other State and National Efforts to License Diabetes Educators

Only two other states, Kentucky and Indiana, have passed legislation to license diabetes educators. Kentucky passed a law to license diabetes educators in 2011, KRS 309.325 – 309.339. In 2013, the Kentucky Legislature amended its law to create two categories of diabetes educators, apprentice diabetes educator and master licensed diabetes educator, to accommodate the practice hours of those seeking licensure. Implementation of the 2011 law has proven to be controversial, and as of this writing, no licenses have been granted in Kentucky.

The governor of Indiana vetoed Indiana's 2013 legislation, HEA 1242, citing creation of barriers to the marketplace and restricted competition.

According to information published by WADE, the effort to gain Medicare recognition of the credential of diabetes educator is one of the factors driving the state licensure initiative.[10] In a related effort, S. 945 and H.R. 1274, identical bills introduced in Congress in May 2013, seek to improve access to diabetes self-management services through recognition of certified diabetes educators as authorized providers of Medicare reimbursed DSMT. Improved access

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[9] Department of Health sponsored Washington State Diabetes Connection website http://diabetes.doh.wa.gov/resources-for-the-general-public/ymca-diabetes-prevention-program

[10] 3013 WADE diabetes educator licensure initiative status. Washington Association of Diabetes Educators Legislative Update Q&A http://wadepage.org/node/22.

to training via Telehealth service under part B of the Medicare program is also a part of the proposal. The federal legislation also requires studies regarding barriers to DSMT and effective outreach methods to physicians and other health care providers.

Washington's Budget Proviso and Upcoming Report

The 2013 biennial budget included direction from the Washington State Legislature to the Department of Health, Health Care Authority, and Department of Social and Health Services to submit a coordinated report on the state's efforts to prevent and control diabetes. The report, due to the legislature in December of 2014, will address:

- The financial impacts and reach that diabetes is having on the programs administered by each agency and individuals, including children with mothers with undiagnosed gestational diabetes, enrolled in those programs.[11]
- An assessment of the benefits of implemented and existing programs and activities aimed at controlling all types of diabetes and preventing the disease.
- The description of the level of coordination existing between agencies on programmatic activities as well as messaging, managing, treating and preventing diabetes and its complications.
- The development or revision of detailed policy-related action plans and budget recommendations for battling diabetes.

Proposal for Sunrise Review

The applicant contends that licensure, which would require specific standards for education, training and scope of practice for diabetes educators, is necessary to ensure patient health and safety. In the narrative proposal, WADE provided two anecdotes of harm stemming from bad advice offered by licensed health care providers to their patients.[12] The applicant suggests that because of the complexity of the disease, health care professionals, including doctors, nurses, pharmacists and dieticians, may not be up-to date on current information and therefore put their patients at risk. WADE also contends that because diabetes education is unregulated, non-health care providers may claim the title of diabetes educator.

Although the voluntary title of CDE® requires 1,000 DSMT practice hours, during the hearing and in a letter following the hearing, the applicant suggested a standard of 250 DSMT practice hours for "quality" DSMT training and for state licensure. A specific number of practice hours weren't included in the proposed bill.

The applicant suggests that disciplinary actions cannot be taken against a health care professional who is providing diabetes education because they, as educators, don't have a defined scope of practice. WADE doesn't appear to understand or acknowledge the authority of the existing regulatory bodies for credentialed healthcare professions and the remedies for unprofessional conduct that already exist under the UDA.

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[11] 3ESSB 5034.SL Section 219 (23), page 103.

[12] Diabetes educator sunrise proposal, question B, the nature of the potential harm to the public if the business or profession is not regulated, and the extent to which there is a threat to public health and safety.

The proposed bill presented for review has a number of serious flaws and internal inconsistencies. The described intention in the narrative proposal and the bill language are confusing, a fact that was confirmed in numerous public comments. As written, the bill:

- Attempts, through licensing, to provide minimum standards for patient safety and for recognizing a health care professional who can legally provide all aspects of DSMT. Although all aspects of DSMT are within the scope of practice of physicians and some other primary care providers, all aspects of DSMT are not currently in the scope of practice for all professions listed in the bill such as dieticians or social workers. Scope of practice for the affected, existing professions cannot be changed, whether restricted or expanded, through creation of a new profession.
- May infringe on the scope of practice of some health care providers. The proposed legislation appears to prohibit practitioners such as doctors, osteopathic physicians, nurses, and pharmacists from providing diabetes education unless working under the supervision of a licensed diabetes educator. The proposed bill places the diabetic educator in the role of supervising primary care practitioners and other high-level licensed practitioners and directing the care for that practitioner's patient. This conflicts with the scope of practice for physicians and other professions. The bill omits professions like naturopaths and osteopaths. Conversely, its use of the generic term "physician" could be read to include chiropractors and optometrists.

  A post-hearing letter from the applicants intending to clarify the intention of the bill suggested that care should be coordinated by the physician/qualified non-physician practioners (diabetes educator). In their post-hearing comments (appendix C) the applicants seemed to imply that other practitioners, such as RNs working within their scope of practice, would be subject to oversight by the licensed diabetes educator when providing diabetes education.
- Doesn't add the profession to the Uniform Disciplinary Act (UDA), chapter 18.130 RCW. All credentialed healthcare professionals in Washington are subject to the UDA. As inferred from its title, the UDA provides uniform licensing and discipline standards meant to ensure all providers practice with reasonable skill and safety.
- Creates the Washington State Board of Licensed Diabetes Educators. The narrative proposal asks for a board to be made up of seven members and the bill draft lists five members. The creation of this board results in currently licensed providers having two disciplining authorities regulating the same essential practice.
- Creates a duplicative process for regulation of a health care provider who already holds an underlying license. It requires a licensed health care provider to obtain a second credential in order to do something he or she can already do. The additional costs and continuing education burden may discourage providers from continuing to provide DSMT.
- Provides for automatic qualification to license individuals who have a voluntary certification by specific national associations. This could be subject to a challenge of

unlawful delegation of licensing authority and fails to consider other critical factors such as background checks for criminal or disciplinary history.

Public Participation and Hearing

Almost 90 comments were received during the initial written comment period. A hearing was held August 2, 2013. Most of the written and oral comments centered on a few themes summarized below:

Themes found in written and verbal testimony *in opposition* to the proposal:

- Scope of practice: Doctors and nurses may have to work under the supervision of a licensed diabetes educator to provide educational services.
- Scope of practice: The proposal may increase the scope of practice for some currently regulated health care providers such as dieticians or social workers.
- Restricting access: It would limit patient and public access to diabetes education by restricting the people who could provide that information, including doctors, nurses and other health care providers who would choose not to be dually licensed. Governmental and non-profit diabetes education providers as well as health and wellness service providers would also be impacted. The Association of Community and Migrant Health Centers opposes the proposed bill for reasons of patient access.
- Access issues: Some patients rarely visit a primary health care provider and often only come once. Of particular concern are those who may be homeless, have mental illness, are very low-income, or those who are isolated due to geography, language, or culture. All appropriate health care providers need to be able to provide diabetes education at the time of the patient visit. It may be their only opportunity to provide crucial information.
- Not needed: Most diabetes educators are health care professionals already licensed and subject to the standards of their profession and the Uniform Disciplinary Act. The Washington Association of Naturopathic Physicians and the Washington State Podiatric Medical Association oppose licensure for this reason.
- Barriers to team-based care: Licensed health care professionals working as a team within their scope of practice to provide all aspects of diabetes education is the standard. This proposal moves away from the team-based approach.
- Some health care providers are left out: The proposed legislation excludes naturopathic physicians, licensed nutritionists (including those at the Ph.D. level), and social workers.
- The proposal is overly broad: People “at risk of diabetes” potentially include most of the state’s population. Non-licensed health and wellness providers play an important role in educating the public about the importance of a healthy diet and exercise. The bill may restrict non-licensed, non-health care providers from providing some level of nutritional guidance to those concerned about the potential for diabetes. The Alliance for Natural Health, American Nutrition Association, National Association of Nutrition Professionals, the Certification Board for Nutrition Specialists, along with

more than 40 letters from individuals, cited their objection to the proposed bill for this reason.

- The National Certification Board for Diabetes Educators, the organization that offers the voluntary CDE credential, is opposed because they believe that 250 practice hours doesn't provide the necessary quality for a diabetes educator.

Themes found in written and verbal testimony *in support* of the proposal:

- Licensing of diabetes educators with practice hours and continuing education standards will ensure competency. Some health care professionals are not knowledgeable about diabetes self-management or up-to-date on current practices and give patients wrong information, putting patients at great risk.
- Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe.
- This proposal will allow registered dieticians an expanded scope of practice so they may fully participate in the education of patients.
- Licensure, with protected title and scope of practice, will attract people to the profession.
- With the growing number of people with diabetes or pre-diabetes, more diabetes educators are needed.

Themes found in written and verbal testimony with position of *neutral or with concerns.*

- Support was voiced for title protection for diabetes educators, but not a protected scope of practice. The particular concern was the limiting of those who could provide education, potentially restricting access to populations served by community health centers and rural clinics.
- Health care professions including doctors, nurses, and pharmacists may have their otherwise authorized scope of practice limited by this proposal. Dual licensure was also a concern. The Washington State Nurses Association and the Washington State Pharmacy Association held this viewpoint.
- There was concern about the make-up of the board, including the professions represented and total number of people serving. Osteopathic physicians would like to be represented on the board if it is created.
- The American Association of Diabetes Educators suggested during testimony that quality diabetes education would not have to go as far as the CDE's 1,000 hours of practice. Instead, 250 hours of practice would be adequate to provide quality patient education.
- Nutritionists were left out of the bill.
- The Washington Physical Therapy Association and the Washington Occupational Association asked for their practitioners to be specifically exempted from this bill so they could continue to offer diabetes education without this license.

- The Washington Osteopathic Medical Association requested osteopathic physicians be included in the list of professions whose practice is not altered or modified by language establishing the license of diabetes educator. Diabetes education is already within their scope of practice.

REVIEW OF PROPOSAL USING SUNRISE CRITERIA

The Sunrise Act, in RCW 18.120.010, states that a health care profession should be regulated or the scope of practice expanded only when:

- Unregulated practice can clearly harm or endanger the health, safety or welfare of the public and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument;
- The public needs can reasonably be expected to benefit from an assurance of initial and continuing professional ability; and
- The public cannot be effectively protected by other means in a more cost-beneficial manner.

First Criterion: Unregulated practice can clearly harm or endanger the health or safety.

The proposal doesn't meet this criterion. The applicants provided anecdotal incidents or generalized examples of harm that, even if verified, would not rise to the level of requiring state regulation. In addition, the substandard professionals they cite already have an existing disciplining authority with the ability to take action against its licensees.

A stronger argument could be made against the licensing of diabetes educators. Licensing educators, with title protection and protected scope of practice, may cause harm to some populations by restricting access to health care professionals who can provide diabetes education. Rural, low-income, or marginalized communities are of particular concern.

Second Criterion: The public needs and can reasonably be expected to benefit from an assurance of initial and continuing professional ability.

The proposal doesn't meet this criterion. The public can reasonably expect to receive initial and continuing professional ability through existing licensure of health care professionals. If a practitioner causes harm, they can be reported to the profession's disciplining authority. Voluntary certifications such as the CDE may provide an additional measure of assurance of professional ability. However, this should not take away from the assumed competency of other health care professionals.

Third Criterion: The public cannot be effectively protected by other, more cost-beneficial means.

The proposal doesn't meet this criterion. Reliance upon the competency of a health care professional operating within their scope of practice and as a part of a team providing diabetes education is the most cost beneficial. Community resources, including governmental and non-profit diabetes education programs, play an important role in the ongoing support of those with diabetes or at risk of diabetes.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The department doesn't support the proposal to require state licensure of diabetes educators. The agency cannot support creating a barrier for the public to access diabetes education from their health care providers, governmental and non-profit programs, and other community providers. The applicant has not provided evidence of a need for the state to protect the interests of the public by restricting the provision of diabetes education.

The proposal doesn't meet the sunrise criteria for the reasons below:

1. The applicant hasn't identified a clear and easily recognizable threat to public health and safety from the unregulated practice of diabetes education.
2. The proposal will likely result in unintended harm to particular populations. Limiting the number of health care professionals who can provide diabetes education may create barriers to access, particularly among those who rely on community health centers and rural clinics for services.
3. The proposed legislation will likely prevent or discourage doctors, nurses, and other qualified health care professionals from providing diabetes education to their patients as fully as they may have otherwise done.
4. The proposal would place a second burden of state licensure, renewal fees, and education requirements on already licensed health care professionals operating within their scope of practice.
5. The proposed legislation would result in expanding the scope of practice beyond the current level of training and experience of some health care practitioners and restricting the existing scope of practice for other practitioners who don't obtain this additional license.
6. There are currently processes in place for the public to file complaints against practioners who provide substandard care or commit unprofessional conduct. Licensing for diabetes educators for the purpose of providing oversight and discipline will be a costly and unnecessary duplication of regulation.
7. The public can already reasonably expect to receive quality team-based diabetes education services from health care professionals working within their scope of practice. With ongoing support from the community, including not-for-profit diabetes and chronic disease education programs, the public can be effectively protected in a cost beneficial manner.

In addition to failing to meet the sunrise criteria, the proposed bill contains numerous factors, errors, and contradictions that would make it difficult to implement because it:

1. Doesn't place this new profession under the Uniform Disciplinary Act (UDA), chapter 18.130 RCW.
2. Appears to both exclude and include certain professions.

3. Requires non-diabetes educators to work under the supervision of a diabetes educator when providing DSMT. Because of contradictory language within the draft bill, considerable confusion exists about whether or not highly trained and independent practitioners such as physicians would be required to work under a diabetes educator when providing DSMT.
4. Defines unprofessional conduct differently than the UDA and has very narrow sanctions.
5. Allows for automatic licensure if the applicant has national certification without regard for other factors such as the applicant's disciplinary and criminal history.

The applicant has stated intent and understanding that are different than the language of the proposed bill. However, our mandate is to review the bill provided to the department.

The department recognizes that the lack of a specific state credential may prevent someone from being compensated for services by insurance or some government programs. However, this potential outcome is not part of the sunrise review criteria.

SUMMARY OF REBUTTALS

We received a response from the applicant acknowledging receipt of the draft report. They did not provide a rebuttal or any corrections.

Kathy Itter, Executive Director of the Washington Osteopathic Medical Association submitted a correction to the draft. Corrections were made on page nine and twelve of the draft, consistent with her recommendations. From her response:

> "On page 12 of the draft it states that osteopathic physicians asked to be included in the list of health care practitioners eligible to be licensed diabetes educators if the bill is enacted. **This is incorrect.** If you review the testimony of David Knutson on page 146, the request was that osteopathic physicians be included in the list of professions whose practice is not altered or modified by language establishing the license of Diabetes Educator. In other words, osteopathic physicians want to be exempt from the requirement to license diabetic educators. Their scope of practice already includes diabetes education and to require a secondary license to do so is a waste of time and money."

Although not solicited during this rebuttal period, we received five letters of general support for the draft report and one letter that wasn't relevant.

Appendix A

Applicant Report

Washington State Department of Health
Sunrise Review

Applicant Report Cover Sheet and Outline

Cover Sheet

- Legislative proposal being reviewed under the sunrise process (include bill number if available): Draft with no bill number.

- Name and title of profession the applicant seeks to credential/institute change in scope of practice: Washington Association of Diabetes Educators (WADE)

- Applicant's organization: National American Association Diabetes Educators (AADE)

  Contact person: Pat Haldi

  Address: 23316 E. Inlet Drive, Liberty Lake WA

  Telephone number: 509-389-7227 Email address: phaldi@comcast.net

  Contact person: Hailey Crean

  Address: 9404 B Linden Ave N, Seattle, WA 98103

  Telephone number: 206-437-9907 Email address: hlym@novonordisk.com

- Number of members in the organization: American Association of Diabetes Educators,

  14,500 national members

  Approximate number of individuals practicing in Washington: 330 plus those not members of WADE (approximate number over 300 not WADE members).
  Name(s) and address (es) of national organization(s) with which the state organization is affiliated:

Name(s) of other state organizations representing the profession:
Members of the following organizations may potentially act as diabetes educators are as listed
Washington Association of Diabetes Educators: 245 members
American Association of Diabetes Educators: 14,500 national members
Washington State Dietetic Association
Washington State Pharmacists Association
Washington State Mental Health Professionals
Washington State Podiatrists
Washington State Exercise Physiologists
Washington State Nurses Association

Outline of Factors to be Addressed

Please refer to RCW 18.120.030 for more detailed criteria and questions to be considered when formulating your responses. Concise, narrative answers are encouraged. Please explain the following:

(1) Define the problem and why regulation is necessary:

Problem: Diabetes is a complex chronic disease and living well with diabetes requires active, diligent, effective self-management. The initiation of DSMT by a qualified professional can greatly affect outcomes for people with diabetes by teaching these self-management skills. We know that poorly managed diabetes can lead to costly kidney failure, non-traumatic limb amputations and is a major cause of heart disease and stroke. Diabetes is also the 7th leading cause of death in United States.

Reason regulation is necessary: With no control over who can provide the critical services of "diabetes self-management training (DSMT) the State of Washington's constituency with diabetes and pre-diabetes are at a great risk for falling victim to the disease and its comorbidities.

(2) The efforts made to address the problem:

Mastery of the knowledge and skills to be a diabetes educator is obtained through professional practice experience, continuing education, individual study, and mentorship. Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM). Unfortunately these voluntary credentials hold no legal standing nor do they have an element of patient protection or legally regulate who can say they are providing this service in a qualified manner.

(3) The alternatives considered:

a. REGULATION OF BUSINESS EMPLOYERS OR PRACTITIONERS RATHER THAN EMPLOYEE PRACTITIONERS;

Regulating the business does not serve to ensure that those practicing diabetes education are adequately trained.

Management of diabetes is complex. It is very important that the health care professionals who set themselves out as diabetes educators be well educated and appropriately credentialed in the delivery of quality diabetes education.

b. REGULATION OF THE PROGRAM OR SERVICE RATHER THAN THE INDIVIDUAL PRACTITIONERS;

Again, Regulating the program or service does not serve to ensure that those practicing diabetes education are adequately trained.

c. REGISTRATION OF ALL PRACTITIONERS;

Registration does not provide a scope of practice and minimum provider qualifications.

d. CERTIFICATION OF ALL PRACTITIONERS;

Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM). Unfortunately these voluntary credentials hold no legal standing nor do they have an element of patient protection or legally regulate who can say they are providing this service in a qualified manner.

(4) The benefit to the public if regulation is granted: Licensure for Diabetes Educators would define a set scope of practice and enforceable standards. It would also provide a much needed consumer protection piece, professional recognition and set the quality guidelines for the profession. The public would benefit from standardized, evidenced based diabetes education provided by qualified professionals.

(5) The extent to which regulation might harm the public: The licensing and regulation of diabetes education is not intended to cause any harm to the public. In fact, regulating the profession will provide a much-needed level of public safety that currently does not exist.

(6) The maintenance of standards:
The proposed legislation will ensure quality by developing a legal scope of practice, education requirements, continuing education requirements, and establishing an outlet for consumers reporting. Additionally, there will be a regulatory body overseeing the process and providing continuous quality improvement in regulating the standards as well as those who are licensed.

(7) A description of the group proposed for regulation, including a list of associations, organizations, and other groups representing the practitioners in this state, an estimate of the number of practitioners in each group, and whether the groups represent different levels of practice.

Diabetes educators are healthcare professionals who have experience in the care of people with diabetes and have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling and education. The role of a diabetes educator can be assumed by professionals from a variety of health disciplines including, but not limited to, registered nurses, registered dietitians, registered pharmacists, physicians, mental health professionals, podiatrists and exercise physiologists.

Washington Association of Diabetes Educators: 245 members
American Association of Diabetes Educators: 14,500 national members
Washington State Dietetic Association
Washington State Pharmacists Association
Washington State Mental Health Professionals
Washington State Podiatrists
Washington State Exercise Physiologists
Washington State Nurses Association

(8) The expected costs of regulation: Licensure of diabetes educators is not expected to impose additional costs to the state or general public. Implementation of the proposed legislation will be factored into the cost to the professional pursuing licensure. Fees for licensure are expected to be around $50.00 but not more than $100.00 for two years

(9) List and describe major functions and procedures performed by members of the profession (refer to titles listed above). Indicate percentage of time typical individual spends performing each function or procedure:

Diabetes self-management education and training follows a comprehensive 5-step process that includes:
1.assessment
2.goal-setting
3.planning
4.implementation
5.evaluation

•Assess basic DM skills/knowledge of diabetes and literacy/numeracy
•Assess for motivation and readiness to learn and make behavior changes
•Assess attitude toward learning and preferred learning style
•Assess impact of social, economic and cultural aspects/circumstances
•Identify potential barriers to behavior change, including: cognitive and physical limitations, literacy, lack of support systems, negative cultural influences
•Screen for acute and long- term complications
•Guide patient in setting individualized behavioral goals
•Guide patient to prioritize goals based upon assessment and preference
•Develop success metrics
•Develop basic plan related to acquiring necessary DM skills based on needs identified in assessment
•Train in blood glucose testing, equipment use & maintenance, interpretation of results
•Train in medication taking, equipment use & maintenance such as insulin pens, decision making
•Train in identification of potential/actual complications of diabetes, treatment and prevention
•Suggest/support DM skill training; offer guidance on accessing care and financial issues
•Refer to prescriber as needed
•Re-assess cognition of goals and plan
•Monitor adherence

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: Making healthy food choices, understanding portion sizes and learning the best times to eat are central to managing diabetes. By making appropriate food selections, children and teenagers grow and develop as they would if they didn't have diabetes. And, by controlling their weight, many adults may be able to manage their condition for a time without medications.
Diabetes self-management education and training classes can assist people with diabetes in gaining knowledge about the effect of food on blood glucose, sources of carbohydrates and fat, appropriate meal planning and resources to assist in making food choices. Skills taught include reading labels, planning and preparing meals, measuring foods for portion control, fat control and carbohydrate counting. Barriers, such as environmental triggers and emotional, financial, and cultural factors, are also addressed.
Being active: Regular activity is important for overall fitness, weight management and blood glucose control. With appropriate levels of exercise, those at risk for type 2 diabetes can reduce that risk, and those with diabetes can improve glycemic control. Being active can also help improve body mass index, enhance weight loss, help control lipids and blood pressure, and reduce stress.
Diabetes educators and their patients collaborate to address barriers, such as physical, environmental, psychological, and time limitations. They also work together to develop an appropriate activity plan that balances food and medication with the activity level.
Monitoring: Daily self-monitoring of blood glucose provides people with diabetes the information they need to assess how food, physical activity, and medications affect their blood glucose levels. Monitoring, however, doesn't stop there. People with diabetes also need to regularly check their blood pressure, urine ketones, and weight.
Diabetes self-management education and training classes instruct patients about equipment choice and selection, timing and frequency of testing, target values, and interpretation and use of results.
Taking medication: Diabetes is a progressive condition. Depending on what type a person has, their healthcare team will be able to determine which medications they should be taking and help them understand how their medications work. They can demonstrate how to inject insulin or explain how diabetes pills work and when to take them. Effective drug therapy in combination with healthy lifestyle choices, can lower blood glucose levels, reduce the risk for diabetes complications, and produce other clinical benefits.
The goal is for the patient to be knowledgeable about each medication, including its action, side effects, efficacy, toxicity, prescribed dosage, appropriate timing and frequency of administration, effect of missed and delayed doses, and instructions for storage, travel, and safety.
Problem solving: A person with diabetes must keep their problem-solving skills sharp because on any given day, a high or low blood glucose episode or a sick day will require them to make rapid, informed decisions about food, activity, and medications. This skill is continuously put to use because even after decades of living with the disease, stability is never fully attained; the disease is progressive, chronic complications emerge, life situations change, and the patient is aging. Collaboratively, diabetes educators and patients address barriers, such as physical, emotional, cognitive, and financial obstacles and develop coping strategies.

References:

American Association of Diabetes Educators. The Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators. 2011. Available at:
http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/Scope Standards_Final2_1_11.pdf. (4)25.
American Association of Diabetes Educators. AADE7 System. Available at:
http://www.diabeteseducator.org/ProfessionalResources/AADE7/A7S.html.(4)
American Association of Diabetes Educator, Guidelines for the Practice of Diabetes Education
www.diabeteseducator.org

A. A DEFINITION OF THE PROBLEM AND WHY REGULATION IS NECESSARY:

In 2010 there were 517,804 people in Washington State with diabetes. The estimated total medical and indirect societal costs associated were $4.99 billion.[i] By 2015 it is estimated that the prevalence will increase to 670,492 or 9.65% of the population growing the projected healthcare costs to $6.49 billion.[ii] Initiating quality diabetes self-management training (DSMT) for these patients in a timely manner is imperative to reducing healthcare costs and improving patient outcomes and overall quality of life.[iii] Currently in Washington the quality of diabetes education varies greatly and in some cases at the expense of the patient and increased cost to the State's budget.

DSMT is a complex service given by qualified healthcare professionals. It is very important that the health care professionals who set themselves out as diabetes educators be well educated and appropriately licensed in the delivery of DSMT. Currently, there is nothing in the Washington State regulations that regulates the delivery of DSMT so persons with diabetes could, and do, get misinformed about the steps necessary to manage their disease thereby adding to the risks of harmful comorbidities and increasing the hospital costs to the state and the patient.

All health care providers need sufficient diabetes knowledge to provide safe, competent care to persons with or at risk for diabetes. Licensure of the diabetes educator will provide minimum standards for patient safety and for recognition of the professional. This will also serve to address the current workforce shortage of qualified professionals who can deliver diabetes education.

B. THE NATURE OF THE POTENTIAL HARM TO THE PUBLIC IF THE BUSINESS PROFESSION IS NOT REGULATED, AND THE EXTENT TO WHICH THERE IS A THREAT TO PUBLIC HEALTH AND SAFETY:

Diabetes is a complex chronic disease and living well with diabetes requires active, diligent, effective self-management. The initiation of DSMT by a qualified professional can greatly affect outcomes for people with diabetes by teaching these self-management skills. We know that poorly managed diabetes can lead to costly kidney failure, non-traumatic limb amputations and is a major cause of heart disease and stroke. Diabetes is also the 7th leading cause of death in United States.

With no control over who can provide this critical service the State of Washington's constituency with diabetes and pre-diabetes are at a great risk for falling victim to the disease and its comorbidities.

Examples of Potential Harm:

- Insulin pump mismanagement
- Medication mismanagement
- Incorrect exercise recommendations
- Mismanagement of Meal Modifications
- Ineffective nutritional therapy
- Misunderstanding A1c testing

EXAMPLES OF ACTUAL HARM AS RESULT OF INCORRECT INFORMATION/TRAINING/TEACHING BY HEALTH CARE PROFESSIONAL RESULTING FROM LACK OF REGULATION OF DIABETES EDUCATION PRACTICE:

CASE #1

Individual names are deleted from this acutal incident due to Hippa laws of confidentiality. However, the Insulin Pump Expert, Diabetes Educator who reported this incident and the patient are both willing and able to present testamony at the "Sunrise Review Public Hearing" and if needed sign an affidavit.

PATIENT: 20 year-old female

COMPLAINTS PRESENTED TO PRACTITIONER IN QUESTION: Pt. received an insulin pump upgrade and needed assistance with insulin pump programing.

PRACTITIONER/SALESPERSON: Medical Assistant in a Physician office

DIAGNOSTIC METHODS USED: Medical assistant had a mother that utilized an insulin pump and felt that she was qualified to program this patient's insulin pump.

DIAGNOSIS: the medical assistant programmed Insulin pump incorrectly.

TREATMENT PRESCRIBED: Medical assistant programed the pump to deliver 2.125 units of insulin over 24 hours instead of 21.25 units of insulin over 24 hours.

MONETARY COST: Approximately $12,000 for inpatient treatment of diabetic ketoacidosis (DKA) related to the patient not receiving adequate insulin because the insulin pump was programmed incorrectly.

RESULTS: Life threatening DKA caused by unqualified medical professional programming a diabetes insulin delivery pump incorrectly.

DIABETES EDUCATOR REPORTING THIS CASE:
CINDY BRINN, MPH RD CDE BCADM
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CASE #2 INDIVIDUAL NAMES ARE DELETED FROM THIS ACUTAL INCIDENT DUE TO HIPPA LAWS OF CONFIDENTIALITY.

I SAW A PATIENT WITH TYPE 2 DIABETES ABOUT 4 YEARS AGO (FOR THE FIRST TIME). SHE HAD PREVIOUSLY SEEN A RD UPON HER DIAGNOSIS OF DIABETES. AT OUR FIRST VISIT I ASKED HER HOW HER BLOOD SUGARS WERE. SHE STATED SHE HAD NOT STARTED CHECKING HER BLOOD GLUCOSE AS SHE WAS TOLD ALL SHE NEEDED TO DO WAS LOSE SOME WEIGHT AND IT WASN'T TIME TO START CHECKING YET. I GOT HER MONITORING HER BLOOD GLUCOSE THAT DAY AND HER BG WAS > 250 MG/DL AND WAS HAVING A VERY DIFFICULT TIME STAYING AWAKE DURING OUR APPOINTMENT. HER A1C WAS AROUND 11%. AFTER SEEING ME FOR 3 MONTHS AND MONITORING HER A1C HAD COME DOWN TO AROUND 7% AND SHE FELT MUCH BETTER AND WAS ALERT DURING OUR ENTIRE APPOINTMENT. NOW 4 YEARS LATER MY PATIENT HAS NEUROPATHY IN HER FEET AND HAS A FAIR AMOUNT OF PAIN RELATED TO THE NEUROPATHY.

THIS RD HAS TOLD PEOPLE SHE IS A DIABETES EDUCATOR YET SHE DOES NOT HAVE THE CREDENTIALS OF CDE, AND DESPITE MY ENCOURAGING HER TO TAKE THE EXAM SHE HAS REFUSED TO GO THE EXTRA MILE FOR HER PATIENTS. I HAVE SEEN SEVERAL PATIENTS IN THE RECENT PAST PREVIOUSLY SEEN BY THIS RD AND SHE HAS TOLD THEM THAT I DON'T REALLY KNOW WHAT I AM DOING WITH DIABETES. I FIND THIS STATEMENT OF HERS TO BE VERY INSULTING AND TOTALLY FALSE AS I HAVE HAD MY CDE SINCE 1994 AND HAVE LIVED WITH TYPE 1 DIABETES SINCE 1988.

THIS RD IS A DANGER TO OUR COMMUNITY WITH DIABETES IF SHE CONTINUES TO GIVE THEM INFORMATION THAT DOES NOT MOVE THEM INTO SELF-MANAGEMENT MODE FOR THEIR DIABETES. ONE REASON FOR LICENSURE WOULD BE TO KEEP THIS

PARTICULAR RD FROM DOING TO OTHER PATIENTS WHAT SHE HAS DONE TO THE PARTICULAR PATIENT.

DIABETES EDUCATOR REPORTING CASE #2

LESLIE MERKLIN-BARBER BSN, RN, CDE
HIGHLINE MEDICAL CENTER
DIABETES NURSE EDUCATOR/
EMPLOYEE HEALTH NURSE
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ADDITIONAL EXAMPLES OF PUBLIC HARM WILL BE ADDED TO THIS REVIEW PRIOR TO THE PUBLIC HEARING

THE EXTENT TO WHICH CONSUMERS NEED AND WILL BENEFIT FROM A METHOD OF REGULATION IDENTIFYING COMPETENT PRACTITIONERS, INDICATING TYPICAL EMPLOYERS, IF ANY, OF PRACTITIONERS IN THE PROFESSION:

The safe and minimum level of understanding of the fundamentals, complexities and competencies of Diabetes Self-Management Training would be a requirement for any person seeking a license to possess. There are many studies that prove the efficacy of DSMT in regards to outcomes on the patients' health as well as cost savings.

Unqualified diabetes educators place an excessive risk on the health, safety and welfare on the persons with diabetes in the State of Washington.

The risks include:

- Misinforming to the extent that it will cause the loss of life
- Higher hospitalization rates and costs
- Increased costs to the patient and states
- Risk in developing a devastating comorbidities

C. THE EXTENT OF AUTONOMY A PRACTITIONER HAS, AS INDICATED BY:

1. THE EXTENT TO WHICH THE PROFESSION CALLS FOR INDEPENDENT JUDGMENT AND THE EXTENT OF SKILL OR EXPERIENCE REQUIRED IN MAKING THE INDEPENDENT JUDGMENT:

Understanding that diabetes is a complex disease and care varies by patient as will the extent of independent judgment. Qualified diabetes educators are highly trained individuals who possess a primary healthcare license in some discipline which include, but are not limited to: registered nurses, registered dietitians, registered pharmacists, licensed mental health professionals, and exercise physiologists. They have gone hours of continuing education, taken competency courses and exams, as well as have years of practical experience in the delivery of Diabetes Self-Management Training.

2. THE EXTENT TO WHICH PRACTITIONERS ARE SUPERVISED:

Diabetes educators are professionals from a variety of health disciplines, including, but not limited to, registered dietitians, registered nurses, registered pharmacists, physicians, mental health professionals, optometrist and exercise physiologists. This varied background greatly affects the extent to which each practitioner is supervised.

3. THE EFFORTS MADE TO ADDRESS THE PROBLEM:

Diabetes educators are highly skilled professionals integral to the multidisciplinary diabetes care team.

The role of the diabetes educator can be assumed by professionals from a variety of health disciplines, including, but not limited to: Registered nurses, registered dietitians, pharmacists, physicians, mental health professionals, podiatrists, optometrists, and exercise physiologists. Some services, such as nutrition counseling, medication counseling and psychological support services, however, may be provided in collaboration with a licensed dietitian, registered pharmacist, a licensed psychologist or social worker, or a psychiatric and mental health clinical nurse specialist or nurse practitioner.

Mastery of the knowledge and skills to be a diabetes educator is obtained through professional practice experience, continuing education, individual study, and mentorship.

Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM).

Unfortunately these voluntary credentials hold no legal standing nor do they have an element of patient protection or legally regulate who can say they are providing this service in a qualified manner.

In addition an attempt to address the value in overall care of the patient with diabetes; cost savings to the healthcare system and access to critical benefit are adequately researched as follows:

SUMMARY

New findings presented at a National Institute of Health (NIH) conference in December 2008, as well as a study slated for publication in early 2009, provide additional compelling evidence that DSMT programs, involving a health team approach that includes credentialed diabetes educators, not only significantly reduce overall health costs but also improve health outcomes. Unfortunately, the findings also show that some aspects of the population most in need of such services underutilize DSMT programs, and that physician awareness of DSMT is limited.

ACTION NEEDED

These findings support the critical need for States to enact legislation to include credentialed diabetes educators as licensed healthcare professionals in order to enhance access to DSMT care that directly impacts diabetes health outcomes and saves money.

FINDINGS

- In a study of over 32,500 high-risk pregnant women with gestational diabetes, DSMT reduced overall pregnancy related health costs by an average of $13 thousand per pregnancy.[iv]
- A 3-year retroactive claims analysis of 4 million covered lives, including 250,000 Medicare beneficiaries, presented at an NIH conference in December 2008, showed an average Medicare cost savings per month/per patient of $135 for those beneficiaries who complete DSMT.[iii]
- Cost savings for inpatient hospital costs, according to the study above, is even more profound, showing savings of $160 per month/per patient. [iii]
- Pharmacy costs for patients in the study above showed a modest increase, as a result of patient adherence to prescribed physician medication regimens. This increase was more than offset by reduced hospitalization and lower overall health expenditures. [iii]
- A systematic review of existing literature on DSMT programs found that 70% of all relevant studies showed DSMT resulted in decreased health care costs.
- Patients who undergo a DSMT program have, at a minimum, a 10% higher adherence and compliance rate with clinically appropriate, evidence based medical treatments to improve their health outcomes. [iii, iv, v] It also includes improvements in risk reduction behaviors, such as blood glucose monitoring and cholesterol monitoring.
- Physician understanding of the role of diabetes education in the treatment of patients with diabetes varies greatly. [iii] This finding supports the ongoing need for legislative support to help educate physicians about DSMT and the need to include credentialed diabetes educators as licensed professionals, to allow them to work more effectively with physician offices to improve patient quality of care.
- Insured patients who are most likely to undergo a DSMT program are younger, female and reside in more affluent areas. [iii] Unfortunately, this means that older, poorer, and --

most likely -- sicker Medicaid beneficiaries do not have access to the type of cost effective, life saving benefits afforded by DSMT.

D. VOLUNTARY EFFORTS, IF ANY, BY MEMBERS OF THE PROFESSION TO:

1. ESTABLISH A CODE OF ETHICS; OR

There is no mandatory code of ethics defined for Diabetes Educators in Washington State. Educators may voluntarily join the American Association of Diabetes Educators. The AADE code of ethics is below:

Members of the American Association of Diabetes Educators accept this Code of Ethics as a statement of the ethical principles of the diabetes education profession. This code represents the values of the profession and provides guidance for the behavior of its members.

- *The diabetes educator provides services with respect for the uniqueness, dignity, and autonomy of each individual as stated in the AADE Scope of Practice for Diabetes Educators.*
- *The diabetes educator will conduct himself/herself in a manner that demonstrates honesty, integrity, and fairness.*
- *The diabetes educator will avoid conflict of interest and maintain the integrity of the profession.*
- *The diabetes educator will accept responsibility and accountability for personal competence in accordance with the AADE Scope of Practice and Standards of Practice for Diabetes Educators.*

2. HELP RESOLVE DISPUTES BETWEEN PRACTITIONERS AND CONSUMERS; AND

In an effort to gain recognition for the qualified diabetes educator and provide an avenue for consumer protection, the American Association of Diabetes Educators has embarked on a state licensure initiative.

Currently the state of Kentucky has passed legislation to require a license to practice diabetes education and there is in the State of Indiana that has passed both the House and Senate and is currently on route to the Governor for a signature.

Without licensure there is no avenue for resolving disputes between the practitioners and consumers. None of the licensing bodies, for the healthcare professionals who are diabetes educators, oversee or regulate the service of DSMT although it is a Medicare benefit at the federal level and some states' Medicaid reimburse for it as well.

3. Recourse to and the extent of use of applicable law and whether it could be strengthened to control the problem;

Being a multidisciplinary specialty there is currently no applicable law that could fix or control the problem outside of legislation and regulation of the profession.

Diabetes educators Licensure is intended for the health care professional who has a defined role as a diabetes educator, not for those who may perform some diabetes related functions as part of or in the course of other routine occupational duties.

E. The alternatives considered:

1. Regulation of business employers or practitioners rather than employee practitioners;

Regulating the business does not serve to ensure that those practicing diabetes education are adequately trained.

Management of diabetes is complex. It is very important that the health care professionals who set themselves out as diabetes educators be well educated and appropriately credentialed in the delivery of quality diabetes education.

2. Regulation of the program or service rather than the individual practitioners;

Again, Regulating the program or service does not serve to ensure that those practicing diabetes education are adequately trained.

3. Registration of all practitioners;

Registration does not provide a scope of practice and minimum provider qualifications.

4. Certification of all practitioners;

Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM).

Unfortunately these voluntary credentials hold no legal standing nor do they have an element of patient protection or legally regulate who can say they are providing this service in a qualified manner.

5. Other alternatives;

See section C subsections 1 through 4

6. WHY THE USE OF THE ALTERNATIVES SPECIFIED IN THIS SUBSECTION WOULD NOT BE ADEQUATE TO PROTECT THE PUBLIC INTEREST; AND

Diabetes education is unique in that its practitioners come from a variety of healthcare disciplines. In Washington State there is no set of enforceable standards to protect the public from a non-qualified individual calling himself or herself a Diabetes Educator and providing poor care.

7. WHY LICENSING WOULD SERVE TO PROTECT THE PUBLIC INTEREST;

Licensure for Diabetes Educators would define a set scope of practice and enforceable standards. It would also provide a much needed consumer protection piece, professional recognition and set the quality guidelines for the profession.

F. THE BENEFIT TO THE PUBLIC IF REGULATION IS GRANTED:

The public would benefit from standardized, evidenced based diabetes education provided by qualified professionals.

1. THE EXTENT TO WHICH THE INCIDENCE OF SPECIFIC PROBLEMS PRESENT IN THE UNREGULATED PROFESSION CAN REASONABLY BE EXPECTED TO BE REDUCED BY REGULATION;

Studies have proven that effective diabetes self-management training (DSMT) management decreases mortality and morbidity and lowers future medical care costs.

Regulating the profession will serve the 517,804 people in Washington State with diabetes by giving them the proper tools to effectively manage their disease. It will also serve to help get a handle $4.99 billion spent on the disease in Washington State.

2. WHETHER THE PUBLIC CAN IDENTIFY QUALIFIED PRACTITIONERS;

Nationally, qualified healthcare professionals may obtain the Certified Diabetes Educator (CDE) or Board Certified in Advanced Diabetes Management (BC-ADM) credential; however the public may not be able to discern the difference between a CDE and some unqualified person who uses the title of Diabetes Educator.

G. THE EXTENT TO WHICH THE PUBLIC CAN BE CONFIDENT THAT QUALIFIED PRACTITIONERS ARE COMPETENT:

1. WHETHER THE PROPOSED REGULATORY ENTITY WOULD BE A BOARD COMPOSED OF MEMBERS OF THE PROFESSION AND PUBLIC MEMBERS, OR A STATE AGENCY, OR BOTH, AND, IF APPROPRIATE, THEIR RESPECTIVE RESPONSIBILITIES IN ADMINISTERING THE SYSTEM OF REGISTRATION, CERTIFICATION, OR LICENSURE, INCLUDING THE COMPOSITION OF THE BOARD AND THE NUMBER OF PUBLIC MEMBERS, IF ANY; THE POWERS AND DUTIES OF THE BOARD OR STATE AGENCY REGARDING EXAMINATIONS AND FOR CAUSE REVOCATION, SUSPENSION, AND NONRENEWAL OF REGISTRATIONS, CERTIFICATES, OR LICENSES; THE PROMULGATION OF RULES AND CANONS OF ETHICS; THE CONDUCT OF INSPECTIONS; THE RECEIPT OF COMPLAINTS AND DISCIPLINARY ACTION TAKEN AGAINST PRACTITIONERS; AND HOW FEES WOULD BE LEVIED AND COLLECTED TO COVER THE EXPENSES OF ADMINISTERING AND OPERATING THE REGULATORY SYSTEM;

In order to ensure that adequate regulations are written the follow recommendations would be submitted for the legislation:

The board would consist of seven (7) members appointed by the governor:

(1) One (1) member who is a physician licensed under
(2) One (1) member who is a registered nurse licensed under
(3) One (1) member who is a pharmacist who has experience in diabetes education.
(4) One (1) member who is a dietitian certified under Washington State Law
(5) One (1) member who:
(A) is a citizen at large;
(B) is not employed in the health care field; and
(C) either:
(i) has diabetes; or
(ii) cares for an individual who has diabetes.
(6) One (1) member who is a nutritionist and is certified by either:
(A) the Certification Board for Nutrition Specialists; or
(B) the American College of Nutrition.
(7) One (1) member who is a psychologist who has experience in diabetes education.
Two (2) of the members appointed must have completed either the credentialing program of the American Association of Diabetes Educators or the National Certification Board for Diabetes Educators.

2. IF THERE IS A GRANDFATHER CLAUSE, WHETHER SUCH PRACTITIONERS WILL BE REQUIRED TO MEET THE PREREQUISITE QUALIFICATIONS ESTABLISHED BY THE REGULATORY ENTITY AT A LATER DATE;

Individuals who are credentialed by the American Association of Diabetes Educators as a board-certified advanced diabetes manager (BC-ADM) or by the National Certification Board for

Diabetes Educators as a certified diabetes educator (CDE), will automatically qualify and may apply to the board for licensure as a diabetes educator by submitting the initial licensure fee and proof of employment, in order to continue to practice diabetes education

3. THE NATURE OF THE STANDARDS PROPOSED FOR REGISTRATION, CERTIFICATION, OR LICENSURE AS COMPARED WITH THE STANDARDS OF OTHER JURISDICTIONS;

4. WHETHER THE REGULATORY ENTITY WOULD BE AUTHORIZED TO ENTER INTO RECIPROCITY AGREEMENTS WITH OTHER JURISDICTIONS; AND

There are no foreseeable reasons that reciprocity agreements with other jurisdictions would be necessary or serve a real benefit.

H. THE NATURE AND DURATION OF ANY TRAINING INCLUDING, BUT NOT LIMITED TO, WHETHER THE TRAINING INCLUDES A SUBSTANTIAL AMOUNT OF SUPERVISED FIELD EXPERIENCE; WHETHER TRAINING PROGRAMS EXIST IN THIS STATE; IF THERE WILL BE AN EXPERIENCE REQUIREMENT; WHETHER THE EXPERIENCE MUST BE ACQUIRED UNDER A REGISTERED, CERTIFICATED, OR LICENSED PRACTITIONER; WHETHER THERE ARE ALTERNATIVE ROUTES OF ENTRY OR METHODS OF MEETING THE PREREQUISITE QUALIFICATIONS; WHETHER ALL APPLICANTS WILL BE REQUIRED TO PASS AN EXAMINATION; AND, IF AN EXAMINATION IS REQUIRED, BY WHOM IT WILL BE DEVELOPED AND HOW THE COSTS OF DEVELOPMENT WILL BE MET;

Diabetes Self-Management Training (DSMT) is a crucial element in the health care of people with diabetes. DSMT is shown to reduce health care costs and deliver health benefits to patients.[v] State licensure sets the quality standards and scope of practice for diabetes educators who wish to provide DSMT. We advocate that state regulatory licensing boards consider the following recommendations:

Discipline

Healthcare professional disciplines include, but are not limited to: registered nurses, registered dietitians, registered pharmacists, licensed mental health professionals, and exercise physiologists.

Education

A bachelor's degree or education that meets the state's healthcare professional licensure requirements for the primary discipline. Completion of AADE's Core Concepts Course or a diabetes education program sponsored by any advanced academic or continuing education

organization that meets state-determined standards and provides a minimum of 15 hours of learning in the biological and social sciences, communication, counseling, and education.

15 hours of continuing education related to diabetes self-management education and training each year.

Professional Practice Experience

Completion of a comprehensive diabetes education course and demonstrative supervised experience as set by the licensure board.

Having already passed a licensing exam for their primary health care discipline diabetes educator licensure would not need an exam only to prove they have met the aforementioned requirements. An examination would only serve to put an unnecessary line item on the state's budget and increase the costs of a license for the professional thereby deterring entry to the field and reducing access to this critical benefit.

1. Assurance of the public that practitioners have maintained their competence:

By establishing a licensure board and regulating the profession the public can be assured through the application process that the practitioners have maintained their competence. The requirements for licensure provide a sufficient minimum baseline for determining competency.

2. Whether the registration, certification, or licensure will carry an expiration date; and

Licenses will be renewed every two years to further ensure that practitioners have maintained their competence and are current in changes in the field and delivery of DSMT,

3. Whether renewal will be based only upon payment of a fee, or whether renewal will involve reexamination, peer review, or other enforcement;

Renewal will be based on a renewal fee as well as meeting the continuing education requirements set in the recommended regulation.

I. The extent to which regulation might harm the public:

The licensing and regulation of diabetes education is not intended to cause any harm to the public. In fact, regulating the profession will provide a much-needed level of public safety that currently does not exist.

J. The extent to which regulation will restrict entry into the profession:

Regulating the profession of diabetes educators does not restrict entry into the profession. It is intended to encourage entry into the field and address the current workforce shortage of qualified professionals who can deliver diabetes education.

As previously stated: by 2015 it is estimated that the prevalence in Washington State will increase to 670,492 or 9.65% of the population growing the projected healthcare costs to $6.49 billion. Initiating quality diabetes self-management training (DSMT) for these patients in a timely manner is imperative to reducing healthcare costs and improving patient outcomes and overall quality of life.

1. WHETHER THE PROPOSED STANDARDS ARE MORE RESTRICTIVE THAN NECESSARY TO INSURE SAFE AND EFFECTIVE PERFORMANCE; AND

The proposed standards for licensure of Diabetes Educators are not more restrictive than necessary to insure safe and effective performance. The license also is non-intrusive on healthcare professionals holding a license in the state of Washington. Licensure only serves to expand the scope of practice for those individuals who set themselves out as a diabetes educator.

a. WHETHER THE PROPOSED LEGISLATION REQUIRES REGISTERED, CERTIFICATED, OR LICENSED PRACTITIONERS IN OTHER JURISDICTIONS WHO MIGRATE TO THIS STATE TO QUALIFY IN THE SAME MANNER AS STATE APPLICANTS FOR REGISTRATION, CERTIFICATION, AND LICENSURE WHEN THE OTHER JURISDICTION HAS SUBSTANTIALLY EQUIVALENT REQUIREMENTS FOR REGISTRATION, CERTIFICATION, OR LICENSURE AS THOSE IN THIS STATE; AND

Yes. As previously stated Management of diabetes is complex. It is very important that the health care professionals who set themselves out as diabetes educators be well educated and appropriately credentialed in the delivery of quality diabetes education.

b. WHETHER THERE ARE SIMILAR PROFESSIONS TO THAT OF THE APPLICANT GROUP WHICH SHOULD BE INCLUDED IN, OR PORTIONS OF THE APPLICANT GROUP WHICH SHOULD BE EXCLUDED FROM, THE PROPOSED LEGISLATION;

Included: Registered Dietitians, Registered Nurses, Pharmacists, Physicians, Podiatrists, Exercise Physiologists, and Licensed Clinical Social Workers or a bachelor's degree or education that meets Washington State's healthcare professional licensure requirements for a primary discipline.

Excluded: The lay person or person that does not hold a bachelor's degree or education that meets Washington State's healthcare professional licensure requirements for a primary discipline.

K. THE MAINTENANCE OF STANDARDS:

1. WHETHER EFFECTIVE QUALITY ASSURANCE STANDARDS EXIST IN THE PROFESSION, SUCH AS LEGAL REQUIREMENTS ASSOCIATED WITH SPECIFIC PROGRAMS THAT DEFINE OR ENFORCE STANDARDS, OR A CODE OF ETHICS; AND

There is an adequate template the Washington State Licensing Board for Diabetes Educators can use as a catalyst for quality assurance in defining standards and a code of ethics.

There is no mandatory code of ethics defined for Diabetes Educators in Washington State. Educators may voluntarily join the American Association of Diabetes Educators. The AADE code of ethics is below:

Members of the American Association of Diabetes Educators accept this Code of Ethics as a statement of the ethical principles of the diabetes education profession. This code represents the values of the profession and provides guidance for the behavior of its members.

- The diabetes educator provides services with respect for the uniqueness, dignity, and autonomy of each individual as stated in the AADE Scope of Practice for Diabetes Educators.
- The diabetes educator will conduct himself/herself in a manner that demonstrates honesty, integrity, and fairness.
- The diabetes educator will avoid conflict of interest and maintain the integrity of the profession.
- The diabetes educator will accept responsibility and accountability for personal competence in accordance with the AADE Scope of Practice and Standards of Practice for Diabetes Educators.

2. HOW THE PROPOSED LEGISLATION WILL ASSURE QUALITY:

The proposed legislation will ensure quality by developing a legal scope of practice, education requirements, continuing education requirements, and establishing an outlet for consumers reporting. Additionally, there will be a regulatory body overseeing the process and providing continuous quality improvement in regulating the standards as well as those who are licensed.

a. THE EXTENT TO WHICH A CODE OF ETHICS, IF ANY, WILL BE ADOPTED; AND

The code of ethics, with the guidance of national accredited organizations, will be developed during the regulatory process.

b. THE GROUNDS FOR SUSPENSION OR REVOCATION OF REGISTRATION, CERTIFICATION, OR LICENSURE;

The initial grounds for suspension or revocation would be failure to comply with continuing education requirements, practicing outside of the defined scope of practice or a failure to comply with licensure fees. Additionally, consumer complaints will be investigated and could result in suspension or revocation of the license.

L. A DESCRIPTION OF THE GROUP PROPOSED FOR REGULATION, INCLUDING A LIST OF ASSOCIATIONS, ORGANIZATIONS, AND OTHER GROUPS REPRESENTING THE PRACTITIONERS IN THIS STATE, AN ESTIMATE OF THE NUMBER OF PRACTITIONERS IN EACH GROUP, AND WHETHER THE GROUPS REPRESENT DIFFERENT LEVELS OF PRACTICE; AND

Diabetes Educators:

Diabetes educators are healthcare professionals who have experience in the care of people with diabetes and have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling and education. The role of a diabetes educator can be assumed by professionals from a variety of health disciplines including, but not limited to, registered nurses, registered dietitians, registered pharmacists, physicians, mental health professionals, podiatrists and exercise physiologists.

Organizations listed but not limited to:

- Washington Association of Diabetes Educators: 330 members
- American Association of Diabetes Educators: 14,500 national members
- Washington State Dietetic Association
- Washington State Pharmacists Association
- Washington State Mental Health Professionals
- Washington State Podiatrists
- Washington State Exercise Physiologists
- Washington State Nurses Association

M. THE EXPECTED COSTS OF REGULATION:

a. THE IMPACT REGISTRATION, CERTIFICATION, OR LICENSURE WILL HAVE ON THE COSTS OF THE SERVICES TO THE PUBLIC; AND

Licensure of diabetes educators is not expected to impose an additional cost to the public. By increasing access to DSMT there will be a cost savings over time by reducing the complications and hospitalization rates associated with diabetes.

b. THE COST TO THE STATE AND TO THE GENERAL PUBLIC OF IMPLEMENTING THE PROPOSED LEGISLATION.

Licensure of diabetes educators is not expected to impose additional costs to the state or general public. Implementation of the proposed legislation will be factored into the cost to the professional pursuing licensure. Cost is expected to be $50.00 not more that $100.00 for two years.

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[i] Source: U.S. Diabetes Index, March 2013. ©2011 National Minority Quality Forum, Inc. All rights reserved Patent Pending.

[ii] Economic Costs of Diabetes in the U.S.in 2012 http://www.diabetes.org/advocate/resources/cost-of-diabetes.html

[iii] Assessing the Value of Diabetes Educators and Diabetes Self-management Education/Training, Ian Duncan FSA FIA FCIA MAAA; Solucia Inc.; Christian Birkmeyer, MA, Solucia Inc; Suzanne Austin Boren, PhD, University of Missouri; Karen Fitzner, PhD, American Association of Diabetes Educators. Poster NIH Disparities Conference, Dec 16-20, 2008, Washington DC.

[iv] An Assessment of Patient Education and Self-management in Diabetes Disease Management, Karen Fitzner, PhD; Deborah Greenwood, Med, APRN, BCADM, CDE; Hildegarde Payne, RN, MA, CDE; John Thomson, Lana Vukovijak, MA, MS; Amber McCulloch; James Specker, Population Health Management, Volume 11, 2008.

[v] Costs and Benefits Associated with Diabetes Education, Suzanne Boren, PhD; Karen Fitzner, PhD; Pallavi Panhalkar; James Specker. Publication date: 2009 The Diabetes Educator.

State of
Washington
House of
Representatives

June 12, 2013

John Wiesman, DrPH, MPH
Secretary
Department of Health
P.O. Box 47890
Olympia, Washington 98504-7890

Dear Secretary Wiesman:

I am requesting that the Department of Health consider a Sunrise Review application for a proposal that would require diabetes educators to become licensed. The proposal, H-1847.3/13, applies the licensure requirement to individuals who develop plans of care for persons with or at risk of diabetes and conduct self-management training for those persons. To become a diabetes educator, the individual must meet education and supervised experience requirements established in the proposal.

The Health Care and Wellness Committee is interested in an assessment of whether or not the proposal meets the sunrise criteria to justify the regulation of this profession. The Washington Association of Diabetes Educators will be submitting a proposal to the Department to support the Sunrise Review.

I appreciate your consideration of this request and I look forward to receiving your report. Please contact my office if you have any questions.

Sincerely,

Eileen Cody

EILEEN CODY, Chair
House Health Care and Wellness Committee

Cc: Donna Christensen
Christopher Blake
Jim Morishima

Appendix B

Proposed Bill

BILL REQUEST - CODE REVISER'S OFFICE

BILL REQ. #: H-1847.3/13 3rd draft

ATTY/TYPIST: AL:lel

BRIEF DESCRIPTION: Requiring diabetes educators to be licensed.

AN ACT Relating to creating license requirements for the practice of diabetes education; adding a new chapter to Title 18 RCW; and prescribing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The legislature finds that:

(1) Diabetes education, also known as diabetes self-management training or diabetes self-management education, is defined as 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. Diabetes education is an interactive, ongoing process involving the person with diabetes or the caregiver or family and a diabetes educator or educators. The intervention is proven to achieve optimal health status, better quality of life, and drastically reduce the need for costly health care;

(2) Diabetes educators are health care professionals who focus on helping people with and at risk for diabetes and related conditions

achieve behavior change goals which, in turn, lead to better clinical outcomes, improved health status, and reduce the economic burden of diabetes and its related conditions. Diabetes educators apply in-depth knowledge and skills in the biological and social sciences, communication, counseling, and education to provide self-management education/self-management training; and

(3) All health care providers need sufficient diabetes knowledge to provide safe, competent care to persons with or at risk for diabetes. Licensure of diabetes educators will provide minimum standards for patient safety and for recognizing a health care professional that can legally provide all of the aspects of diabetes self-management training. This will also address the current workforce shortage of qualified professionals who can deliver diabetes education.

NEW SECTION. **Sec. 2.** The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Accredited training programs" means diabetes self-management training and education programs which are accredited as meeting quality standards of a centers for medicare and medicaid services-approved national accrediting organization, which includes, but is not limited to, the American diabetes association and the American association of diabetes educators.

(2) "Board" means the Washington state board of licensed diabetes educators.

(3) "Department" means the department of health.

(4) "Diabetes education" means a comprehensive 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.

(5) "Diabetes educator" means a person who is educated and trained in accordance with the department as set by the board.

(6) "Licensed diabetes educator" means a health care professional who has met the requirements of section 6 of this act and who focuses on training or educating people with or at risk for diabetes and

related conditions to change their behavior to achieve better clinical outcomes and improved health status.

(7) "Practice of diabetes education" means assessing and developing a plan of care for a person with or at risk of diabetes, identifying self-management goals for the person, providing self-management training according to the plan, evaluating the individual's outcome, and recording a complete record of the individual's experience and follow-ups.

(8) "Supervisor" means the legally enabled health care provider who provides mentoring and general oversight for the delivery of appropriate, effective, ethical, and safe patient care.

NEW SECTION. **Sec. 3.** (1) No person may represent himself or herself as a licensed diabetes educator or use any title or description of services without applying for licensure, meeting the required qualifications, and being licensed as a diabetes educator by the board, unless otherwise exempted by this chapter.

(2) A nondiabetes educator health care professional or a nonhealth care professional who provides or supports health care services to individuals with diabetes as defined by the American association of diabetes educators, competencies for diabetes educators, must work under the direction of a licensed diabetes care provider.

NEW SECTION. **Sec. 4.** (1) This chapter does not modify or alter the practice of a person licensed, certified, or registered in a health care discipline in the state of Washington including, but not limited to, physicians, nurses, pharmacists, dietitians, psychiatrists, clinical social workers, or students in accredited training programs in those professions, and nothing in this chapter may be construed to limit, interfere with, or restrict the practice, descriptions of services, or manner in which they hold themselves out to the public.

(2) Nothing in this chapter may be construed to alter, amend, or interfere with the legal practice of those who provide health care

services, including but not limited to physicians, nurses, pharmacists, dietitians, psychiatrists, and clinical social workers.

(3) This chapter does not apply to activities and services of an accredited institution of higher education as part of a program of studies.

NEW SECTION. **Sec. 5.** (1) The Washington state board of licensed diabetes educators is established.

(2) The board consists of five members appointed by the governor as follows:

(a) One member who is a physician licensed under chapter 18.71 RCW;

(b) One member who is a registered nurse licensed under chapter 18.79 RCW;

(c) One member who is a pharmacist licensed under chapter 18.64 RCW;

(d) One member who is a dietitian certified under chapter 18.138 RCW;

(e) One member who is a citizen at large who is not employed in the health care field.

(3) Two of the members appointed under subsection (2)(a) through (d) of this section must have completed either the credentialing program of the American association of diabetes educators or the national certification board for diabetes educators.

(4) Each member of the board serves a term of four years or until a successor is appointed. The governor shall initially appoint:

(a) Two members for a term of four years;

(b) Two members for a term of three years; and

(c) One member for a term of two years.

(5) A member may not serve for more than two consecutive terms.

(6) The board shall organize annually and elect one of the members as chairperson and one of the members as secretary.

(7) A quorum consists of three members.

(8) The board shall meet at least semiannually and upon the call of the chairperson or at the request of two members.

(9) The board shall adopt rules establishing:

(a) Standards for professional responsibility or a code of ethics for the profession of diabetes educator;

(b) Standards of practice that are based upon the scope of practice, standards of practice, and standards of professional performance for diabetes educators adopted by the American association of diabetes educators; and

(c) Standards for continuing education requirements for diabetes educators.

(10) The board shall adopt rules to establish fees for:

(a) Filing an application for licensure under this chapter;

(b) Issuing an original license under this chapter;

(c) Renewing a license issued under this chapter;

(d) Replacing a license that has been lost or destroyed; and

(e) Any other purposes prescribed by this chapter.

(11) The board shall investigate alleged violations brought under this chapter, conduct investigations, and schedule and conduct administrative hearings under chapter 34.05 RCW.

(12) The board shall keep a record of:

(a) The proceedings of the board; and

(b) All individuals licensed by the board.

NEW SECTION. **Sec. 6.** (1) After the effective date of this section, a person may not use the title of "licensed diabetes educator" or profess to be a licensed diabetes educator unless the person holds a license under this chapter.

(2) An application for an original license must be made to the department in writing on a form prescribed by the department and must be accompanied by the required fee, which is not refundable. An application must require information that in the judgment of the department will enable the board to pass judgment on the qualifications of the applicant for a license.

(3) An applicant must provide evidence to the board showing the following:

(a) Discipline: A health care professional qualified to provide aspects of diabetes self-management training or diabetes self-management education under the laws of the state including, but not limited to, physicians, registered nurses, registered or licensed dietitians, registered pharmacists, licensed mental health professionals, and exercise physiologists.

(b) Education: A bachelor's degree or education that meets the state's health care professional licensure requirements for the primary discipline.

(c) Professional practice experience: Completion of a comprehensive diabetes education course and demonstrative supervised experience as set by the licensure board.

(d) Requirements established by the board, including a core body of knowledge and skills in:

(i) The biological and social sciences;

(ii) Communication;

(iii) Counseling;

(iv) Education; and

(v) Experience in the care of individuals with diabetes.

(4) A license issued under this chapter is valid for two years after the date of issuance.

(5) The board shall require each licensee to complete annually fifteen hours of board-approved continuing education.

NEW SECTION. **Sec. 7.** (1) For purposes of this section, "unprofessional conduct" includes:

(a) Obtaining or attempting to obtain a license by fraud, misrepresentation, concealment of material facts, or making a false statement to the board;

(b) Conviction of a felony if the conviction has direct bearing on whether the person is trustworthy to serve the public as a licensed diabetes educator;

(c) Violation of any lawful order issued or rule adopted by the board.

(2) The board may:

(a) Suspend or revoke a license; or

(b) Issue a reprimand if the licensee engages in unprofessional conduct that has endangered or is likely to endanger the health, welfare, or safety of the public.

(3) A person who recklessly, knowingly, or intentionally violates this chapter is guilty of a misdemeanor.

NEW SECTION. **Sec. 8.** (1) Notwithstanding section 6 (3) and (4) of this act, prior to the effective date of this section, a person who the board finds to have successfully achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education, by training or instruction, as well as experience in the care of people with diabetes under supervision that meets the requirements specified in administrative rules adopted by the board, may be issued an initial license by the board upon payment of an initial licensing fee, completion of a written application on forms provided by the board, and submission of any other information requested by the board.

(2) Notwithstanding section 6 (3) and (4) of this act, individuals who are credentialed by the American association of diabetes educators as a board-certified advanced diabetes manager or by the national certification board for diabetes educators as a certified diabetes educator will automatically qualify and may apply to the board for licensure as a diabetes educator by submitting the initial licensure fee and proof of employment, in order to continue to practice diabetes education.

NEW SECTION. **Sec. 9.** Sections 1 through 8 of this act constitute a new chapter in Title 18 RCW.

Appendix C

Applicant Follow Up

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Mrs. Thomas:

On behalf of the Washington Association of Diabetes Educators (WADE) we would like to extend our gratitude for your departments public hearing and review of the issue of licensing diabetes educators in your state. We are extremely appreciative of the opportunity to present our case before the panel of experts from the department of health and interested parties from the general public. We feel that the concerns raised and the questions asked gave us an invaluable awareness of the state of diabetes in Washington. In addition we do believe we effectively communicated an awareness of the need to ensure that those giving diabetes education (American Association of Diabetes Educators, 2007) are adequately trained and educated and at the same time are more cognizant of the areas that need to be communicated in a more transparent manner.

We also appreciate the opportunity to follow-up to the questions, concerns, public comments and letters that were submitted on the issue. We hope the following as well as the supplementary documents serve to address these concerns as well as shed a brighter light on the areas where there was some confusion over the proposed regulations and requirements.

DEFINITION OF "QUALITY"

Quality in the context of diabetes education is defined by the American Association of Diabetes Educators Competencies for Diabetes Educators document (American Association of Diabetes Educators , 2010). That is this designation includes healthcare professionals who have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education and who have experience in the care of people with diabetes.

These individuals have completed 250 hours of DSME/T related work experience within a two year timeframe and meet practice standards based on state/local regulations for specific health care disciplines.

In addition these quality and qualified HCPs complete 40 hours of continuing education related to diabetes and/or DSME/T within a two year timeframe.

PERCENTAGES OF CDE VS BC-ADM BOTH STATE AND NATIONAL

60.1 % of the 589 qualified (or quality) diabetes educators in the State of Washington currently holds a CDE or BC-ADM.54.16% of the roughly 30,000 qualified (or quality) diabetes educators in the United States currently hold a CDE or BC-ADM

Currently there are 589 CDEs and 26 BC-ADMs in the state of Washington compared to 17,000 CDEs and 725 BC-ADMs in the United States.

WILL A LICENSED DE BE ABLE TO WORK SOLO?

Diabetes Self-Management Education and Support is always coordinated through a physician or qualified non-physician practitioner.

The National Standards for Diabetes Self-Management Education and Support states:

STANDARD 7

"The Diabetes Educational Process is comprised of an individualized assessment, goal setting, development of an educational plan, implementation of the educational plan and evaluation of the effectiveness of the DSMT interventions. The process is collaborative between/among the participant and instructor/s. An integral part of the process includes documentation in the education/medical/clinical record which promotes continuity of care.

Communication back to the referring physician and other members of the diabetes care team is essential to high quality patient care and optimal health outcomes and demonstrated within the education process and patient charts." (Linda Haas, 2012)

STANDARD 8

"There shall be documentation that identifies that the patient's outcomes and goals, and the plan for DSMS are communicated to the referring physician (or qualified non-physician practitioner)."

"Must submit a policy for personalized process and on-going self-management support strategies and communication of educational services to physician/ qualified non-physician practitioner" (Linda Haas, 2012)

WOULD DE LICENSURE BE A BARRIER IN RURAL COMMUNITIES IN REGARDS TO DIABETES EDUCATION?

No. Not only would it open opportunities for those in rural areas to get the quality and adequate care they deserve through the use of telehealth/telemedicine technologies which Washington has already adopted at certain facilities for a number of services including Endocrinology and Diabetes. It also has the opportunity to incentivize this benefit by encouraging more qualified HCPs to seek out advanced training and education in the care of persons with diabetes thereby increasing access to those in rural areas where there is the greatest prevalence.

According the "PRACTICE ADVISORY – telehealth and the Impact on Diabetes Self-Management and Training (DSMT)" telehealth is of particular interest to diabetes educators who are searching for ways to increase patient access to their services. telehealth could magnify the reach of educators and help them meet the needs of the ever-growing diabetes population.

The educator is an essential part of the diabetes care team that participates in providing DSMT, both in-person and via telehealth. The primary challenge is that current telehealth regulations do not allow certain healthcare professional, such as RNs or pharmacists to provide DSMT via telehealth within an accredited program. (American Association of Diabetes Educators, 2011)

PERCEPTION OF WHAT INVOLVES THE "RISK FACTORS" FOR DIABETES. A RESPONSE TO THE STATEMENT MADE THAT "EVERYONE IS AT RISK FOR DIABETES."

Although conceptually everyone is "at risk" for diabetes we have to follow the scientific research and fact-based evidence of the statistical probability for those who are "at risk" developing the disease.

Evidence shows that obesity, genetic predisposition, ethnic background (Diabetes occurs more often in Hispanic/Latino Americans, African-Americans, Native Americans, Asian-Americans, Pacific Islanders, and Alaska natives), and Age are the most common reasons for developing type-2 diabetes.

Given the demographic of Washington State having access to this service would not only help to reduce the onset of the comorbidities associated with diabetes and reduce the economic impact it would also serve to prevent a person from developing full diabetes at the point of being diagnosed with pre-diabetes by their physician or qualified non-physician practitioner.

Physicians, qualified non-physician practitioners and qualified diabetes educators consider risk factors that make an individual at higher risk than the general public for diabetes. The Mayo Clinic asserts:

The same factors that increase the risk of developing type 2 diabetes increase the risk of developing pre-diabetes, including:

- Extra weight. Being overweight is a primary risk factor for pre-diabetes. The more fatty tissue you have — especially inside and between the muscle and skin around your abdomen — the more resistant your cells become to insulin.
- Inactivity. The less active you are, the greater your risk of pre-diabetes. Physical activity helps you control your weight, uses up glucose as energy and makes your cells more sensitive to insulin.
- Advancing age. The risk of pre-diabetes increases as you get older, especially after age 45. This may be because people tend to exercise less, lose muscle mass and gain weight as they age. However, older people aren't the only ones at risk of pre-diabetes and type 2 diabetes. The incidence of these disorders is also rising in younger age groups.
- Family history. The risk of pre-diabetes increases if a parent or sibling has type 2 diabetes.
- Race. Although it's unclear why, people of certain races — including African-Americans, Hispanics, American Indians, Asian-Americans and Pacific Islanders — are more likely to develop pre-diabetes.
- Gestational diabetes. If you developed gestational diabetes when you were pregnant, your risk of later developing diabetes increases. If you gave birth to a baby who weighed more than 9 pounds (4.1 kilograms), you're also at increased risk of diabetes.
- Polycystic ovary syndrome. For women, having polycystic ovary syndrome — a common condition characterized by irregular menstrual periods, excess hair growth and obesity — increases the risk of diabetes.
- Sleep. Several recent studies have linked a lack of sleep or too much sleep to an increased risk of insulin resistance. Research suggests that regularly sleeping fewer than six hours or more than nine hours a night might up your risk of pre-diabetes or type 2 diabetes.

Other conditions associated with diabetes include:

- High blood pressure
- Low levels of HDL, or the "good" cholesterol

- High levels of triglycerides — a type of fat in your blood

When these conditions — high blood pressure, high blood sugar, and abnormal blood fats and cholesterol — occur together along with obesity, they are associated with resistance to insulin. This is often referred to as metabolic syndrome (Mayo Clinic Staff).

RESPONSE TO THE PERCEPTION THAT A LICENSED DIABETES EDUCATOR WOULD NEED TO SUPERVISE ANYONE GIVING DIABETES EDUCATION IN ANY VENUE

The care of a person with diabetes should always be supervised by, and coordinated through, the physician/qualified non-physician practitioner.

The Licensed Diabetes Educator would only supervise those community, lay, or peer workers without training in health or diabetes who are participate in the provision of diabetes self-management education/training (DSME/T) and provide diabetes self-management support (DSMS) (Linda Haas, 2012)

RESPONSE TO THE PERCEPTION THAT LICENSED DIABETES EDUCATOR INTENDS TO LEGISLATE ONE SPECIFIC CHRONIC DISEASE THEREBY LIMITING ACCESS TO VALUABLE EDUCATION IN DIABETES SELF-MANAGEMENT

Diabetes Self-Management Training and Support will not conflict with existing programs or treatment of other chronic diseases. The intent of licensure is to ensure that the person with diabetes is receiving an enhanced level of education by a qualified individual to assist with the management and reduce the incidence of developing a more harmful and costly comorbidity.

The fact is that Diabetes Self-Management Support overlaps and reinforces with some other chronic illnesses to better manage all aspects of those diseases to improve health. If you have diabetes you have the risk factors for heart disease, depression, dementia, and others which will improve when the expertise of the educator can help develop the behaviors and habits that make a difference for better health covering all other chronic illnesses

WADE'S RESPONSE TO THE PERCEPTION THAT LICENSED DIABETES EDUCATOR WOULD MEAN THAT RNS AND OTHERS WHO GIVE DIABETES EDUCATION AS A FUNCTION OF THEIR JOB WOULD NEED TO OBTAIN A DE LICENSE OR BE SUPERVISED BY A LICENSED DIABETES EDUCATOR

No. The licensure is to ensure that in those cases where the recommended team approach to DSMT is not being given that the person facilitating the case through the physician/ qualified non-physician practitioner is adequately trained in all of the aspects of Diabetes Self-Management Training. Although the National Standards and Guidelines recommend the team approach

> The individual serving as the coordinator will have knowledge of the lifelong process of managing a chronic disease and facilitating behavior change, in addition to experience with program and/or clinical management. In some cases, particularly solo or other small practices, the coordinator may also provide DSME and/or DSMS. (Linda Haas, 2012, p. 622)
>
> Expert consensus supports the need for specialized diabetes and educational training beyond academic preparation for the primary instructors on the diabetes team. Professionals serving as instructors must document appropriate continuing education or comparable activities to ensure their continuing competence to serve in their instructional, training, and oversight roles. (Linda Haas, 2012, p. 622)

THE PERCEPTION THAT THE 250 HOURS OF PRACTICE IS NOT ENOUGH

The 250 hours (plus competency courses and continuing education) are based on a national average of comparable licensing requirements and supported by the AADE competencies for diabetes education. As the aforementioned states quality is defined as healthcare professionals who have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education and who have experience in the care of people with diabetes.

These individuals have completed 250 hours of DSME/T related work experience within a two year timeframe and meet practice standards based on state/local regulations for specific health care disciplines.

In addition these quality and qualified HCPs complete 40 hours of continuing education related to diabetes and/or DSME/T within a two year timeframe.

At this level the qualified (or quality) diabetes educator falls within five main domains that include pathophysiology, epidemiology, and clinical guidelines of diabetes; culturally competent supportive care across the lifespan; teaching and learning skills; self-management education; and program and business

Domain I: Pathophysiology, Epidemiology, and Clinical Guidelines of Diabetes

<u>Pathophysiology</u>

1. Outlines the pathophysiology of gestational diabetes and its relationship to the development of type 2 diabetes
2. Describes the pathophysiologic basis of hypoglycemia, DKA, and HHS
3. Explains the relationship between chronic hyperglycemia and the development of chronic complications
4. Relates particular signs and symptoms to specific long-term complications of uncontrolled diabetes

<u>Epidemiology of Diabetes Disease State</u>

1. Organizes community screening events
2. Defines community
3. Facilitates diabetes education referral networks on a community and/or regional level

<u>Clinical Practice Guidelines</u>

1. Implements evidence-based clinical practice guidelines to provide diabetes education in a variety of patient care settings
2. Examines agency-specific policies and procedures for consistency with established guidelines
3. Critically appraises current diabetes-related research for use in practice
4. Applies clinical practice guidelines to the evaluation of program, unit, or agency

Domain II: Culturally-Competent Supportive Care Across the Lifespan

<u>Lifespan</u>

1. Uses age-appropriate theories for information, application, health, and chronic disease self-management education
2. Assists patients to develop coping skills appropriate for chronologic and developmental age

3. Identifies effective community support systems
4. Acknowledges relationship between rising rates of obesity and diabetes throughout the life cycle

Culture

1. Assesses impact of social, economic, and cultural aspects/circumstances
2. Ensures that DSME/T is provided in a culturally-competent fashion
3. Works with community groups to meet the needs of specific cultural populations and remove barriers

Domain III: Teaching and Learning Skills

Teaching and Learning

1. Assesses patient's diabetes self-management education needs, attitude toward learning, and preferred learning style
2. Assesses patient's readiness for and barriers to learning
3. Develops basic plan related to acquiring necessary diabetes management skills based on needs identified in assessment
4. Applies fundamental principles of adult and/or child learning theories and instructional strategies to provide essential DSME/T for patients with chronic, stable diabetes mellitus
5. Expands on knowledge and basic skill acquisition with continued focus on survival skills and greater attention to more complex self-management tasks

Behavior Change

1. Assesses patient's readiness to change
2. Assists patients to identify barriers to change
3. Demonstrates familiarity with skills, techniques, and strategies to facilitate behavior change and assist patients with individualized goal setting and evaluation
4. Identifies variety of different frameworks useful for promoting behavior change
5. Develops, implements, and evaluates behavioral goal plan using selected frameworks
6. Guides patient in setting and prioritizing individualized behavioral goals based upon assessment and preference
7. Develops success metrics
8. Begins situational problem-solving using more advanced thinking skills

Domain IV: Self-Management Education

Healthy Eating

1. Provides instruction about nutrition as a framework to guide patient toward successful management of personal meal plans
2. Assesses patient's ability to follow complex meal plan
3. Provides instruction on completing a food record
4. Introduces fundamental concepts of carbohydrate counting and meal-based insulin dosing
5. Explains the relationship between food, activity, and medication in preventing hypoglycemia
6. Explains interaction of food, activity, and medication

Being Active

1. Explains physiological responses that occur during physical activity for all types of diabetes at different blood glucose levels
2. Assists patient to develop and evaluate a physical activity plan based on individual needs or condition

Monitoring

1. Possesses ability to demonstrate correct use of all blood glucose meters common to geographic area/location
2. Serves as local resource on monitoring-related issues
3. Verifies patient's monitoring technique
4. Assists patients with monitoring-related problem solving
5. Works with patient and diabetes care team to develop appropriate monitoring schedule
6. Assists patient to analyze blood glucose values to explain variations in intake or exercise
7. Uses results of A1C (or equivalent) to reinforce teaching
8. Discusses value of monitoring during periods of illness (i.e., sick day monitoring strategies)
9. Focus on intermediate level skill building, pattern control, CGM or pump consideration, and interpretation

Taking Medications

1. Uses information about common oral and injectable medications for diabetes and co-morbid conditions
1. (i.e., focus is on understanding the relationship between food, exercise, and medications)
2. Instructs patient to safely and correctly prepare and inject insulin using vial and syringe or commonly used insulin pen methods
3. Explains and uses correct site selection and rotation technique
4. Develops algorithm or protocol-based medication adjustments for changes in meal plan or exercise

Reducing Risk

1. Assesses patient's knowledge and skills used to reduce diabetes related risks
2. Clarifies patient's skill accuracy in performing self-blood glucose monitoring and CGM
3. Teaches, reinforces, and validates survival skills, monitoring, medicines, etc.
4. Screens for acute and long-term complications
5. Instructs other members of the healthcare team in proper recognition and treatment of hypoglycemia

Domain V: Program and Business Management

Program Management

1. Demonstrates initiative in implementing a plan for effectively managing a diabetes education program
2. Implements care using the typical strategies and resources available for problem-solving
3. Collaborates with all members of the healthcare team to provide for needed changes in the patient's plan of care
4. Uses evidence to guide the delivery of diabetes care and education
5. Assists with the development, selection, or evaluation of diabetes-related resources
6. Identifies patterns of behavior among staff requiring conflict management

Business Management

1. Works with other agency staff to evaluate safety, effectiveness, and cost relative to diabetes-related materials and equipment
2. Uses expertise in application of sound judgment to decisions related to resource acquisition and use

In closing we hope that the responses provided and the supplemental documents paint a better picture of why there is a need to ensure that persons with diabetes need access to quality diabetes self-management training and that those providing it are adequately trained, educated and credentialed.

We look forward to hearing your recommendations and will take them in high regard as we move forward in this effort.

Respectfully,

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Works Cited

American Association of Diabetes Educators . (2010). *Competencies for Diabetes Educators*. Retrieved from http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/general/Competencies2011.pdf

American Association of Diabetes Educators. (2007). *What is Diabetes Education?* Retrieved August 19, 2013, from AADE: http://www.diabeteseducator.org/DiabetesEducation/Definitions.html

American Association of Diabetes Educators. (2011). *AADE Practice Advisories*. Retrieved August 14, 2013, from Diabetes Educator: http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/research/PRACTICE_ADVISORY_Telehealth.pdf

Linda Haas, M. M. (2012). National Standards for Diabetes Self-Management Education and Support. *The Diabetes Educator*, 619 - 630 .

Mayo Clinic Staff. (n.d.). *Pre-diabetes: Risk Fators*. Retrieved August 16, 2013, from Mayo Clinic: http://www.mayoclinic.com/health/pre-diabetes/DS00624/DSECTION=risk-factors

A STATE COORDINATING BODY of the

AADE American Association of Diabetes Educators

July 19, 2013

Sherry Thomas, Policy Coordinator
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850, Olympia, WA 98504-7850

Dear Ms. Thomas:

It is my pleasure to write a letter in support of state licensure for diabetes educator.

As a person living with diabetes for the past 24 ½ years I know I would not be where I am at without the support I received from my CDEs (Certified Diabetes Educators) back in 1988. I was given such a great start with my diabetes that I went on to become a Diabetes Educator 5 years later and earned my own CDE in 1994, by sitting for the exam, which I've sat for a total of 3 times and most recently renewed by CE of 75 hours over 5 years . I am very proud to carry the credential of CDE.

What I am now very concerned about is that anyone can say they are a health educator or life coach and teach patients about diabetes without having the credential of CDE or the knowledge and experience a CDE carries. I have personally worked with dietitians and other health care providers who "claim" to have the same knowledge as I have in regards to diabetes management and care. However, when I see patients who have been in the care of these "counterfeit" diabetes educators I find patients with diabetes so out of control and disillusioned about their own abilities to manage their diabetes, I have to start back at the beginning. I frequently hear "if I had this information when I first got started, I would be in better health today". (Research has shown that when patients get their diabetes in control and maintain control for the first 10 years, they can delay/prevent complications by 20 to 30 years.)

The following is an example of what I am most concerned about. I saw a patient with type 2 diabetes about 4 years ago (for the first time). She had previously seen a RD upon her diagnosis of diabetes. At our first visit I asked her how her blood sugars were. She stated she had not started checking her blood glucose as she was told all she needed to do was lose some weight and it wasn't time to start checking yet. I got her monitoring her blood glucose that day and her BG was > 250 mg/dl and was having a very difficult time staying awake during our appointment. Her A1C was around 11%. After seeing me for 3 months and monitoring her A1C had come down to around 7% and she felt much better and alert during our entire appointment. Now 4 years later my patient has neuropathy in her feet and has a fair amount of pain related to the neuropathy.

This RD has told people she is a diabetes educator yet she does not have the credentials of CDE, and despite my encouraging her to take the exam she has refused to go the extra mile for her patients. I have seen several patients in the recent past previously seen by this RD

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and everyone of them I go back to the basics on blood glucose monitoring and daily management routines (eating 3 balanced meals/day with snacks as needed, how to take their medications, the importance of activity, coping with diabetes, reducing the risks for complications and problem solving).. This RD is a danger to our community with diabetes if she continues to give them information that does not move them into self-management mode for their diabetes. One reason for licensure would be to keep this particular RD from doing to other patients what she has done to the particular patient.

Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation.

In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.

Sincerely,

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The Diabetes Educator
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National Standards for Diabetes Self-Management Education and Support

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What is This?

National Standards for Diabetes Self-Management Education and Support

By the most recent estimates, 18.8 million people in the United States have been diagnosed with diabetes, and an additional 7 million are believed to be living with undiagnosed diabetes. At the same time, 79 million people are estimated to have blood glucose levels in the prediabetes range. Thus, more than 100 million Americans are at risk of developing the devastating complications of diabetes.[1]

Diabetes self-management education (DSME) is a critical element of care for all people with diabetes and is necessary to prevent or delay the complications of diabetes.[2-6] Elements of DSME related to lifestyle change are also essential for people with prediabetes, as part of efforts to prevent the disease.[7,8] The National Standards for Diabetes Self-Management Education are designed to define quality DSME and support and to assist diabetes educators in providing evidence-based education and self-management support. The standards are applicable to educators in solo practice as well as those in large multicenter programs—and everyone in between. There are many good models for the provision of diabetes education and support. The standards do not endorse any one approach but rather seek to delineate the commonalities among effective and excellent self-management education strategies. These are the standards used in the field for recognition and accreditation. They also serve as a guide for nonaccredited and nonrecognized providers and programs.

Because of the dynamic nature of health care and diabetes-related research, the standards are reviewed and revised approximately every 5 years by key stakeholders and experts within the diabetes education community. In the fall of 2011, a task force was jointly convened by the

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Acknowledgments: Linda Haas and Melinda Maryniuk were co-chairs of the Task Force. Leslie E. Kolb, RN, BSN, MBA, and Paulina N. Duker, MPH, RN, BC-ADM, worked on behalf of AADE and ADA, respectively, coordinating the effort on this document. Sara Sklaroff was the medical writer.

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American Association of Diabetes Educators (AADE) and the American Diabetes Association. Members of the task force included experts from the areas of public health, underserved populations including rural primary care and other rural health services, individual practice, large urban specialty practice, and urban hospitals. They also included people with diabetes, diabetes researchers, certified diabetes educators, registered nurses, registered dietitians, physicians, pharmacists, and a psychologist. The task force was charged with reviewing the current National Standards for Diabetes Self-Management Education for their appropriateness, relevance, and scientific basis and updating them based on the available evidence and expert consensus.

The task force made the decision to change the name of the standards from the National Standards for Diabetes Self-Management Education to the National Standards for Diabetes Self-Management Education and Support. This name change is intended to codify the significance of ongoing support for people with diabetes, particularly to encourage behavior change and the maintenance of healthy diabetes-related behaviors and to address psychosocial concerns. Given that self-management does not stop when a patient leaves the educator's office, self-management support must be an ongoing process.

Although the term *diabetes* is used predominantly, the standards should be understood to apply to the education and support of people with prediabetes. Currently, there are significant barriers to the provision of education and support to those with prediabetes. And yet, the strategies for supporting successful behavior change and the healthy behaviors recommended for people with prediabetes are largely identical to those for people with diabetes. As barriers to care are overcome, providers of DSME and diabetes self-management support (DSMS), given their training and experience, are particularly well equipped to assist people with prediabetes in developing and maintaining behaviors that can prevent or delay the onset of diabetes.

Many people with diabetes have or are at risk for developing comorbidities, including heart disease, lipid abnormalities, nerve damage, hypertension, and depression. In addition, the diagnosis, progression, and daily work of managing the disease can take a major emotional toll on people with diabetes that makes self-care even more difficult.[9] The standards encourage providers of DSME and DSMS to address the entire panorama of each participant's clinical profile. Regular communication among the members of participants' health care teams is essential to ensure high-quality, effective education and support for people with diabetes and prediabetes.

In the course of its work on the standards, the task force identified areas in which there is currently an insufficient amount of research. In particular, there are 3 areas for which the task force recommends additional research:

1. What is the influence of organizational structure on the effectiveness of the provision of DSME?
2. What is the impact of using a structured curriculum in DSME?
3. What training should be required for those community, lay, or peer workers without training in health or diabetes who are to participate in the provision of DSME and provide DSMS?

Finally, the standards emphasize that the person with diabetes is at the center of the entire diabetes education and support process. It is people with diabetes who do the hard work of managing their condition, day in and day out. The educator's role, first and foremost, is to make that work easier.[10]

Definitions

Diabetes self-management education: the ongoing process of facilitating the knowledge, skill, and ability necessary for prediabetes and diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes or prediabetes and is guided by evidence-based standards. The overall objectives of DSME are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.

Diabetes self-management support: activities that assist the person with prediabetes or diabetes in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis beyond or outside of formal self-management training. The type of support provided can be behavioral, educational, psychosocial, or clinical.[11-15]

Standard 1

Internal Structure

The provider(s) of DSME will document an organizational structure, mission statement, and goals. For those providers working within a larger organization,

that organization will recognize and support quality DSME as an integral component of diabetes care.

Documentation of an organizational structure, mission statement, and goals can lead to efficient and effective provision of DSME and DSMS. In the business literature, case studies and case report investigations of successful management strategies emphasize the importance of clear goals and objectives, defined relationships and roles, and managerial support. Business and health policy experts and organizations emphasize written commitments, policies, support, and the importance of outcomes reporting to maintain ongoing support or commitment.[16,17]

Documentation of an organizational structure that delineates channels of communication and represents institutional commitment to the educational entity is critical for success. According to the Joint Commission on Accreditation of Healthcare Organizations, this type of documentation is equally important for small and large health care organizations.[18] Health care and business experts overwhelmingly agree that documentation of the process of providing services is a critical factor in clear communication and provides a solid basis from which to deliver quality diabetes education. In 2010, the joint commission published the *Disease-Specific Care Certification Manual*, which outlines standards and performance measurements for chronic care programs and disease management services, including "supporting self-management."[18]

Standard 2

External Input

The provider(s) of DSME will seek ongoing input from external stakeholders and experts to promote program quality.

For individual and group providers of DSME and DSMS, external input is vital to maintain an up-to-date, effective program. Broad participation of community stakeholders, including people with diabetes, health professionals, and community interest groups, will increase the program's knowledge of the local population and allow the provider to better serve the community. Often, but not always, this external input is best achieved by the establishment of a formal advisory board. The DSME and DSMS provider(s) must have a documented plan for seeking outside input and acting on it.

The goal of external input and discussion in the program planning process is to foster ideas that will enhance the quality of the DSME and/or DSMS being provided while building bridges to key stakeholders.[19] The result is effective, dynamic DSME that is patient centered, more responsive to consumer-identified needs and the needs of the community, more culturally relevant, and more appealing to consumers.[17,19,20]

Standard 3

Access

The provider(s) of DSME will determine whom to serve, how best to deliver diabetes education to that population, and what resources can provide ongoing support for that population.

Currently, the majority of people with diabetes and prediabetes do not receive any structured diabetes education.[19,20] While there are many barriers to DSME, one crucial issue is access.[21] Providers of DSME can help address this issue by doing the following.

* Clarifying the specific population to be served.

Understanding the community, service area, or regional demographics is crucial to ensuring that as many people as possible are being reached, including those who do not frequently attend clinical appointments.[9,17,22-24]

* Determining that population's self-management education and support needs.

Different individuals, their families, and communities need different types of education and support.[25] The provider of DSME needs to work to ensure that the necessary education alternatives are available.[25-27] This means understanding the population's demographic characteristics, such as ethnic/cultural background, gender, and age, as well as their levels of formal education, literacy, and numeracy.[28-31] It may also entail identifying resources outside the provider's practice that can assist in the ongoing support of the participant.

* Identifying access issues and working to overcome them.

It is essential to determine factors that prevent people with diabetes from receiving self-management education and support. The assessment process includes the identification of these barriers to access.[32-34] These barriers may

include the socioeconomic or cultural factors mentioned above, as well as, for example, health insurance shortfalls and the lack of encouragement from other health providers to encourage their patients to pursue diabetes education.[35,36]

Standard 4

Program Coordination

A coordinator will be designated to oversee the DSME program. The coordinator will have oversight responsibility for the planning, implementation, and evaluation of education services.

Coordination is essential to ensure that quality DSME and support are delivered through an organized, systematic process.[37,38] As the field of DSME continues to evolve, the coordinator plays a pivotal role in ensuring accountability and continuity in the education program.[39-41] The coordinator's role may be viewed as that of coordinating the program (or education process) and/or supporting the coordination of the many aspects of self-management in the continuum of diabetes and related conditions when feasible.[42-49] This oversight includes designing an education program or service that helps the participant access needed resources and assists him or her in navigating the health care system.[37,50-55]

The individual serving as the coordinator will have knowledge of the lifelong process of managing a chronic disease and facilitating behavior change, in addition to experience with program and/or clinical management.[56-59] In some cases, particularly solo or other small practices, the coordinator may also provide DSME and/or DSMS.

Standard 5

Instructional Staff

One or more instructors will provide DSME and, when applicable, DSMS. At least one of the instructors responsible for designing and planning DSME and DSMS will be an RN, RD, or pharmacist with training and experience pertinent to DSME, or another professional with certification in diabetes care and education, such as a CDE or BC-ADM. Other health workers can contribute to DSME and provide DSMS with appropriate training in diabetes and with supervision and support.

Historically, nurses and dietitians were the main providers of diabetes education.[3,4,60-64] In recent years, the role of the diabetes educator has expanded to other disciplines, particularly pharmacists.[65-67] Reviews comparing the effectiveness of different disciplines for education have not identified clear differences in the quality of services delivered by different professionals.[3-5] However, the literature favors the registered nurse, registered dietitian, and pharmacist serving both as the key primary instructors for diabetes education and as members of the multidisciplinary team responsible for designing the curriculum and assisting in the delivery of DSME.[1-7] Expert consensus supports the need for specialized diabetes and educational training beyond academic preparation for the primary instructors on the diabetes team.[68-71] Professionals serving as instructors must document appropriate continuing education or comparable activities to ensure their continuing competence to serve in their instructional, training, and oversight roles.[72]

Reflecting the evolving health care environment, a number of studies have endorsed a multidisciplinary team approach to diabetes care, education, and support. The disciplines that may be involved include, but are not limited to, physicians, psychologists and other mental health specialists, physical activity specialists (including physical therapists, occupational therapists, and exercise physiologists), optometrists, and podiatrists.[73-75] More recently, health educators (e.g. certified health education specialists and certified medical assistants), case managers, lay health and community workers,[76-83] and peer counselors or educators[84,85] have been shown to contribute effectively as part of the DSME team and in providing DSMS. While DSME and DSMS are often provided within the framework of a collaborative and integrated team approach, it is crucial that the individual with diabetes be viewed as central to the team and that he or she take an active role.

Certification as a diabetes educator by the National Certification Board for Diabetes Educators is one way that a health professional can demonstrate mastery of a specific body of knowledge, and this certification has become an accepted credential in the diabetes community.[86] An additional credential that indicates specialized training beyond basic preparation is board certification in advanced diabetes management offered by the AADE, which is available for nurses, dietitians, pharmacists, physicians, and physician assistants.[73,75,87]

Individuals who serve as lay health and community workers and peer counselors or educators may contribute to the provision of DSME instruction and provide DSMS if they have received training in diabetes management, 2

the teaching of self-management skills, group facilitation, and emotional support. For these individuals, a system must be in place that ensures supervision of the services they provide by a diabetes educator or other health care professional and professional backup to address clinical problems or questions beyond their training.[88-90]

For services outside the expertise of any provider of DSME and DSMS, a mechanism must be in place to ensure that the individual with diabetes is connected with appropriately trained and credentialed providers.

Standard 6

Curriculum

A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the provision of DSME. The needs of the individual participant will determine which parts of the curriculum will be provided to that individual.

People with prediabetes and diabetes and their families and caregivers have much to learn to become effective self-managers of their condition. DSME can provide this education via an up-to-date, evidence-based, and flexible curriculum.[8,91]

The curriculum is a coordinated set of courses and educational experiences. It also specifies learning outcomes and effective teaching strategies.[92,93] The curriculum must be dynamic and reflect current evidence and practice guidelines.[93-97] Recent education research endorses the inclusion of practical, problem-solving approaches, collaborative care, psychosocial issues, behavior change, and strategies to sustain self-management efforts.[12,13,19,73,86,98-101]

The following core topics are commonly part of the curriculum taught in comprehensive programs that have demonstrated successful outcomes.[2,3,5,91,102-104]

- Describing the diabetes disease process and treatment options
- Incorporating nutritional management into lifestyle
- Incorporating physical activity into lifestyle
- Using medication safely and for maximum therapeutic effectiveness
- Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making
- Preventing, detecting, and treating acute complications
- Preventing, detecting, and treating chronic complications
- Developing personal strategies to address psychosocial issues and concerns
- Developing personal strategies to promote health and behavior change

While the content areas listed above provide a solid outline for a diabetes education and support curriculum, it is crucial that the content be tailored to match each individual's needs and be adapted as necessary for age, type of diabetes (including prediabetes and diabetes in pregnancy), cultural factors, health literacy and numeracy, and comorbidities.[14,105-108] The content areas will be able to be adapted for all practice settings.

Approaches to education that are interactive and patient centered have been shown to be effective.[12,13,109-112] Also crucial is the development of action-oriented behavioral goals and objectives.[12-14,113] Creative, patient-centered, experience-based delivery methods—beyond the mere acquisition of knowledge—are effective for supporting informed decision making and meaningful behavior change and addressing psychosocial concerns.[114,115]

Standard 7

Individualization

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

Research has demonstrated the importance of individualizing diabetes education to each participant's needs.[116] The assessment process is used to identify what those needs are and to facilitate the selection of appropriate educational and behavioral interventions and self-management support strategies, guided by evidence.[2,63,116-118] The assessment must garner information about the individual's medical history, age, cultural influences, health beliefs and attitudes, diabetes knowledge, diabetes self-management skills and behaviors, emotional response to diabetes, readiness to learn, literacy level (including health literacy and numeracy), physical limitations, family support, and financial status.[11,106,108,117,119-128]

The education and support plan that the participant and instructors develop will be rooted in evidence-based approaches to effective health communication and

education while taking into consideration participant barriers, abilities, and expectations. The instructor will employ clear health communication principles, avoiding jargon, making information culturally relevant, using language- and literacy-appropriate education materials, and using interpreter services when indicated.[107,129,130,131] Evidence-based communication strategies are also effective, such as collaborative goal setting, motivational interviewing, cognitive behavior change strategies, problem solving, self-efficacy enhancement, and relapse prevention strategies.[101,132-134] Periodic reassessment can determine whether there is need for additional or different interventions and future reassessment.[6,71,134-137] A variety of assessment modalities, including telephone follow-up and other information technologies (eg, Internet, text messaging, automated phone calls), may augment face-to-face assessments.[71,87,138-141]

The assessment and education plan, intervention, and outcomes will be documented in the education/health record. Documentation of participant encounters will guide the education process, provide evidence of communication among instructional staff and other members of the participant's health care team, prevent duplication of services, and demonstrate adherence to guidelines.[117,135,142,143] Providing information to other members of the participant's health care team through documentation of educational objectives and personal behavioral goals increases the likelihood that all members will work in collaboration.[86,143] Evidence suggests that the development of standardized procedures for documentation, training health professionals to document appropriately, and the use of structured standardized forms based on current practice guidelines can improve documentation and may ultimately improve quality of care.[135,143-145]

Standard 8

Ongoing Support

The participant and instructor(s) will together develop a personalized follow-up plan for ongoing self-management support. The participant's outcomes and goals and the plan for ongoing self-management support will be communicated to other members of the healthcare team.

While DSME is necessary and effective, it does not in itself guarantee a lifetime of effective diabetes self-care.[113] Initial improvements in participants' metabolic and other outcomes have been found to diminish after approximately 6 months.[3] To sustain the level of self-management needed to effectively manage prediabetes and diabetes over the long term, most participants need ongoing DSMS.[15]

The type of support provided can be behavioral, educational, psychosocial, or clinical.[11-14] A variety of strategies are available for providing DSMS both within and outside the DSME organization. Some patients benefit from working with a nurse case manager.[6,86,146] Case management for DSMS can include reminders about needed follow-up care and tests, medication management, education, behavioral goal setting, psychosocial support, and connection to community resources.

The effectiveness of providing DSMS through disease management programs, trained peers and community health workers, community-based programs, information technology, ongoing education, support groups, and medical nutrition therapy has also been established.[7-11,88-90,86,142]

While the primary responsibility for diabetes education belongs to the providers of DSME, participants benefit by receiving reinforcement of content and behavioral goals from their entire health care team.[135] Additionally, many patients receive DSMS through their primary care provider. Thus, communication among the team regarding the patient's educational outcomes, goals, and DSMS plan is essential to ensure that people with diabetes receive support that meets their needs and is reinforced and consistent among the health care team members.

Because self-management takes place in participants' daily lives and not in clinical or educational settings, patients will be assisted to formulate a plan to find community-based resources that may support their ongoing diabetes self-management. Ideally, DSME and DSMS providers will work with participants to identify such services and, when possible, track those that have been effective with patients, while communicating with providers of community-based resources to better integrate them into patients' overall care and ongoing support.

Standard 9

Patient Progress

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

Effective diabetes self-management can be a significant contributor to long-term, positive health outcomes. The provider(s) of DSME and DSMS will assess each participant's personal self-management goals and his or her progress toward those goals.[147,148]

The AADE Outcome Standards for Diabetes Education specify behavior change as the key outcome and provide a useful framework for assessment and documentation. The AADE7™ lists 7 essential factors: healthy eating, physical activity, taking medications, monitoring, diabetes self-care related problem solving, reducing risks of acute and chronic complications, and psychosocial aspects of living with diabetes.[93,149,150] Differences in behaviors, health beliefs, and culture as well as their emotional response to diabetes can have a significant impact on how participants understand their illness and engage in self-management. DSME providers who account for these differences when collaborating with participants on the design of personalized DSME or DSMS programs can improve participant outcomes.[151,152]

Assessments of participant outcomes must occur at appropriate intervals. The interval depends on the nature of the outcome itself and the time frame specified based on the participant's personal goals. For some areas, the indicators, measures, and time frames will be based on guidelines from professional organizations or government agencies.

Standard 10

Quality Improvement

The provider(s) of DSME will measure the effectiveness of the education and support and look for ways to improve any identified gaps in services or service quality, using a systematic review of process and outcome data.

Diabetes education must be responsive to advances in knowledge, treatment strategies, education strategies, and psychosocial interventions, as well as consumer trends and the changing health care environment. By measuring and monitoring both process and outcome data on an ongoing basis, providers of DSME can identify areas of improvement and make adjustments in participant engagement strategies and program offerings accordingly.

The Institute for Healthcare Improvement suggests 3 fundamental questions that should be answered by an improvement process:[153]

* What are we trying to accomplish?
* How will we know a change is an improvement?
* What changes can we make that will result in an improvement?

Once areas for improvement are identified, the DSME provider must designate timelines and important milestones, including data collection, analysis, and presentation of results.[154] Measuring processes and outcomes helps to ensure that change is successful without causing additional problems in the system. Outcome measures indicate the result of a process (ie, whether changes are actually leading to improvement), while process measures provide information about what caused those results.[154] Process measures are often targeted to those processes that typically affect the most important outcomes.

References

1. Centers for Disease Control and Prevention. *National Diabetes Fact Sheet: National Estimates and General Information on Diabetes and Prediabetes in the United States, 2011*. Atlanta, GA: Centers for Disease Control and Prevention; 2011.
2. Brown SA. Interventions to promote diabetes self-management: state of the science. *Diabetes Educ*. 1999;25(6)(suppl):52-61.
3. Norris SL, Lau J, Smith SJ, et al. Self-management education for adults with type 2 diabetes: a meta-analysis of the effect on glycemic control. *Diabetes Care*. 2002;25(7):1159-1171.
4. Gary TL, Genkinger JM, Guallar E, et al. Meta-analysis of randomized educational and behavioral interventions in type 2 diabetes. *Diabetes Educ*. 2003;29(3):488-501.
5. Deakin T, McShane CE, Cade JE, et al. Group based training for self-management strategies in people with type 2 diabetes mellitus. *Cochrane Database Syst Rev*. 2005;2:CD003417.
6. Renders CM, Valk GD, Griffin SJ, et al. Interventions to improve the management of diabetes in primary care, outpatient, and community settings: a systematic review. *Diabetes Care*. 2001;24(10):1821-1833.
7. Ratner RE. An update on the Diabetes Prevention Program. *Endocr Pract*. 2006;12(suppl 1):20-24.
8. Diabetes Prevention Program Research Group. The Diabetes Prevention Program (DPP): description of lifestyle intervention. *Diabetes Care*. 2002;25(12):2165-2171.
9. Peyrot M, Rubin RR, Funnell MM, et al. Access to diabetes self-management education: results of national surveys of patients, educators, and physicians. *Diabetes Educ*. 2009;35(2):246-248, 252-246, 258-263.
10. Inzucchi SE, Bergenstal RM, Buse JB, et al. Management of hyperglycemia in type 2 diabetes: a patient-centered approach. Position statement of the American Diabetes Association (ADA) and the European Association for the Study of Diabetes (EASD). *Diabetes Care*. 2012;35(6):1364-1379.
11. Anderson RM, Funnell MM, Nwankwo R, et al. Evaluating a problem-based empowerment program for African Americans with diabetes: results of a randomized controlled trial. *Ethn Dis*. 2005;15(4):671-678.

12. Tang TS, Gillard ML, Funnell MM, et al. Developing a new generation of ongoing: diabetes self-management support interventions. A preliminary report. *Diabetes Educ*. 2005;31(1):91-97.
13. Funnell MM, Nwankwo R, Gillard ML, et al. Implementing an empowerment-based diabetes self-management education program. *Diabetes Educ*. 2005;31(1):53, 55-56, 61.
14. Glazier RH, Bajcar J, Kennie NR, et al. A systematic review of interventions to improve diabetes care in socially disadvantaged populations. *Diabetes Care*. 2006;29(7):1675-1688.
15. Fjeldsoe BS, Marshall AL, Miller YD. Behavior change interventions delivered by mobile telephone short-message service. *Am J Prev Med*. 2009;36(2):165-173.
16. Armstrong G, Headrick L, Madigosky W, et al. Designing education to improve care. *Jt Comm J Qual Patient Saf*. 2012;38(1):5-14.
17. Martin AL. Changes and consistencies in diabetes education over 5 years: results of the 2010 National Diabetes Education Practice Survey. *Diabetes Educ*. 2012;38(1):35-46.
18. Joint Commission on Accreditation of Healthcare Organizations. *Disease-Specific Care Certification Manual*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2010.
19. Siminerio LM, Piatt GA, Emerson S, et al. Deploying the chronic care model to implement and sustain diabetes self-management training programs. *Diabetes Educ*. 2006;32(2):253-260.
20. Siminerio LM, Piatt G, Zgibor JC. Implementing the chronic care model for improvements in diabetes care and education in a rural primary care practice. *Diabetes Educ*. 2005;31(2):225-234.
21. Boren SA, Fitzner KA, Panhalkar PS, et al. Costs and benefits associated with diabetes education: a review of the literature. *Diabetes Educ*. 2009;35(1):72-96.
22. McWilliams JM, Meara E, Zaslavsky AM, et al. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*. 2007;298(24):2886-2894.
23. Bell RA, Mayer-Davis EJ, Beyer JW, et al. Diabetes in non-Hispanic white youth: prevalence, incidence, and clinical characteristics. The SEARCH for Diabetes in Youth Study. *Diabetes Care*. 2009;32(suppl 2):S102-S111.
24. Glasgow RE. Interactive media for diabetes self-management: issues in maximizing public health impact. *Med Decis Making*. 2010;30(6):745-758.
25. Lorig K, Ritter PL, Villa FJ, et al. Community-based peer-led diabetes self-management: a randomized trial. *Diabetes Educ*. 2009;35(4):641-651.
26. Duke SA, Colagiuri S, Colagiuri R. Individual patient education for people with type 2 diabetes mellitus. *Cochrane Database Syst Rev*. 2009;1:CD005268.
27. Siminerio LM, Drab SR, Gabbay RA, et al. Diabetes educators: implementing the chronic care model. *Diabetes Educ*. 2008;34(3):451-456.
28. Rosal MC, Ockene IS, Restrepo A, et al. Randomized trial of a literacy-sensitive, culturally tailored diabetes self-management intervention for low-income latinos: Latinos en control. *Diabetes Care*. 2011;34(4):838-844.
29. Mayer-Davis EJ, Beyer J, Bell RA, et al. Diabetes in African American youth: prevalence, incidence, and clinical characteristics. The SEARCH for Diabetes in Youth Study. *Diabetes Care*. 2009;32(suppl 2):S112-S122.
30. Liu LL, Yi JP, Beyer J, et al. Type 1 and type 2 diabetes in Asian and Pacific Islander US youth: the SEARCH for Diabetes in Youth Study. *Diabetes Care*. 2009;32(suppl 2):S133-S140.
31. Hill-Briggs F, Batts-Turner M, Gary TL, et al. Training community health workers as diabetes educators for urban African Americans: value added using participatory methods. *Prog Community Health Partnersh*. 2007;1(2):185-194.
32. Unutzer J, Schoenbaum M, Katon WJ, et al. Healthcare costs associated with depression in medically ill fee-for-service Medicare participants. *J Am Geriatr Soc*. 2009;57(3):506-510.
33. Walker EA, Shmukler C, Ullman R, et al. Results of a successful telephonic intervention to improve diabetes control in urban adults: a randomized trial. *Diabetes Care*. 2011;34(1):2-7.
34. Wubben DP, Vivian EM. Effects of pharmacist outpatient interventions on adults with diabetes mellitus: a systematic review. *Pharmacotherapy*. 2008;28(4):421-436.
35. Remler DK, Teresi JA, Weinstock RS, et al. Health care utilization and self-care behaviors of Medicare beneficiaries with diabetes: comparison of national and ethnically diverse underserved populations. *Popul Health Manag*. 2011;14(1):11-20.
36. Peikes D, Chen A, Schore J, et al. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA*. 2009;301(6):603-618.
37. Rothman RL, Malone R, Bryant B, et al. A randomized trial of a primary care-based disease management program to improve cardiovascular risk factors and glycated hemoglobin levels in patients with diabetes. *Am J Med*. 2005;118(3):276-284.
38. Holmes-Walker DJ, Llewellyn AC, Farrell K. A transition care programme which improves diabetes control and reduces hospital admission rates in young adults with type 1 diabetes aged 15-25 years. *Diabet Med*. 2007;24(7):764-769.
39. Glasgow RE, Nelson CC, Strycker LA, et al. Using RE-AIM metrics to evaluate diabetes self-management support interventions. *Am J Prev Med*. 2006;30(1):67-73.
40. Baker LC, Johnson SJ, Macaulay D, et al. Integrated telehealth and care management program for Medicare beneficiaries with chronic disease linked to savings. *Health Aff (Millwood)*. 2011;30(9):1689-1697.
41. Piatt GA, Anderson RM, Brooks MM, et al. 3-year follow-up of clinical and behavioral improvements following a multifaceted diabetes care intervention: results of a randomized controlled trial. *Diabetes Educ*. 2010;36(2):301-309.
42. Kerr EA, Heisler M, Krein SL, et al. Beyond comorbidity counts: how do comorbidity type and severity influence diabetes patients' treatment priorities and self-management? *J Gen Intern Med*. 2007;22(12):1635-1640.
43. Bowen ME, Rothman RL. Multidisciplinary management of type 2 diabetes in children and adolescents. *J Multidiscip Healthc*. 2010;3:113-124.
44. Dejesus RS, Vickers KS, Stroebel RJ, et al. Primary care patient and provider preferences for diabetes care managers. *Patient Prefer Adherence*. 2010;4:181-186.
45. Stuckey HL, Dellasega C, Graber NJ, et al. Diabetes nurse case management and motivational interviewing for change (DYNAMIC): study design and baseline characteristics in the chronic care model for type 2 diabetes. *Contemp Clin Trials*. 2009;30(4):366-374.

46. Heuer LJ, Hess C, Batson A. Cluster clinics for migrant Hispanic farmworkers with diabetes: perceptions, successes, and challenges. *Rural Remote Health*. 2006;6(1):469.
47. Cebul RD, Love TE, Jain AK, et al. Electronic health records and quality of diabetes care. *N Engl J Med*. 2011;365(9):825-833.
48. Rosal MC, White MJ, Borg A, et al. Translational research at community health centers: challenges and successes in recruiting and retaining low-income Latino patients with type 2 diabetes into a randomized clinical trial. *Diabetes Educ*. 2010;36(5):733-749.
49. Austin SA, Claiborne N. Faith wellness collaboration: a community-based approach to address type II diabetes disparities in an African-American community. *Soc Work Health Care*. 2011;50(5):360-375.
50. Parekh AK, Goodman RA, Gordon C, et al. Managing multiple chronic conditions: a strategic framework for improving health outcomes and quality of life. *Public Health Rep*. 2011;126(4):460-471.
51. Rothman RL, So SA, Shin J, et al. Labor characteristics and program costs of a successful diabetes disease management program. *Am J Manag Care*. 2006;12(5):277-283.
52. May CR, Finch TL, Cornford J, et al. Integrating telecare for chronic disease management in the community: what needs to be done? *BMC Health Serv Res*. 2011;11:131.
53. Williams AS. Making diabetes education accessible for people with visual impairment. *Diabetes Educ*. 2009;35(4):612-621.
54. Reichard A, Stolzle H. Diabetes among adults with cognitive limitations compared to individuals with no cognitive disabilities. *Intellect Dev Disabil*. 2011;49(3):141-154.
55. Gimpel N, Marcee A, Kennedy K, et al. Patient perceptions of a community-based care coordination system. *Health Promot Pract*. 2010;11(2):173-181.
56. Welch G, Allen NA, Zagarins SE, et al. Comprehensive diabetes management program for poorly controlled Hispanic type 2 patients at a community health center. *Diabetes Educ*. 2011;37(5):680-688.
57. Peterson KA, Radosevich DM, O'Connor PJ, et al. Improving diabetes care in practice: findings from the TRANSLATE trial. *Diabetes Care*. 2008;31(12):2238-2243.
58. Bojadzievski T, Gabbay RA. Patient-centered medical home and diabetes. *Diabetes Care*. 2011;34(4):1047-1053.
59. Wagner EH. The role of patient care teams in chronic disease management. *BMJ*. 2000;320(7234):569-572.
60. Koproski J, Pretto Z, Poretsky L. Effects of an intervention by a diabetes team in hospitalized patients with diabetes. *Diabetes Care*. 1997;20(10):1553-1555.
61. Weinberger M, Kirkman MS, Samsa GP, et al. A nurse-coordinated intervention for primary care patients with non-insulin-dependent diabetes mellitus: impact on glycemic control and health-related quality of life. *J Gen Intern Med*. 1995;10(2):59-66.
62. Spellbring AM. Nursing's role in health promotion. An overview. *Nurs Clin North Am*. 1991;26(4):805-814.
63. Glasgow RE, Toobert DJ, Hampson SE, et al. Improving self-care among older patients with type II diabetes: the "Sixty Something . . ." Study. *Patient Educ Couns*. 1992;19(1):61-74.
64. Delahanty L, Simkins SW, Camelon K. Expanded role of the dietitian in the Diabetes Control and Complications Trial: implications for clinical practice. The DCCT Research Group. *J Am Diet Assoc*. 1993;93(7):758-764, 767.
65. Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc (Wash)*. 2003;43(2):173-184.
66. Garrett DG, Bluml BM. Patient self-management program for diabetes: first-year clinical, humanistic, and economic outcomes. *J Am Pharm Assoc (2003)*. 2005;45(2):130-137.
67. Shane-McWhorter L, Fermo JD, Bultemeier NC, et al. National survey of pharmacist certified diabetes educators. *Pharmacotherapy*. 2002;22(12):1579-1593.
68. Anderson RM, Donnelly MB, Dedrick RF, et al. The attitudes of nurses, dietitians, and physicians toward diabetes. *Diabetes Educ*. 1991;17(4):261-268.
69. Lorenz RA, Bubb J, Davis D, et al. Changing behavior: practical lessons from the diabetes control and complications trial. *Diabetes Care*. 1996;19(6):648-652.
70. Ockene JK, Ockene IS, Quirk ME, et al. Physician training for patient-centered nutrition counseling in a lipid intervention trial. *Prev Med*. 1995;24(6):563-570.
71. Leggett-Frazier N, Swanson MS, Vincent PA, et al. Telephone communications between diabetes clients and nurse educators. *Diabetes Educ*. 1997;23(3):287-293.
72. Baksi AK, Al-Mrayat M, Hogan D, et al. Peer advisers compared with specialist health professionals in delivering a training programme on self-management to people with diabetes: a randomized controlled trial. *Diabet Med*. 2008;25(9):1076-1082.
73. Piatt GA, Orchard TJ, Emerson S, et al. Translating the chronic care model into the community: results from a randomized controlled trial of a multifaceted diabetes care intervention. *Diabetes Care*. 2006;29(4):811-817.
74. Campbell EM, Redman S, Moffitt PS, et al. The relative effectiveness of educational and behavioral instruction programs for patients with NIDDM: a randomized trial. *Diabetes Educ*. 1996;22(4):379-386.
75. Emerson S. Implementing diabetes self-management education in primary care. *Diabetes Spectrum*. 2006;19(2):79-83.
76. Satterfield D, Burd C, Valdez L, et al. The "in-between people": participation of community health representatives and lay health workers in diabetes prevention and care in American Indian and Alaska Native communities. *Health Promot Pract*. 2002;3:66-175.
77. American Association of Diabetes Educators. Community Health Workers position statement. http://www.diabeteseducator.org/ProfessionalResources/position/position_statements.html. Accessed June 26, 2012.
78. American Public Health Association. Support for community health workers to increase health access and to reduce health inequities. http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1393. Accessed June 26, 2012.
79. Norris SL, Chowdhury FM, Van Le K, et al. Effectiveness of community health workers in the care of persons with diabetes. *Diabet Med*. 2006;23(5):544-556.
80. Lewin SA, Dick J, Pond P, et al. Lay health workers in primary and community health care. *Cochrane Database Syst Rev*. 2005(1):CD004015.
81. Lorig KR, Ritter P, Stewart AL, et al. Chronic disease self-management program: 2-year health status and health care utilization outcomes. *Med Care*. 2001;39(11):1217-1223.
82. Ruggiero L, Moadsiri A, Butler P, et al. Supporting diabetes self-care in underserved populations: a randomized pilot study using medical assistant coaches. *Diabetes Educ*. 2010;36(1):127-131.

83. Spencer MS, Rosland AM, Kieffer EC, et al. Effectiveness of a community health worker intervention among African American and Latino adults with type 2 diabetes: a randomized controlled trial. *Am J Public Health*. 2011;101(12):2253-2260.
84. Heisler M. *Building Peer Support Programs to Manage Chronic Disease: Seven Models for Success*. Oakland, CA: California Health Care Foundation; 2006.
85. Long JA, Jahnle EC, Richardson DM, et al. Peer mentoring and financial incentives to improve glucose control in African American veterans: a randomized trial. *Ann Intern Med*. 2012;156(6):416-424.
86. American Association of Diabetes Educators. The scope of practice, standards of practice, and standards of professional performance for diabetes educators. http://www.diabeteseducator.org/DiabetesEducation/position/Scope_x_Standards.html. Accessed June 26, 2012.
87. Valentine V, Kulkarni K, Hinnen D. Evolving roles: from diabetes educators to advanced diabetes managers. *Diabetes Educ*. 2003;29(4):598-602, 604, 606.
88. American Association of Diabetes Educators. AADE guidelines for the practice of diabetes self-management education and training (DSME/T). *Diabetes Educ*. 2009;35(3):85S-107S.
89. American Association of Diabetes Educators. Competencies for diabetes educators: a companion document to the guidelines for the practice of diabetes education. http://www.diabeteseducator.org/ProfessionalResources/position/competencies.html. Accessed June 26, 2012.
90. American Association of Diabetes Educators. A sustainable model of diabetes self-management education/training involves a multi-level team that can include community health workers. http://www.diabeteseducator.org/DiabetesEducation/position/White_Papers.html.
91. Gillett M, Dallosso HM, Dixon S, et al. Delivering the Diabetes Education and Self Management for Ongoing and Newly Diagnosed (DESMOND) programme for people with newly diagnosed type 2 diabetes: cost effectiveness analysis. *BMJ*. 2010;341:c4093.
92. Redman BK. *The Practice of Patient Education*. 10th ed. St. Louis, MO: Mosby; 2007.
93. Mulcahy K, Maryniuk M, Peeples M, et al. Diabetes self-management education core outcomes measures. *Diabetes Educ*. 2003;29(5):768-770, 773-784, 787-768.
94. Reader D, Splett P, Gunderson EP. Impact of gestational diabetes mellitus nutrition practice guidelines implemented by registered dietitians on pregnancy outcomes. *J Am Diet Assoc*. 2006;106(9):1426-1433.
95. Boucher JL, Evert A, Daly A, et al. American Dietetic Association revised standards of practice and standards of professional performance for registered dietitians (generalist, specialty, and advanced) in diabetes care. *J Am Diet Assoc*. 2011;111(1): 156-166,e151-e127.
96. American Diabetes Association. Standards of medical care in diabetes: 2012. *Diabetes Care*. 2012;35(suppl 1):S11-S63.
97. Bantle JP, Wylie-Rosett J, Albright AL, et al. Nutrition recommendations and interventions for diabetes: a position statement of the American Diabetes Association. *Diabetes Care*. 2008;31(suppl 1):S61-S78.
98. Wagner EH, Austin BT, Von Korff M. Organizing care for patients with chronic illness. *Milbank Q*. 1996;74(4):511-544.
99. Norris SL. Health-related quality of life among adults with diabetes. *Curr Diab Rep*. 2005;5(2):124-130.
100. Herman AA. Community health workers and integrated primary health care teams in the 21st century. *J Ambul Care Manage*. 2011;34(4):354-361.
101. Weinger K, Beverly EA, Lee Y, et al. The effect of a structured behavioral intervention on poorly controlled diabetes: a randomized controlled trial. *Arch Intern Med*. 2011;171(22):1990-1999.
102. Norris SL, Zhang X, Avenell A, et al. Long-term effectiveness of lifestyle and behavioral weight loss interventions in adults with type 2 diabetes: a meta-analysis. *Am J Med*. 2004;117(10):762-774.
103. Ellis SE, Speroff T, Dittus RS, et al. Diabetes patient education: a meta-analysis and meta-regression. *Patient Educ Couns*. 2004;52(1):97-105.
104. Armour TA, Norris SL, Jack L, Jr, et al. The effectiveness of family interventions in people with diabetes mellitus: a systematic review. *Diabet Med*. 2005;22(10):1295-1305.
105. Magee M, Bowling A, Copeland J, et al. The ABCs of diabetes: diabetes self-management education program for African Americans affects A1C, lipid-lowering agent prescriptions, and emergency department visits. *Diabetes Educ*. 2011;37(1):95-103.
106. Cavanaugh K, Huizinga MM, Wallston KA, et al. Association of numeracy and diabetes control. *Ann Intern Med*. 2008;148(10):737-746.
107. Rothman RL, DeWalt DA, Malone R, et al. Influence of patient literacy on the effectiveness of a primary care-based diabetes disease management program. *JAMA*. 2004;292(14):1711-1716.
108. Schillinger D, Grumbach K, Piette J, et al. Association of health literacy with diabetes outcomes. *JAMA*. 2002;288(4):475-482.
109. Rubin RR, Peyrot M, Saudek CD. The effect of a diabetes education program incorporating coping skills, training on emotional well-being, and diabetes self-efficacy. *Diabetes Educ*. 1993;19(3):210-214.
110. Trento M, Passera P, Borgo E, et al. A 5-year randomized controlled study of learning, problem solving ability, and quality of life modifications in people with type 2 diabetes managed by group care. *Diabetes Care*. 2004;27(3):670-675.
111. Izquierdo RE, Knudson PE, Meyer S, et al. A comparison of diabetes education administered through telemedicine versus in person. *Diabetes Care*. 2003;26(4):1002-1007.
112. Garrett N, Hageman CM, Sibley SD, et al. The effectiveness of an interactive small group diabetes intervention in improving knowledge, feeling of control, and behavior. *Health Promot Pract*. 2005;6(3):320-328.
113. Piette JD, Glasgow R. Strategies for improving behavioral health outcomes among patients with diabetes: self-management, education. In Gerstein HC, & Haynes RB, eds. *Evidence-Based Diabetes Care*. Ontario, Canada: BC Decker Publishers; 2001:207-251.
114. Boren SA. AADE7TM self-care behaviors: systematic reviews. *Diabetes Educ*. 2007;33(6):866, 871.
115. American Association of Diabetes Educators. AADE 7 self-care behaviors, American Association of Diabetes Educators position statement. http://www.diabeteseducator.org/DiabetesEducation/position/position_statements.html. Accessed June 26, 2012.
116. American Association of Diabetes Educators. AADE position statement: individualization of diabetes self-management education. *Diabetes Educ*. 2007;33(1):45-49.
117. Gilden JL, Hendryx M, Casia C, et al. The effectiveness of diabetes education programs for older patients and their spouses. *J Am Geriatr Soc*. 1989;37(11):1023-1030.
118. Brown SA. Effects of educational interventions in diabetes care: a meta-analysis of findings. *Nurs Res*. 1988;37(4):223-230

119. Barlow J, Wright C, Sheasby J, et al. Self-management approaches for people with chronic conditions: a review. *Patient Educ Couns*. 2002;48(2):177-187.
120. Skinner TC, Cradock S, Arundel F, et al. Four theories and a philosophy: self-management education for individuals newly diagnosed with type 2 diabetes. *Diabetes Spectrum*. 2003;16(2):75-80.
121. Brown SA, Hanis CL. Culturally competent diabetes education for Mexican Americans: the Starr County Study. *Diabetes Educ*. 1999;25(2):226-236.
122. Sarkisian CA, Brown AF, Norris KC, et al. A systematic review of diabetes self-care interventions for older, African American, or Latino adults. *Diabetes Educ*. 2003;29(3):467-479.
123. Chodosh J, Morton SC, Mojica W, et al. Meta-analysis: chronic disease self-management programs for older adults. *Ann Intern Med*. 2005;143(6):427-438.
124. Anderson-Loftin W, Barnett S, Bunn P, et al. Soul food light: culturally competent diabetes education. *Diabetes Educ*. 2005;31(4):555-563.
125. Mensing CR, Norris SL. Group education in diabetes: effectiveness and implementation. *Diabetes Spectrum*. 2003;16(2):96-103.
126. Brown SA, Blozis SA, Kouzekanani K, et al. Dosage effects of diabetes self-management education for Mexican Americans: the Starr County Border Health Initiative. *Diabetes Care*. 2005;28(3):527-532.
127. Hosey GM, Freeman WL, Stracqualursi F, et al. Designing and evaluating diabetes education material for American Indians. *Diabetes Educ*. 1990;16(5):407-414.
128. Thomson FJ, Masson EA. Can elderly patients co-operate with routine foot care? *Diabetes Spectrum*. 1995;8:218-219.
129. Hawthorne K, Robles Y, Cannings-John R, et al. Culturally appropriate health education for type 2 diabetes in ethnic minority groups: a systematic and narrative review of randomized controlled trials. *Diabet Med*. 2010;27(6):613-623.
130. Cavanaugh K, Wallston KA, Gebretsadik T, et al. Addressing literacy and numeracy to improve diabetes care: two randomized controlled trials. *Diabetes Care*. 2009;32(12):2149-2155.
131. Doak CC, Doak LG, Root JH. *Teaching Patients with Low Literacy Skills*. Philadelphia, PA: Lippincott; 2008.
132. Schillinger D, Piette J, Grumbach K, et al. Closing the loop: physician communication with diabetic patients who have low health literacy. *Arch Intern Med*. 2003;163(1):83-90.
133. Channon SJ, Huws-Thomas MV, Rollnick S, et al. A multicenter randomized controlled trial of motivational interviewing in teenagers with diabetes. *Diabetes Care*. 2007;30(6):1390-1395.
134. Naik AD, Palmer N, Petersen NJ, et al. Comparative effectiveness of goal setting in diabetes mellitus group clinics: randomized clinical trial. *Arch Intern Med*. 2011;171(5):453-459.
135. Glasgow RE, Funnell MM, Bonomi AE, et al. Self-management aspects of the improving chronic illness care breakthrough series: implementation with diabetes and heart failure teams. *Ann Behav Med*. 2002;24(2):80-87.
136. Estey AL, Tan MH, Mann K. Follow-up intervention: its effect on compliance behavior to a diabetes regimen. *Diabetes Educ*. 1990;16(4):291-295.
137. Beverly EA, Ganda OP, Ritholz MD, et al. Look who's (not) talking: diabetic patients' willingness to discuss self-care with physicians. *Diabetes Care*. 2012;35(7):1466-1472.
138. Mulvaney SA, Rothman RL, Wallston KA, et al. An Internet-based program to improve self-management in adolescents with type 1 diabetes. *Diabetes Care*. 2010;33(3):602-604.
139. Osborn CY, Mayberry LS, Mulvaney SA, et al. Patient web portals to improve diabetes outcomes: a systematic review. *Curr Diab Rep*. 2010;10(6):422-435.
140. Mulvaney SA, Ritterband LM, Bosslet L. Mobile intervention design in diabetes: review and recommendations. *Curr Diab Rep*. 2011;11(6):486-493.
141. Polonsky WH, Fisher L, Earles J, et al. Assessing psychosocial distress in diabetes: development of the diabetes distress scale. *Diabetes Care*. 2005;28(3):626-631.
142. Davis ED. Role of the diabetes nurse educator in improving patient education. *Diabetes Educ*. 1990;16(1):36-38.
143. Glasgow RE, Davis CL, Funnell MM, et al. Implementing practical interventions to support chronic illness self-management. *Jt Comm J Qual Saf*. 2003;29(11):563-574.
144. Daly A, Leontos C. Legislation for health care coverage for diabetes self-management training, equipment and supplies: past, present and future. *Diabetes Spectrum*. 1999;12:222-230.
145. Grebe SK, Smith RB. Clinical audit and standardised follow up improve quality of documentation in diabetes care. *N Z Med J*. 1995;108(1006):339-342.
146. Aubert RE, Herman WH, Waters J, et al. Nurse case management to improve glycemic control in diabetic patients in a health maintenance organization: a randomized, controlled trial. *Ann Intern Med*. 1998;129(8):605-612.
147. Glasgow RE, Peeples M, Skovlund SE. Where is the patient in diabetes performance measures? The case for including patient-centered and self-management measures. *Diabetes Care*. 2008;31(5):1046-1050.
148. Beebe CA, Schmitt SS. Engaging patients in education for self-management in an accountable care environment. *Clin Diabetes*. 2011;29(3):123-126.
149. American Association of Diabetes Educators. Standards for outcomes measurement of diabetes self-management education. http://www.diabeteseducator.org/ProfessionalResources/position/position_statements.html. Accessed June 26, 2012.
150. American Association of Diabetes Educators. Standards for outcomes measurement of diabetes self-management education, technical review. http://www.diabeteseducator.org/ProfessionalResources/position/position_statements.html. Accessed June 26, 2012.
151. Anderson D, Christison-Lagay J. Diabetes self-management in a community health center: improving health behaviors and clinical outcomes for undeserved patients. *Clin Diabetes*. 2008;26(1):22-27.
152. Duncan I, Ahmed T, Li QE, et al. Assessing the value of the diabetes educator. *Diabetes Educ*. 2011;37(5):638-657.
153. Institute for Healthcare Improvement. Science of improvement: how to improve. http://www.ihi.org/knowledge/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx. Accessed June 25, 2012.
154. Joint Commission on Accreditation of Healthcare Organizations. *Joint Commission Resources: Cost-Effective Performance Improvement in Ambulatory Care*. Oakbrook Terrace, IL: Joint Commission on Accreditation of Healthcare Organizations; 2003.

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Assessing the Value of Diabetes Education

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What is This?

Assessing the Value of Diabetes Education

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Purpose

The purpose of this study was to evaluate the impact of diabetes self-management education/training (DSME/T) on financial outcomes (cost of patient care).

Methods

Commercial and Medicare claims payer-derived datasets were used to assess whether patients who participate in diabetes education are more likely to follow recommendations for care than similar patients who do not participate in diabetes education, and if claims of patients who participate in diabetes education are lower than those of similar patients who do not.

Results

Patients using diabetes education have lower average costs than patients who do not use diabetes education. Physicians exhibit high variation in their referral rates to diabetes education.

Conclusions

The collaboration between diabetes educators and physicians yields positive clinical quality and cost savings. The analysis indicates that quality can be improved, and cost reduced, by increasing referral rates to diabetes education among low-referring physicians, specifically among men and people in disadvantaged areas. More needs to be done to inform physicians about ways to increase access to diabetes education for underserved populations.

Diabetes self-management education/training (DSME/T) is the ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes and is guided by evidence-based standards. The overall objectives of DSME/T are to support informed decision-making, self-care behaviors, problem-solving and active collaboration with the health care team, and improve clinical outcomes, health status, and quality of life.[1] DSME/T is considered to be essential in successfully managing diabetes and a body of evidence recognizes a range of DSME/T interventions shown to improve diabetes management outcomes.[2] These include clinical outcomes managing the physiological aspects of diabetes and effective risk management of the morbidity of diabetes for high risk individuals—either preventing or delaying the onset of diabetes or of a serious complication. Increased diabetes knowledge, lifestyle changes, skilled self-care, and improved quality of life have all been identified as behavioral outcomes of DSME/T. DSME/T is an essential element of diabetes care.[3,4] The professional society representing diabetes educators in the United States is the American Association of Diabetes Educators (AADE). The AADE defines diabetes education as "an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator(s). The DMSE/T intervention aims to achieve optimal health status, better quality of life and reduce the need for costly health care."[5]

Diabetes educators are healthcare professionals who have specialized training in diabetes care, traditionally drawn from nursing and dietetics, and more recently involving registered pharmacists. The role of the diabetes educator may also be adopted by other members of a healthcare team including physicians, exercise physiologists, ophthalmologists, optometrists, and podiatrists. Studies suggest that an effective diabetes self-management education program includes a nurse, dietitian, and pharmacist as primary instructors and contributors to the curriculum.[6] Diabetes educators provide DSME/T, but may extend beyond that to include case management, program management, educational activities, health and wellness promotion, and research. Most diabetes educators have undertaken advanced professional, educational, and credentialing requirements to become either certified diabetes educators (CDE) or board certified in advanced diabetes management (BC-ADM).

Evidence suggests that DSME/T is most effective when using a skills-based approach that is focused on making informed self-management choices,[4] delivered by a multidisciplinary team with specialized knowledge in diabetes care management, and following a comprehensive plan of care using educational delivery skills[4,6-10] and behavioral and psychosocial strategies.[4,7,8]

Despite its proven success, only around 50% of Americans with diabetes participate in formal diabetes education and the *Healthy People 2010* policy goal is to increase the proportion of people receiving formal diabetes education from the 1998 baseline of 45% to 60% by 2010.[11,12] The utilization rates of certain preventive care practices by adults aged 18 and older in 42 states is generally high. In 2005, 89% had at least an annual doctor visit, around 70% of people had an annual eye exam, an annual foot exam, and at least 2 glycated hemoglobin (A1C) tests in the year, and 53.1% reported having attended a diabetes self-management class.[13,14] Attendance at a self-management class has increased from 51.4% in 2000 to 53.1% in 2005.[13,14] The value and worth of diabetes self-management education is recognized through reimbursement by the Centers for Medicare and Medicaid (CMS) and other third-party payers.

The terms diabetes self-management education (DSME) and diabetes self-management training (DSMT) are often used interchangeably to refer to "a formal process through which persons with or at risk for diabetes develop and use the knowledge and skill required to reach their self-defined diabetes goals."[4] For simplicity, DSME/T is used throughout this article.

National Standards Underlie Diabetes Self-Management Education

Evidence-based national standards for DSME/T define and address the quality and processes of diabetes self-management education.[6] These standards are reviewed every 5 years to incorporate updated evidence-based knowledge by a task force including the AADE, the American Diabetes Association (ADA), industry organizations, and federal agencies. Based on evidence that diabetes education delivered from a behavioral change perspective achieves improved clinical outcomes and enhanced quality of life, 10 standards cover organizational structures and processes necessary to deliver a high quality service. The procedures of delivering quality education services including curriculum, educator credentials, and experience, and the outcomes achieved for

individual participants including assessment, evaluation, and follow-up.[6]

Effective Diabetes Self-Management Addresses Seven Self-Care Behaviors

The national standards suggest that an individual's self-management goals be measured by progress toward 7 self-care standards known as the AADE7 self-care behaviors. Developed to complement the national standards,[7] these self-care behaviors are considered to be "a useful framework for assessment and documentation" of an individual's progress.[6] The AADE describes the AADE7 as "seven self-care behaviors that are essential for improved health status and greater quality of life."[7] Five core outcome measures (reproduced below), which include the 7 self-care behaviors, form the framework for measuring the outcomes of DSME/T. The AADE7 cover skills and knowledge acquisition in key self-care areas of healthy eating, physical activity, monitoring, medication management, reducing risks of acute and chronic complications, problem solving of diabetes care related issues, and psychosocial adaptation to living with diabetes. In addition to providing a set of core measures of an individual's outcomes, this skill set was also intended to provide a key data set to establish the effectiveness of DSME/T at a population level in the management of diabetes.[7]

Outcomes of Diabetes Self-Management Education

There is a considerable amount of literature devoted to assessing the outcomes of DSME/T. The AADE 5 core standards for outcomes measurement of DSME/T are:

1. Behavior change is the unique outcome measurement for diabetes self-management education.
2. Seven diabetes self-care behavior measures determine the effectiveness of diabetes self-management education at individual, participant, and population levels.
3. Diabetes self-care behaviors should be evaluated at baseline and then at regular intervals after the education program.
4. 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.
5. 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.

Financial Outcomes of Diabetes Self-Management Education

While DSME/T has been shown to improve quality of life and clinical outcomes, the impact of DSME/T on financial outcomes (cost of patient care) has not been similarly studied. We studied the value of diabetes education by testing the following 2 hypotheses:

1. Patients who participate in diabetes education are more likely to follow diabetes care standards than similar patients who do not participate in diabetes education.
2. Claims of patients who participate in diabetes education are lower than those of similar patients who do not participate in diabetes education.

We tested these hypotheses within administrative claims data from the Solucia database of multiple millions of lives of claims experience (nationally) over several years (a description of the data and the database may be found in Appendix 1, which is available on the AADE website[5]).

Methods

Study Design

In a perfect world one would construct a randomized test of the hypotheses and compare results of equivalent groups of patients or would have access to patient chart information on which to build a complete health record for each patient. In a situation where it is neither possible to construct a randomized design nor to obtain patient chart data, the researcher is forced to use other available data, such as administrative claims. This study used administrative claims data to compare process measures and costs of those patients who participate in diabetes education and those who do not.

Study Population

The study population consists of members of commercial and Medicare Advantage health plans from a private national database of payer data. Medicare Advantage (risk-taking HMO) members are included; Medicare fee-for-service patients or Medicaid patients are excluded. Medicare members have access to diabetes education services because it is a covered Medicare benefit. It is likely that the commercial members in the database have access to reimbursement for diabetes education services (because it is generally a covered benefit under most employer plans).

Table 1

Number of Individuals Who are Identified as Having Diabetes for Each Year

	Commercial			Medicare		
Year	With Diabetes Education	Without Diabetes Education	Total	With Diabetes Education	Without Diabetes Education	Total
2005	10 994	142 829	153 823	1664	42 000	43 664
2006	11 957	149 860	161 817	2309	49 756	52 065
2007	12 277	154 654	166 931	2443	53 902	56 345

Data

The data supporting the analyses is compiled from national healthcare payer data with 3 years of complete data. Data consists of claims of 8 749 569 health plan members who are employees and dependents of health plan purchasers (often employers), referred to as commercial, and 631 931 members who are eligible for Medicare benefits as enrollees in Medicare Advantage plans, referred to as Medicare. Table 1 presents the number of these individuals who are identified as having diabetes for each of the 3 years for which data were available.

In addition to the clinical (service and diagnosis) information included in claims records, claims also include financial information. Aggregating financial information over time at the member level results in claims by member. On a monthly basis, this is referred to as claims per member per month (PMPM).

Comparisons were made between health plan members who were subject to diabetes education and those who were not. Longitudinal analysis was also used. Because the analysis was observational, a standard actuarial technique, risk adjustment, was used to ensure equivalence between the 2 populations.

Identifying Diabetes Education Claims

Members were identified for inclusion in the study according to the presence of diabetes education services in their claims history. Every time a service is rendered to a health plan member (or Medicare patient) the provider of service submits a claim for reimbursement. These claims represent a valuable source of nonclinician information about the patient's health history and services received. Table 2 presents the procedure codes, developed in conjunction with AADE's research and professional practice committees, that were used to identify diabetes education in the dataset.

Table 2

Identifying Codes for Diabetes Education

97802: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97803: Medical nutrition therapy; reassessment and intervention, individual, face-to-face with the patient, each 15 minutes.
97804: Medical nutrition therapy; group (2 or more individuals), each 30 minutes.
99078: Physician educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions).
G0108: Diabetes outpatient self-management training services, individual, per 30 minutes
G0109: Diabetes self-management training services, group session (2 or more), per 30 minutes.
G0270: Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.
G0271: Medical nutrition therapy, reassessment, and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group session (2 or more individuals), each 30 minutes.

Other medical nutrition therapy codes were considered, but were primarily follow-up codes. These codes identified only 15 additional members as potential patients for diabetes education and were therefore omitted from the identifying code set.

Controlling for Differences in Risk, Bias, and Confounding

In designing the study, efforts were taken to reduce potential bias that could occur if patients who were already better managed and/or educated are more likely to participate in diabetes education. Adjustments were made for known bias and confounding. Elements of bias that could arise from, for example, access to education programs, insurance coverage, availability of programs, or the participation of less-severe patients with less comorbidity in diabetes education simply because they enjoy a better (current) quality of life and are more able to participate in education. There is also a possibility that providers may discriminate in some way between patients, for example referring those that are more likely to be compliant to a diabetes educator. This tendency would also result in differential results when comparing patients with and without diabetes education.

To overcome the issue of potential bias due to self-selection by the patient, the results of patient panels of physicians who appeared to be relatively frequent prescribers of diabetes education were compared to those of relatively infrequent prescribers. In addition, the analysis considered the experience over time of a cohort of patients with diabetes. The advantage of looking at a cohort of patients with diabetes in a commercial payer database, such as the one used, is that it allows one to observe some dose-response reaction over time. This allowed for comparison of, for example, rates of compliance with best practice and HEDIS process measures (eg, A1C, lipids, microalbumin, foot checks, eye exams) over time.

This study controls for differences in severity of illness by applying risk adjustment, a technique found frequently in actuarial literature and used by, for example, CMS to assess the relative quality of physicians and in reimbursement for healthcare services. Risk Adjustment is a statistical technique frequently encountered in applications such as provider reimbursement in Medicare, Medicaid, and commercial populations. Risk Adjustment is a method for reducing medical condition differences to a single number at the patient level, allowing the investigator to construct average disease burden measures for different populations. Risk scores are calculated based on demographic factors (eg, age, sex) and diagnoses found on claims. A relatively high correlation exists between the risk score and the overall resource utilization (cost) of a population. Risk adjustment is a useful method when outcomes are related to consistent, measurable, administrative claims-based data.

Results

Overall Outcomes

Commercially insured members who use diabetes education cost, on average, 5.7% less ($P < .0001$) than members who do not participate in diabetes education (Table 3). Participating Medicare members (Table 4) cost significantly less (14%, $P < .0001$). An important validator of these results is the source of the differences. Commercial members with diabetes education have lower claims for acute services (inpatient claims, $P < .0001$) and higher claims for primary and preventive services (outpatient, $P = .0030$; prescription drug claims, $P < .0001$). Claims for professional services are significantly lower ($P = .0006$) in nondiabetes education group.

Analysis by Provider Likelihood of Referring to DSME/T

To avoid selection on the part of patients, patient cost and adherence were analyzed by category of providers. Examination of the data indicated very different rates of diabetes education participation by physician category,[5] even though physician panels appeared to be similar in other respects. The population was segmented according to percentage of diabetes education referrals in the provider practice, which are called least likely (0%-5% prevalence of diabetes education), middle (5%-10% diabetes education), and most likely (greater than 10% prevalence of diabetes education). Figure 1 shows results for commercial members. Figure 2 shows results for Medicare members.

Longitudinal Analysis

To test the effectiveness of diabetes education and avoid the self-selection issues identified above (either at the individual or the provider level) a third (longitudinal) analysis was used. This analysis began with a cohort of patients identified with diabetes in 2005 who were followed for

Table 3

Costs and Service Measures of Patients with Diabetes

Commercial	Nondiabetes Education	Diabetes Education	Total	*P*-value
PMPM cost average	$959.65	$905.39	$955.62	<.0001
PMPM inpatient average	$311.61	$223.09	$305.02	<.0001
PMPM outpatient average	$198.83	$212.28	$199.83	.003
PMPM professional average	$315.92	$310.69	$315.53	.0006
PMPM pharmacy average	$133.29	$159.33	$135.23	<.0001
A1C 1 + test (%)	70.7	81.3	71.5	<.0001
A1C 2 + tests (%)	33.2	46.2	34.2	<.0001
Lipid testing (%)	65.5	69.0	65.8	<.0001
Microalbuminuria (%)	32.9	44.0	33.7	<.0001
Eye exam %	28.9	28.1	28.9	.0003

Abbreviation: PMPM, per member per month.

Table 4

Costs and Service Measures of Patients with Diabetes

Medicare	Nondiabetes Education	Diabetes Education	Total	*P*-value
PMPM cost average	$1196.21	$1029.39	$1189.02	<.0001
PMPM inpatient average	$468.87	$308.08	$461.94	<.0001
PMPM outpatient average	$184.76	$192.72	$185.10	.3361
PMPM professional average	$308.48	$285.84	$307.50	<.0001
PMPM pharmacy average	$234.11	$242.75	$234.48	.0800
A1C 1 + test (%)	85.9	96.1	86.3	<.0001
A1C 2 + tests (%)	45.2	61.5	45.9	<.0001
Lipid testing (%)	80.4	90.6	80.9	<.0001
Microalbuminuria (%)	43.8	60.2	44.5	<.0001
Eye exam (%)	47.4	53.6	47.6	<.0001

Abbreviation: PMPM, per member per month.

3 years, provided they were enrolled for the entire period (ie, members who terminated from the database prior to the end of the period were omitted).

In the commercial population, the population that does not have diabetes education has initial costs that are slightly higher than those of the diabetes education population (2%). However, these values are not significantly different ($P = .4226$) to each other. Over time the costs of the 2 populations diverge significantly. What is particularly compelling about these results is that the gap between the cost of the diabetes education population and the noneducation population increases over time, so that by year 3 (2007) the nondiabetes population average cost is 12% higher ($P < .0001$). Similar results are seen in the

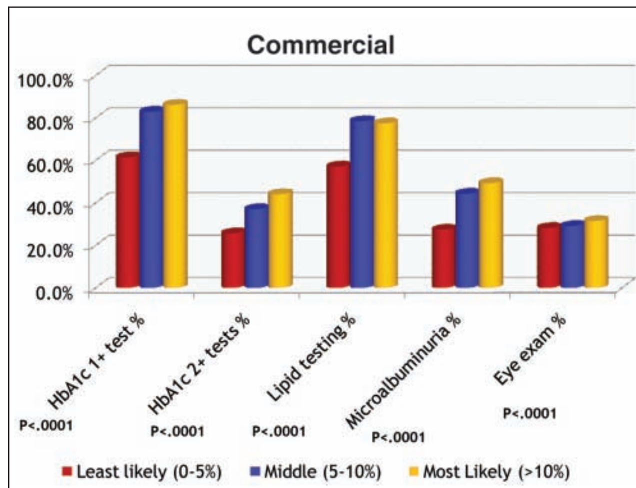

Figure 1. Patient diabetes process measures by provider's likeliness to refer to DSME/T commercial. HbA1c 1 + test % refers to the proportion of patients with diabetes who had at least one HbA1c test per year. HbA1c 2 + test % refers to the proportion of patients with diabetes who had at least two HbA1c tests per year.

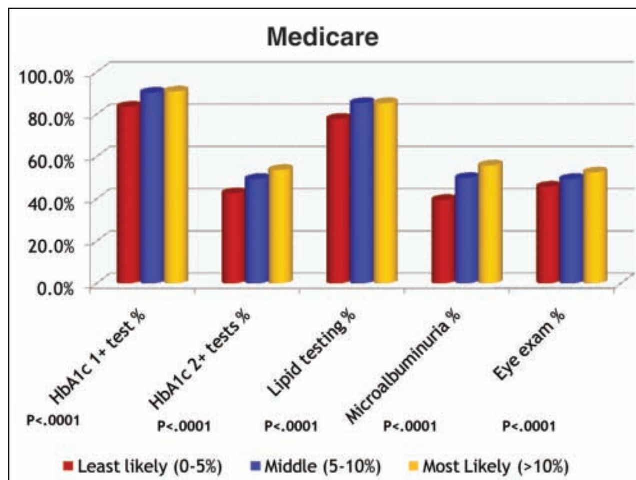

Figure 2. Patient diabetes process measures by provider's likeliness to refer to DSME/T Medicare. HbA1c 1 + test % refers to the proportion of patients with diabetes who had at least one HbA1c test per year. HbA1c 2 + test % refers to the proportion of patients with diabetes who had at least two HbA1c tests per year.

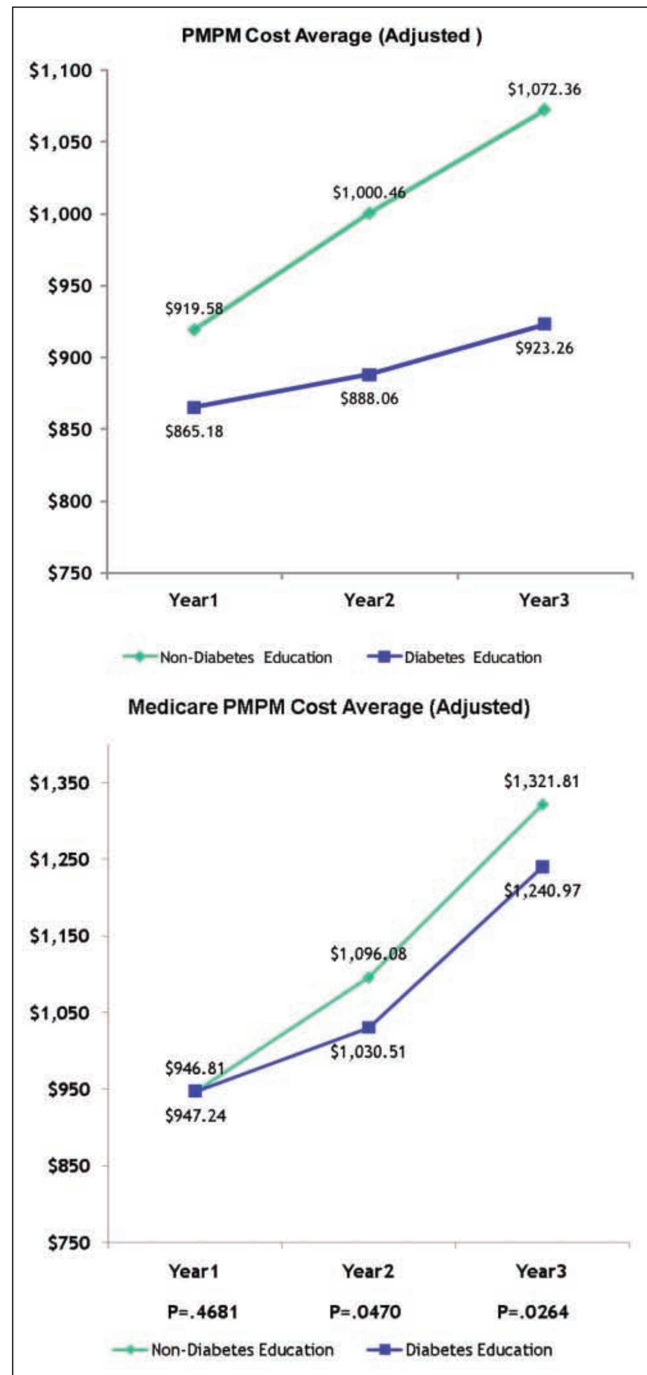

Figure 3. Trend in cost of patients with diabetes (2005-2007).

Medicare population, although the differences are smaller. For the Medicare population, initial cost of the nondiabetes education population is 3% lower ($P = .0914$) than that of the diabetes education population. However, by 2007, this population's cost is 3% higher ($P = .0587$) than that of the diabetes education population. This analysis could, however, be affected by the relative risk of those patients who enroll in diabetes education and those who do not. The analysis was conducted again with risk adjustment; the adjusted results are presented in Figure 3.

Risk-adjusted, the nondiabetes education population begins with costs 6% higher ($P = .0350$) than those of the diabetes education population. At year 3 the divergence continues in the unadjusted claims, and the difference grows to 16.0% ($P < .0001$). Because the initial

average costs are different, the rate of claims increase was analyzed. The analysis shows that for the nondiabetes education population, claims increased at 8% ($P < .0001$) per year on average. For the diabetes education population, the average rate of cost increase is 3.3% ($P = .0131$).

For Medicare, applying risk-adjustment results in initial cost of the 2 populations being the same ($P = .4681$). By year 3, the nondiabetes education population cost is 6% higher ($P = .0264$) than that of the diabetes education population. The average annual cost increase in the nondiabetes education population is 18.2% ($P < .0001$); for the diabetes education population it is 14.5% ($P < .0001$).

The analysis found rates of Healthcare Effectiveness Data and Information Set (HEDIS) process measures that are higher in the diabetes education population as compared to the population that did not receive diabetes education. The study indicates a positive correlation between the number of diabetes education claims in the population and adherence to process measures. Patients who have 1 or more claim for diabetes education in a year are more likely ($P < .0001$) to have an A1C test or a micro albumin test than those who do not have diabetes education. They are more likely ($P < .0001$) to have a lipid test (the lipid testing rate for all patients with diabetes is already high) and slightly more likely to have an eye exam (although the percentage of patients who comply with the eye exam is relatively low overall and *P*-values are not significant). With the exception of the measure 2 + A1C tests in the year, all measures improve over time ($P < .0001$) for the diabetes education group.

In looking at the overall HEDIS diabetes process measures by year, Medicare patient rates are higher ($P < .0001$) than those of commercial patients whose rates generally improve over time ($P < .05$).

Discussion

The findings from this study indicate that diabetes education is associated with increased use of primary and preventive services and lower use of acute, inpatient hospital services. Overall, health plan members who participate in diabetes education are also more likely to follow best practice treatment recommendations (eg, HEDIS measures) and to have lower claims costs. The results quoted above show the association between diabetes education and the likelihood to follow treatment and experience lower costs. Diabetes education is associated with higher compliance rates for nearly all HEDIS measures, particularly for the Medicare population.

In all cases, claims for best practice treatment process measures are positively correlated with the extent of diabetes education prevalence at the provider practice level. It may be argued that higher rates of best practices are more likely in practices that prescribe diabetes education because these providers are higher quality. The higher diabetes education prescribers may in general be higher quality providers (analysis of this aspect was beyond the scope of our study). Nevertheless, if this is true, an important conclusion is that diabetes education is (like testing and eye exams) an important component, and possibly an indicator of best practice of diabetes care.

The advantage of looking at a cohort of patients with diabetes in a commercial payer database such as the one used is that it allows one to observe dose-response reaction over time. This allows for comparison of outcomes over time of a more homogeneous cohort with regard, for example, to rates of compliance with best practice, HEDIS process measures. It is noteworthy that the risk adjusted longitudinal analysis shows that for the commercial nondiabetes education population, claims increased at 8% per year on average while for the diabetes education population, the average rate of cost increase is only 3.3%. The average annual cost increase in the Medicare nondiabetes education population is 18.2%. For the diabetes education population it is 14.5%. The divergence observed in costs and diabetes care process measures over time in both the commercial and Medicare populations suggests that this divergence would continue with a longer series of data.

The indications are that diabetes education is helping to reduce the rate of increase in average cost of care. The strength of the correlations identified between diabetes education and both HEDIS process measures and cost suggest that it should be able to replicate this analysis in other datasets.

Limitations

The findings from this study do not indicate causation but do provide strong findings based on a large number of covered lives of all ages included in the analysis. Some biases cannot be controlled (eg, perhaps patients who are already compliant are more likely to seek out and receive diabetes education). Information on provider prescribing behavior was not available because this study is based on payer data. Therefore, it was necessary to group providers into categories according to the extent to which their patients participated in diabetes education.

Since diabetes education is ordered by physicians, this design corrects for selection on the part of the patient. It does not necessarily correct for selection of providers. As in any similar study, the results should be treated with some caution.

Conclusion

This analysis of a very large administrative claims dataset shows that patients participating in diabetes education are younger, more female, located in more affluent areas, and have lower clinical risk, higher adherence to diabetes standards of care, and lower average costs than patients who do not use diabetes education. The differences between average costs of patients who use diabetes education versus those that do not are entirely driven by reduced inpatient costs. Conversely, outpatient and pharmacy costs are higher for patients who use diabetes education, indicating that these patients are receiving more primary, preventive care and less acute, affordable care. Over time, diabetes education is associated with somewhat lower cost trends (Medicare) and significantly lower cost trends (commercial). Physicians exhibit high variation in their use of diabetes education. Patients with diabetes who are treated by high users of diabetes education are more likely to receive recommended care (eg, tests and exams) and have lower average cost.

References

1. American Association of Diabetes Educators. The scope of practice, standards of practice, and standards of professional performance for diabetes educators. http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/the_scope_of_practice_07_14_08_Update.pdf. Accessed December 2008.
2. Norris SL, Engelgau MM, Narayan KM. Effectiveness of self-management training in type 2 diabetes. *Diabetes Care*. 2001; 24:561-587.
3. American Diabetes Association. Economic costs of diabetes in the US in 2007. *Diabetes Care*. 2008;31:596-615.
4. American Diabetes Association. Standards of medical care in diabetes—2008. *Diabetes Care*. 2008;31:S12-S54.
5. American Association of Diabetes Educators. Http://www.diabeteseducators.org. Accessed August 2008.
6. Funnell MM, Brown TL, Childs BP, et al. National standards for diabetes self-management education. *Diabetes Educ*. 2007;33: 599-606.
7. American Association of Diabetes Educators. Standards for outcomes measurement of diabetes self-management education. *Diabetes Educ*. 2003;29:804-816.
8. Booker S, Morris M, Johnson A. Empowered to change: evidence from a qualitative exploration of a user-informed psycho-educational program for people with type 1 diabetes. *Chronic Illn*. 2008;4:41-53.
9. Anderson RM, Funnell MM. The art and science of diabetes education: a culture out of balance. *Diabetes Educ*. 2008;34:109-117.
10. Renders CM, Valk GD, Griffin SJ, Wagner EH, Eijk Van JT, Assendelft WJ. Interventions to improve the management of diabetes in primary care, outpatient, and community settings. *Diabetes Care*. 2001;24:1821-1833.
11. Norris SL, Nichols PJ, Caspersen CJ, et al. Increasing diabetes self-management education in community settings a systematic review. *Am J Prev Med*. 2002;22:39-66.
12. US Department of Health and Human Services. *Healthy People 2010: Understanding and Improving Health*. 2nd ed. Washington, DC: US Government Printing Office; 2000. http://www.healthypeople.gov/data/midcourse/html/focusareas/FA05Objectives.htm. Accessed August 2008.
13. Centers for Disease Control and Prevention. Rates of preventive care practices per 100 adults with diabetes, United States. http://www.cdc.gov/diabetes/statistics/preventive/fAllPractices.htm. 2005. Accessed August 2008.
14. Centers for Disease Control and Prevention. Age-adjusted rates of ever attended diabetes self-management class per 100 adults with diabetes, United States. http://www.cdc.gov/diabetes/statistics/preventive/fY_class.htm 2000-2005. Accessed August 2008.

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What is This?

Costs and Benefits Associated With Diabetes Education

A Review of the Literature

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Purpose

The purpose of this article was to review the published literature and evaluate the economic benefits and costs associated with diabetes education.

Methods

The Medline database (1991-2006) and Google were searched. Articles that addressed the economic and/or financial outcomes of a diabetes-related self-care or educational intervention were included. The study aim, population, design, intervention, financial and economic outcomes, results, and conclusions were extracted from eligible articles.

Results

Twenty-six papers were identified that addressed diabetes self-management training and education. Study designs included meta-analysis (1); randomized controlled trials (8); prospective, quasi-experimental, and pre-post studies (8); and retrospective database analyses (9). The studies conducted cost analyses (6), cost-effectiveness analyses (13), cost-utilization analyses (7), and number needed to treat analyses (2). More than half (18) of the 26 papers identified by the literature review reported findings that associated diabetes education (and disease management) with decreased cost, cost saving, cost-effectiveness, or positive return on investment. Four studies reported neutral results, 1 study found that costs increased, and 3 studies did not fit into these categories.

Conclusions

The findings indicate that the benefits associated with education on self-management and lifestyle modification for people with diabetes are positive and outweigh the costs associated with the intervention. More research is needed to validate that diabetes education provided by diabetes educators is cost-effective.

In 2006, the United States spent 16% of its gross domestic product (GDP) or $2 trillion on health care,[1] and people with chronic conditions accounted for 85% of the expenditure.[2] Diabetes affects 7% of Americans and represents more than $116 billion of these expenditures.[3] The overall economic cost of diabetes in 2007 was $174 billion, with reduced national productivity accounting for $58 to $105 billion.[3,4] Moreover, the prevalence of the disease is rising, and total health care is expected to reach 20% of GDP by 2016.[1] Interestingly, even with these considerable expenditures, in 2005, the Centers for Medicare and Medicaid Services (CMS) reimbursed only $4.8 million on diabetes self-management training codes G108 and G109.

Diabetes education, also known as diabetes self-management training (DSMT) or diabetes self-management education (DSME), is defined as 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. DSMT/DSME is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator(s).[5] Diabetes educators are health care professionals who focus on helping people with and at risk for diabetes and related conditions achieve behavior change goals that, in turn, lead to better clinical outcomes and improved health status.

Diabetes education is effective in helping people with diabetes control their illness and maximize their health[6-9] and is generally accepted as a cost-effective strategy. There is, however, a lack of available published information regarding economic evaluations of the benefits and costs of diabetes education and the value that may be added by a diabetes educator. Even among those providing diabetes self-management education and training, the studies that demonstrate this fact are not well-known.

In late 2007, the authors undertook an analysis of the literature to better understand the economic benefits and costs associated with diabetes education. This article reports on the review of published literature and evaluates the economic benefits and costs associated with diabetes education.

Methods

Data Sources

The authors searched MEDLINE (1991-2006) and Google in the fourth quarter of 2007 using combinations and variations of the following search terms: (1) diabetes complications, diabetes mellitus, type 1 diabetes mellitus, or type 2 diabetes mellitus; (2) disease management, health promotion, patient education as topic, or self care; and (3) cost control, cost of illness, cost savings, cost-benefit analysis, costs and cost analysis, direct service costs, health care costs, health expenditures, health services, outcome assessment (health care), program evaluation, or quality-adjusted life years.

Inclusion and Exclusion Criteria

Diabetes self-management training and education programs were defined broadly. By defining the topic broadly, this study was able to identify a wider variety of economic studies on diabetes education to support this analysis. Inclusion criteria were any article reporting the economic and/or financial outcomes of a diabetes-related self-care or educational intervention. This study excluded articles published prior to 1991, not published in English, or not reporting the results in a quantifiable manner.

Study Selection and Data Extraction

Two of the investigators (KAF, JES) reviewed the titles and abstracts of the identified citations and applied a screening algorithm based on the inclusion and exclusion criteria described above. The "potentially eligible" studies were then reviewed in full. Data abstraction was performed by one investigator independently (KAF) using a structured abstraction process, and the abstractions were independently reviewed by another investigator (PP). Any discrepancies between the 2 investigators were resolved through discussion and consensus. The information extracted from the articles into the tables

included (1) study aim, (2) study population (eg, sample size, age, type 1 or type 2 diabetes, gender, race/ethnicity, and recruitment location), (3) study design, (4) intervention, (5) financial and economic outcomes, (6) results, and (7) conclusions.

Results

Literature searches identified 609 articles. The titles and abstracts were screened, and 26 articles were identified that addressed the costs and benefits of diabetes education, using this study's broad definition, and were included in this review (Table 1).[10-35] Most studies were conducted in the United States, and 2 studies were conducted in the Netherlands.[16,25] Data from 40 588 patients are represented in the studies. Most of the studies included adults, and 1 study focused on adolescents.[13] Studies involved patients with impaired glucose tolerance (IGT),[18,22,23,27] type 1 diabetes,[13] type 2 diabetes,[30,32,34] or both type 1 and type 2 diabetes.[10,12,14,24-26,28,29,31,35] Several studies did not specify the type of diabetes.[11,15-17,19-21,33] Study designs included meta-analysis,[26] randomized controlled trials (RCTs),[13,16,18,22-24,27,34] prospective quasi-experimental pre-post studies,[10-12,14,15,20,25,29] and retrospective database analyses.[17,19,21,28,30,31-33,35] The studies conducted cost analyses,[13,19,22,28,29,32] cost-effectiveness analyses,[10-12,14-16,18,21,23,24,26,34,35] cost-utilization analyses,[10,11,17,20,30,31,33] or number needed to treat (NNT) analyses.[25,27] The types interventions that were studied included comprehensive diabetes education or disease management programs,[10-12,14-17,19,20,25,29,31,33] diabetes prevention programs,[18,22,23,27] education for depression,[24] transmission of glucose values,[13] initiation of insulin therapy,[30] diet education,[34] and retrospective analysis based on A1C level.[21,28,32,35] The outcome measures generally addressed cost savings and included the following: total health care costs,[11,12,14-17,19-21,30,31,33,35] total diabetes-related costs,[10,16,25,30,32] outpatient costs,[13,24] inpatient costs,[28] medication costs,[16] cost per quality-adjusted life year,[18,23,24] cost of primary prevention of diabetes,[22,22,29] number needed to treat to reduce 1 case of diabetes,[27] cost per depression-free day,[24] and cost of restricted activity.[34]

Based on the results and conclusions presented in Table 1, each of the articles was assigned to 1 of 3 cost impact categories: (1) cost reduction/cost-effectiveness associated with the intervention (18 studies),[10,11,13-15,17,19,20,25,26,28-35] (2) neutral impact associated with the intervention (4 studies),[16,18,23,24] or (3) increased cost associated with the intervention (1 study).[22] Three studies did not fit into these categories.[12,21,27] More than half (18) of the 26 articles identified by the literature review reported findings that associated diabetes education (and disease management) with decreased cost, cost saving, cost-effectiveness, or positive return on investment (ROI). One study demonstrated increased productivity at the workplace.[34] Three studies did not report on diabetes education per se but imply that a well-designed diabetes education program could be effective in reducing costs. These are Gilmer et al's work on costs associated with rising A1C,[21] Rubin et al's findings that inpatient utilization declines with better management,[31] and Rosenblum et al's report of a 40% decrease in health care costs following initiation of insulin.[30] One study found the Diabetes Prevention Program (DPP) to be too costly for broad implementation and called for more affordable approaches for achieving weight loss outcomes that are associated with better health for people with or at risk of diabetes.[18] The DPP group suggests that self-management interventions are likely to be affordable in routine clinical practice when education is conducted in a group and generic drugs are prescribed.[27] The oldest of the studies reported on a randomized control study that found no effect from education.[16]

Discussion

Health care policy makers and payers, faced with considerable resource constraints, are increasingly focused on interventions that work well and do so for reasonable cost. Glycemic control among those with diabetes is a cost-effective strategy,[36] and health management programs that empower people with chronic illnesses to self-manage their conditions are of interest in the workplace.[37,38] Behavior change is crucial to effective self-management. Diabetes educators are experts at fostering positive behavior change in people with diabetes, and the interventions they use are effective.[10] The CMS and many other payers reimburse for diabetes self-management education/training, implicitly recognizing the importance and value of the intervention.[39] Diabetes education aims to achieve optimal health status and better quality of life, as well as reduce the need for costly health care. The primary purpose of this analysis is to increase understanding of the economic value of diabetes education for people with diabetes.

Table 1

Diabetes Education

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Balamurugan et al (2006)[10]	Implement a diabetes self-management education (DSME) program for Medicaid recipients using a continuous quality improvement (CQI) process and evaluate results of the participants' clinical outcomes and health care costs	212 Arkansas Medicaid recipients with diabetes for at least 1 year and enrolled in Medicaid for 11 continuous months. Children (<19 years), end-stage renal disease patients, and pregnant women were excluded.	Participants received 12 hours of group education (over 3 visits-initial visit, 6 months, and 1 year) on nutrition and self-management from a registered nurse and a registered dietician.	Diabetes self-management education program	Expenditures; overall and those related to diabetes	Over 1 year, DSME participants had a 0.45% decline in mean A1C, fewer hospital admissions, emergency room visits, and outpatient visits. Over 3 years, the estimated savings in diabetes-related cost was $415 per program completer. Over 10 years, completers were estimated to experience a decrease in coronary heart disease event and microvascular disease events by 12% and 15%, respectively.	This DSME program reduced health care use among Medicaid recipients with diabetes within 1 year and is likely to reduce costs associated with decreased utilization over a longer period of time.
Berg and Wadhwa (2002)[11]	Assess differences in behavior and medical service use comparing baseline, 6-month, and 1 year results	127 persons with diabetes in a health maintenance organization (HMO) and preferred provide organization (PPO).	Historical control comparison of diabetes disease management participants in community-based setting	Diabetes disease management program	Return on investment (ROI)	The number of participants getting an A1C test increased by 44.9% ($P < .001$), and hyperglycemia symptoms decreased by 53.2% ($P = .002$). Inpatient admissions decreased by 391 per	The implementation of the diabetes program that provides comprehensive information and counseling for self-management of diabetes is associated with positive behavioral change and substantial reduction in

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
						1000 for each group ($P <$ .001), while controlling for age, length of membership, and the number of comorbid claims for congestive heart failure.	medical service utilization. Cost analysis of disease management program costs found a $4.34:1 ROI.
Burton and Connerty (1998)[12]	Assess a worksite diabetes education program	53 employed individuals	Mean A1C values at baseline and 3 months were calculated	3-month worksite diabetes education program	Direct and indirect health care cost, productivity	The mean fasting blood glucose levels fell from 197.8 to 179.6 mg% ($P = .12$), mean glycohemoglobin declined from 11.5% to 10.1% ($P < .001$), and mean A1C declined from 9.0% to 8.3% ($P < .001$).	Although the values in this study were still higher than the ideal, any improvement in glycemic control has been shown to reduce the risk for diabetes-related complications and subsequent direct and indirect health care costs.
Chase et al (2003)[13]	Comparison of a modem transmission intervention to usual clinic visit	70 adolescents with type 1 diabetes for at least 1 year, ages 15-20	Randomized control trial (RCT)	Control group (quarterly clinic visits) vs modem group (transmitted glucose readings every 2 weeks for 6 months instead of clinic visits)	Savings/patient for the modem group as compared with the control group	The average cost for 6 months was $305 for the visit group and $163 for the modem group (savings of $142 per patient per 6 months).	While the A1C values did not differ significantly between the control and modem groups, the average occurrence of mild to moderate hypoglycemic episodes was similar between groups with no severe hypoglycemic episodes for either.

(continued)

Diabetes Educator Sunrise Report - Appendices

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Christensen et al (2004)14	Evaluate the cost savings and clinical effectiveness of a diabetes education program for improving nutrition knowledge, food portioning skills, hemoglobin A1C, and anthropometric indices	155 participants; ages 54.54 (11.87) years; females, 71.4%; type 1, 5.8%; type 2, 67.7%; no diabetes, 26.5%; 63.2%, ≥ college graduate	Quasi-experimental, pre- and postcourse anthropometric measurements; a written food portion test; an observational food-portioning skill test; and A1C test were administered and scored for all participants.	3-month diabetes education course focusing on food-portioning skills	Medical cost savings (inpatient)	Improved food portion knowledge (49.67% pre vs 59.56% post, *P* = .004), improved food-portioning skills out of 5 (2.43 pre vs 4.29 post, *P* = .023), A1C decreased 0.73% (*P* = .000), body mass index (BMI) decreased 0.82 kg/m2 (*P* = .000), waist circumference decreased 1.27 in (*P* = .000), hip circumference decreased 0.6 in (*P* = .000), and waist-to-hip ratio decreased 0.01 (*P* = .000).	Improved nutrition knowledge, anthropometric measures, and glucose control are estimated to reduce medical costs (hospitalizations) by $94 010.
Cranor et al (2003)[15]	Assess the continuity of outcomes for 5 years, ensuing after the initiation of community-based pharmaceutical care services	136 patients with diabetes covered by self-insured employers' health plans	Quasi-experimental, longitudinal pre-post cohort study	Education by certified diabetes educators (CDEs), long-term community pharmacist follow-up using scheduled consultations,	Mean total direct medical cost; productivity estimates in dollars and days of sick time	Mean A1C decreased at all follow-ups. The number of patients with optimal A1C values (<7%) also increased at each follow-up. More than 50% of patients demonstrated improvement in A1C values and in lipid levels at every measurement.	Patients maintained improvement in A1C over time, and employers experienced a decline in mean total direct medical costs.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
	(PCS) for diabetic patients			clinical assessment, goal setting, monitoring, and collaborative drug therapy management with physicians		Patients with higher baseline A1C values were more likely to improve; those with higher baseline costs were likely to have lower costs following education. Total mean direct medical costs decreased by $1200 to $1872 per patient per year compared with baseline. Days of sick time decreased every year (1997-2001) for one employer group, with estimated increases in productivity estimated at $18 000 annually.	
De Weerdt et al (1991)[16]	Evaluate if an outpatient education program for insulin-treated diabetic patients improved the level of self-care	558 patients from 15 hospitals	Randomized control study; 2 experimental groups (guided by a health care professional or a fellow patient) and a control group	Education program designed to assist insulin-treated diabetic patients in self-care	Cost of therapy	The effect of the program on metabolic control, quality of life, and costs of therapy was assessed, but no significant changes were noted.	No significant effect of education on any one of these variables could be identified.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
"Diabetes Cost Savings Legislation Would Save Millions for Ohio Insurance Industry, Business, and Taxpayers in Productivity, Emergency Room Visits, and Hospital Stays" (2005)[17]	Rationalize the implementation of the Diabetes Cost Reduction Act (DCRA) in Ohio by providing evidence of cost savings in states with DCRA and highlighting increased costs for Ohio in absence of the act	Persons with diabetes	Comparing cost in medical claims for patients who took the diabetes education course to patients with similar symptoms and problems who did not attend diabetes chronic disease workshops	Diabetes chronic disease workshops	Medical claims cost	Patients who completed a diabetes education course had $2324 less in medical claims per year than patients with similar symptoms and problems who did not go to a diabetes education workshop.	The implementation of the DCRA in Ohio will enable Ohioans with diabetes to obtain a better control of their blood glucose, thereby minimizing the occurrence of costly diabetes-related complications, promoting cost savings for the insurance industry in terms of decreased medical claims, emergency room visits, hospital stays, and surgeries.
Eddy et al (2005)[18]	Estimate the effects of the lifestyle modification program used in the Diabetes Prevention Program (DPP) on health and economic outcomes	3234 adults at high risk for diabetes (BMI >24 kg/m2, fasting plasma glucose level of 5.2725-6.9375 mmol/L [95-125 mg/dL], 2-hour glucose tolerance test	Cost-effectiveness analysis using the Archimedes model	No prevention, DPP's lifestyle modification program, lifestyle modification initiating after a person develops diabetes, and metformin	Cost-effectiveness of DPP lifestyle program in terms of quality-adjusted life years (QALYs) gained and cost/person	The DPP compared with no prevention would reduce a high-risk person's 30-year chances of getting diabetes by about 11%, the chances of getting a serious complication by 8%, and the chances of dying of a complication of diabetes by 2.3%. Compared with the	Lifestyle modification should be recommended to all high-risk people because it is likely to have important effects on the morbidity and mortality of diabetes. The program used in the DPP study, however, may be too expensive for health plans or a national program to

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
		result of 7.77-11.0445 mmol/L [140-199 mg/dL])				no-prevention program, the expected 30-year cost/QALY of the DPP lifestyle intervention from the health plan's perspective would be about $143 000. From a societal perspective, the cost/QALY of the lifestyle intervention compared with doing nothing would be about $62 600. Either using metformin or delaying the lifestyle intervention until after a person develops diabetes would be more cost-effective, costing about $35 400 or $24 500 per QALY gained, respectively, compared with no program. Compared with delaying the lifestyle program until after diabetes is diagnosed, the marginal cost-effectiveness of beginning the DPP lifestyle program immediately would be about $201 800.	implement. Less expensive alternatives are needed.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Fries and McShane (1998)[19]	Compare effectiveness and cost savings of health education programs in high-risk persons to those persons with all risk levels	2586 participants of the high-risk group were mostly members of employee groups, were white-collar workers, had private health insurance, and had a mean age of 49.7 years. Employee group had a mean age of 41.2 years. Senior group had a mean age of 73.3 years.	Historical control comparison of management of participants	Randomly selected participants received health assessment questionnaire, letter, a report, and health education material based on high-risk program areas (arthritis, diabetes, high blood pressure, smoking, etc).	Direct and total costs; ROI	Previous year costs were $1138 in direct costs for high-risk groups (HR) compared with $352 in employee (E) and $995 in senior group (S). At 6 months, direct costs were reduced by $304 (HR) compared with $57 (E) and $70 (S). Total costs were reduced by $484 (HR) vs $87 (E) and $120 (S). The ROI was 6:1 in the high-risk group vs 4:1 in the comparison groups.	Intensive educational interventions may be justified in high-risk groups when they result in larger changes in high-risk persons than in unscreened persons for use and costs.
Garrett and Bluml (2005)[20]	Assess clinical benefits, satisfaction, and economic measures from a collaborative health management program involving community	256 diabetic patients under self-insured employers' health plans; 80 community pharmacy providers with training who were reimbursed by employers	Quasi-experimental, pre-post cohort study	Community pharmacist patient care services using scheduled consultations, clinical goal setting, monitoring, and collaborative drug therapy	Mean projected total direct medical costs	95.7% reported being very satisfied/satisfied with care from pharmacist. Influenza vaccination rates increased from 52% to 77%, eye exam rates increased from 46% to 82%, foot exam rates increased from 38% to 80%, and patient satisfaction with overall	Patients who participated in the program had increased satisfaction with diabetes care, higher rates of self-management goal setting and achievement, and significant improvement in clinical indicators of diabetes management. Employers experienced a decline in

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
	pharmacists and health care providers aimed to assist diabetic patients with treatment, education, and self-management strategies			management with physicians and referrals to diabetes educators		diabetes care improved 57% to 87% in highest range. Mean A1C decreased from 7.9% to 7.1%, mean low-density lipoprotein cholesterol (LDL-C) decreased from 113.4 to 104.5 mg/dL, and mean systolic blood pressure decreased from 136.2 to 131.4 mm Hg. Total mean costs/patient were $918 lower than projection from initial year of enrollment.	mean projected total direct medical costs.
Gilmer et al (1997)[21]	Assess changes in economic and clinical indicators	3017 adults with diabetes who were continuously enrolled in a large HMO over a 4-year period	Regression analysis used to estimate relationship between glycemic control and medical care charges	Diagnosis of diabetes was ascertained from diagnostic and pharmaceutical databases with sensitivity of 0.91 and specificity of 0.99.	Standardized cost differentials for 1% changes in A1C for patients with diabetes and other chronic diseases and for those with diabetes only	Standardized 3-year estimates of charges ranged from $10 439 (patients without comorbidities) to $44 417 (patients with heart disease and hypertension). Medical care charges increased significantly for every	A1C provides useful information to providers and patients regarding both health status and future medical care charges. Economic data suggest that clinicians should assign high importance to low A1C results and aggressively

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
						1% increase of A1C above 7%. For example, for a person with an A1C value of 6%, successive 1% increases in A1C resulted in cumulative increases in charges of approximately 4%, 10%, 20%, and 30%. The increase in charges accelerated as the A1C value increased. The rate of increase in charges with A1C was consistent for patients with diabetes only as well as diabetes plus other chronic conditions.	maintain the A1C status of patients who have low A1C values. The medical charge data suggest that investment in clinical systems to improve diabetes care may benefit both payers and patients.
Herman et al (2003)[22]	Report the costs of the DPP interventions	3234 participants with impaired glucose tolerance (IGT) enrolled in the DPP interventions	Cost analysis	Lifestyle intervention or metformin use	Direct medical costs, direct nonmedical costs, and indirect costs of the placebo, metformin, and	Over 3 years, the direct medical costs of the groups assigned to the interventions were $79/participant for the placebo, $2542 for metformin, and $2780	Modest incremental costs are associated with metformin use and lifestyle interventions when comparisons are made to a placebo intervention. Future

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/Economic Outcome	Results	Conclusions
					intensive lifestyle interventions over the 3-year study period of the DPP from the perspective of the health system and society	for lifestyle. Direct medical costs (direct nonmedical costs) of care were $272 ($9) less per participant for the metformin group and $432 less ($1445 greater) for the lifestyle group as compared with the placebo group. Indirect costs by intervention were $230 more/participant for metformin and $174 less for lifestyle as compared with the placebo group.	evaluation of costs relative to health benefits can be used to establish the value of these interventions to health systems.
Herman et al (2003)[23]	Assess the cost-effectiveness of the DPP lifestyle and metformin interventions relative to the placebo intervention	3234 participants with IGT enrolled in the DPP interventions	Cost-effectiveness analysis of the DPP interventions from both health system and societal perspective	Intensive lifestyle and metformin interventions	Direct medical costs, direct nonmedical costs, and indirect costs; QALY from a societal and health system perspective	Over 3 years, the lifestyle and metformin interventions cost approximately $2250 more per participant than did the placebo in the DPP study. If implemented in clinical practice (and from a societal perspective), the lifestyle intervention cost $13 200 and metformin	Over 3 years, the lifestyle and metformin interventions were found to be both effective and cost-effective from a health system and societal perspective. Moreover, these interventions are likely to be affordable in routine clinical practice when education is conducted in a group and

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
						cost $14 300 per case of diabetes delayed or prevented. Lifestyle interventions cost $27 100/QALY; metformin cost $35 000/QALY gained. The lifestyle intervention was more cost-effective than the metformin intervention from both the health system and societal perspectives.	generic drugs are prescribed. Health plans are likely to acquire important personal and member benefits at a reasonable cost and in a short term by adoption of the diabetes prevention programs.
Katon et al (2006)[24]	Determine the incremental cost-effectiveness and net benefit of a depression collaborative care program compared with usual care for patients with diabetes and depression	A total of 418 of 1801 patients randomized to the Improving Mood-Promoting Access to Collaborative (IMPACT) intervention (n = 204) vs usual care (n = 214) had coexisting diabetes	Preplanned subgroup analysis of patients with diabetes from the IMPACT RCT	IMPACT, through a depression care manager (DCM), who offered education, behavioral activation, and a choice of problem-solving treatment or support of antidepressant management	Incremental cost-effectiveness and net benefit	Relative to usual care, intervention patients experienced 115 more depression-free days over 24 months. Total outpatient costs were $25 higher during this same period. The incremental cost per depression-free day was 25 cents, and the incremental cost per QALY ranged from $198 to $397. An incremental net benefit of $1129 was found.	The IMPACT intervention is associated with high clinical benefits at no greater cost than usual care.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Keers et al (2005)[25]	Determine the cost and benefits of an intensive diabetes education program for patients with prolonged self-management problems and to determine the inclusion criteria for optimal outcomes	61 participants of a diabetes education program	Pre- and postintervention data on glycemic control (A1C), diabetes-related distress, and costs were compared with a reference group of 230 nonreferred consecutive outpatients.	Multidisciplinary intensive diabetes education program (MIDEP)	Diabetes-related costs; immediate and future costs of diabetes complications; number needed to treat	The effect of MIDEP on A1C and diabetes-related distress was satisfactory, with 1 in less than 3 patients having a 0.5% reduction in A1C and 1 in slightly more than 2 patients reporting a decrease of >1 SD at the diabetes-related distress. Selection of patients with A1C 8.0% and diabetes-related distress scores ≥ 40 further increased MIDEP's efficiency without excluding many patients.	The intervention is effective and cost-effective in improving glycemic control and diabetes-related distress for patients with prolonged self-management difficulties. Stricter inclusion criteria related to A1C and diabetes-related distress scores may enhance the program's efficiency.
Klonoff and Schwartz (2000)[26]	Stratify interventions for diabetes according to their economic impact	Articles documenting or modeling the achievement of a desired outcome or benefit along with an economic	Meta-analysis/ literature review	Diabetes disease management programs	Cost saving and cost-effectiveness	(1) Clearly cost-saving interventions included eye care and preconception care. (2) Clearly cost-effective interventions included nephropathy prevention in type 1 diabetes and improved glycemic	Widely practiced interventions for patients with diabetes can be cost saving and cost-effective from both a medical and an economic perspective.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
		analysis for 17 widely practiced interventions for diabetes				control. (3) Possibly cost-effective interventions included nephropathy interventions in type 2 diabetes and self-management training. Unclear economic impact interventions include case management, MNT, self-monitoring of blood glucose, foot care, blood pressure (BP) control, blood lipid control, smoking cessation, exercise, weight loss, A1C measurement, and influenza and pneumococcus vaccinations.	
Knowler et al (2002)[27]	Assess a lifestyle intervention for controlling and preventing diabetes	3234 participants with IGT enrolled in the DPP interventions	RCT	Comparison of a placebo group with groups assigned to an intensive lifestyle change or metformin use	Efficacy at decreasing the incidence of diabetes	The lifestyle intervention was more effective than metformin. Fifty percent of the participants in lifestyle intervention experienced >7% loss of body weight. The incidence of diabetes reduced by 58% in the	While not explicitly stated, the reader could assume that by reducing the incidence of diabetes, costs relating to the treatment of the disease and comorbid conditions are reduced.

(continued)

Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
						lifestyle intervention group and by 31% in the metformin group as compared with the placebo group.	
Menzin et al (2001)[28]	Examine impact of improved glycemic control on short-term complications of diabetes and associated costs	3294 adults with diabetes in a managed care setting	Retrospective cohort design	No intervention; patients divided into 3 groups on basis of mean A1C level: good control (≤ 8%), fair control (8%-10%), and poor control (>10%)	Savings	About 10% of 2394 patients with diabetes had at least 1 inpatient stay for a short-term complication. Over 3 years, the adjusted rate of inpatient treatment for 3 groups ranged from 13:16:31 per 100 patients for good:fair:poor A1C control ($P = .05$). The corresponding mean adjusted charges were $970, $1380, and $3040, respectively.	Patients with good glycemic control on average saved $410 to $2070 over the span of 3 years when compared with fair and poor control group costs.
Ragucci et al (2005)[29]	Evaluate the effectiveness of pharmacist-administered diabetes mellitus education and management	191 patients with diabetes at 3 university-based primary care clinics	One-year observational study	Pharmacist-administered diabetes education and management services	Savings and cost avoidance for those patients with improved patient care outcomes-reductions in A1C	Average A1C at 1 year was 7.8% (range, 4.5%-13.9%) vs 9.5% (range, 5.4%-19%) at baseline (change -1.7%, $P < .05$). Of the patients, 38% had a 1% or greater	Clinical pharmacist provision of diabetes management services achieved significant improvements in A1C values, blood pressure, and aspirin use. Continued

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
	services on selected diabetes performance measures				of at least 1%, blood pressure control, and documented aspirin use	reduction in A1C. Average blood pressure decreased over the study period from 141/79 to 135/75 mm Hg ($P =$ .007), but average LDL levels did not change to a statistically significant extent (114-112 mg/dL, $P >$ .05). There was an increase from 34% at baseline to 73% at 1 year ($P <$ .0001) in aspirin use. The program achieved the A1C and LDL values that would qualify for National Committee for Quality Assurance (NCQA) diabetes recognition. Cost avoidance was calculated as $59 040, based on an estimated savings of $820 for each 1% decrease in A1C.	efforts in diabetes education and management are needed to further improve clinical, economic, and humanistic outcomes.

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Rosenblum and Kane (2003)[30]	Analysis of the cost and utilization of health care services before and after the initiation of insulin therapy in patients with type 2 diabetes	1177 patients with type 2 diabetes between the ages of 18 and 65 years and continuously enrolled in a managed care organization for 9 months before and after their insulin start date	Medical, facility, and pharmaceutical services in the preinsulin and postinsulin time period were examined along with a subanalysis of all types of medical service cost categories	Initiation of insulin therapy for patients with type 2 diabetes to determine decrease in disease-related and total health care costs	Total costs, disease-related costs, and costs associated with various aspects of direct care	Average total and disease-related costs increased after insulin was started, with a mean difference of \$2220 ($P < .001$) for average total costs and \$430 ($P < .001$) for disease-related costs. Much of the cost increase after the start of insulin occurred in the initial 2-month postinsulin period, after which both total costs and disease-related costs decreased by 57% ($P < .001$) and 49% ($P < .001$), respectively, throughout the remainder of the postinsulin time period. Facility costs decreased at all postinsulin measurement intervals. Pharmacy costs were the only treatment component to remain above the preinsulin period.	Initiation of insulin therapy in the management of type 2 diabetes involves an approximate 10% increase in total health care expenditures. This is offset by a 40% decrease in subsequent total health care expenditures 9 months following insulin initiation.

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Rubin et al (1998)[31]	Identify the potential to reduce diabetes complications and costs through intensive management	7000 people with diabetes being treated through 7 managed care plans	Retrospective analysis of short-term baseline and follow-up clinical, economic, member, and provider satisfaction	Implementation of a comprehensive health care management program for people with diabetes	Gross economic savings	Gross-adjusted savings of $50/member with diabetes/month (12.3%) was achieved, with gross unadjusted savings of $44/diabetic member/month (10.9%). Hospital admissions per 1000 diabetic member years decreased by 18%, and bed days fell by 21%. Patients with diabetes were more likely to get A1C tests, foot exams, eye exams, and cholesterol screenings while enrolled in the program.	Implementation of a comprehensive health care management program for people with diabetes cannot only lead to substantial improvements in costs and clinical outcomes in the short term but also result in continuing improvements in health status and a reduction in the number of future diabetic complications over time.
Shetty et al (2005)[32]	Assess difference in costs associated with different A1C levels	3121 patients (46%) at target A1C level ($\leq$ 7%) and 3659 patients (54%) above target A1C level ($\leq$ 7%)	Retrospective database analysis using eligibility data, medical and pharmacy administrative claims data, and laboratory data from a large US managed care organization	No intervention; type 2 diabetes patients <7% vs >7% A1C levels were followed for 1 year to determine difference in costs	Diabetes-related costs	After adjusting for confounders, the predicted total diabetes-related cost for the above-target group during the 1-year follow-up period was $1540/patient, 32% higher than the total diabetes-related cost ($1171) for the at-target group ($P < .001$).	Managed care members with type 2 diabetes who stayed continuously at the target A1C of 7% or less over a 1-year period incurred lower diabetes-related costs vs those who were continuously over the target of $\leq$ 7% A1C.

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
Sidorov et al (2002)[33]	Assess the impact of diabetes disease management (DDM) program on medical costs for patients with diabetes	6799 patients fulfilling Health Plan Employer Data and Information Set (HEDIS) criteria for diabetes, of whom 3118 patients (45.9%) enrolled in DDM and 3681 patients (54.1%) not enrolled in DDM	Retrospective examination of paid health care claims and other measures of health care use by the cohort over 2 years	DDM program	Average gross savings; ROI	Lower inpatient use among DDM patients (0.12 admissions and 0.56 inpatient days/patient/year vs 0.16 admissions and 0.98 inpatient days/patient/year for non-DDM). Mean number of emergency room visits was 0.49 (DDM) vs 0.56 (non-DDM). DDM patients had more primary care office visits 8.4 vs 7.8/patient/year but lower mean paid claims among commercial insurance ($302.19 DDM vs $527.96 non-DDM) and Medicare ($424.00 DDM vs $500.37 non-DDM).	Patients enrolled in the DDM averaged $394.62/member/month in paid claims vs $502.48 for those not in DDM (21% statistically significant reduction in costs for both commercial and Medicare risk insurance). Average gross savings: $1294.32 per person/year. Patients in DDM not only experienced lower charges but also had significantly higher measures in the key diabetes HEDIS measures.
Testa and Simonson (1998)[34]	Examine short-term outcomes of glycemic control in type 2 diabetes	569 employed individuals with type 2 diabetes	12-week randomized, controlled, double-blind study	Diet and titration with either 5 to 20 mg of glipizide gastrointestinal therapeutic	Change in glucose and A1C levels, symptom distress, quality of life (QOL), and health economic	At 12 weeks, mean A1C and fasting blood glucose levels decreased with active therapy (glipizide GITS) vs placebo (7.5% ± 0.1% vs	Lost earnings associated with absenteeism were $24/male worker/month with improved glycemic control but were $115 for those without uncontrolled

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
				system (GITS) or placebo	indicators (productivity) from questionnaires and diaries	9.3% ± 0.1% and 7.0 ± 0.1 mmol/L [126 ± 2 mg/dL] vs 9.3 ± 0.2 mmol/L [168 ± 4 mg/ dL], respectively; *P* < .001). Quality-of-life treatment differences for symptom distress general perceived health and cognitive functioning were significantly better for those in active therapy. Economic outcomes for glipizide GITS included higher retained employment (97% vs 85%; *P* < .001) and productive capacity (99% vs 87%; *P* < .001), less absenteeism (losses = $24 vs $115/worker per month; *P* < .001), fewer bed days (losses = $1539 vs $1843 per 1000 person days; *P* =.05), and fewer restricted-activity days (losses = $2660 vs	blood sugar. Lost earning due to restricted activity were $2660/1000 person days for male employees with good glycemic control vs $4275 for those without. Lost wages for those restricted to bed rest were $1539/1000 person days compared with $1843 for poor glycemic control. Improved glycemic control for patients with type 2 diabetes is associated with substantial short-term symptomatic, QOL, and health economic benefits. Employees who improved their glycemic control were more productive on the job (99% vs 87%) and able to remain employed longer (97% vs 85%) than employees who did not control and lower their blood sugar levels.

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Table 1 (continued)

Author (Year)	Study Aim	Study Population	Study Design	Intervention	Financial/ Economic Outcome	Results	Conclusions
						$4275 per 1000 person days; $P = .01$).	Absenteeism rate dropped by 1% compared with an 8% increase in employees with poor glycemic control.
Wagner et al (2001)[35]	Determine impact on cost of patients with improved A1C	4744 diabetes patients ≥ 18 years, continuously enrolled, and had A1C measured at least once a year	Historical cohort study between 1992 and 1997 in a staff-model HMO; 732 patients whose A1C decreased ≥ 1% between 1992 and 1993 and was maintained through 1994 formed the improved group. 4012 patients whose levels decreased 0.9% comprised the unimproved group.	Compare patients with diabetes whose A1C improved to those whose did not	Mean total costs; cost savings	Patients with diabetes whose A1C improved had similar demographics to those whose did not but had higher baseline measurements (10.0% vs 7.7%). Cost savings in improved cohort were statistically significant only among those with the highest baseline levels (>10%) and were unaffected by complications at baseline. Utilization was consistently lower in the improved cohort for primary care and specialty visits.	A sustained reduction in A1C level among adult patients with diabetes is associated with significant cost savings (mean total health care costs were $685 to $950 less each year in the cohort with improved A1C measurements) within 1 to 2 years of improvement.

MNT: medical nutrition therapy.

Most professional diabetes educators are members of the American Association of Diabetes Educators. Some diabetes educators are certified diabetes educators (CDEs) or Board Certified Advanced Diabetes Managers, having met certain eligibility and exam requirements. The American Association of Diabetes Educators advocates diabetes education that is provided by a diabetes educator and focuses on 7 self-care behaviors (ie, healthy eating, being active, monitoring, taking medication, problem solving, healthy coping, and reducing risks) that are essential for improved health status and greater quality of life. No economic studies were available that met this more restricted definition of diabetes education. Hence, this study adopted a very broad definition of diabetes education for its literature review. The strength of this decision is that more than 25 studies were identified as being relevant. The weakness is that the studies varied considerably in design, outcome metric, population studied, and their aims.

In summary, the review of the literature addresses economic and financial outcomes relating to diabetes education interventions that are supportive of diabetes education as a cost-effective intervention. One could posit that diabetes education reduces cost because it is guided by the best available science-based evidence; incorporates the needs, goals, and life experiences of the person with or at risk of diabetes; and supports the work of health care providers who treat these patients.

Most but not all published papers on the topic appear in Medline. Some of the studies are more robust than others. The inclusion criteria were broad, and hence it is not possible to grade the rigor of the studies and the importance of the findings of each. This study did, however, include findings from RCTs and a recent systematic review. Finally, it is not possible to identify the importance of the diabetes educator in the provision and outcomes of the programs in the study because of the broad definition of diabetes education that was used.

The findings indicate that the benefits associated with education on self-management and lifestyle modification for people with diabetes are positive and outweigh the costs associated with the intervention. More research is needed to validate that diabetes education provided by diabetes educators is cost-effective.

Implications/Relevance

- Behavior change, lifestyle modification, and self-management are crucial elements to the cost-effective management of chronic illnesses such as diabetes.
- For optimal comparisons, a standardized definition of diabetes education should be adopted for future economic studies.
- The benefits associated with diabetes education are positive and, based on the literature, outweigh the costs associated with the intervention.

References

1. Schoen C, Guterman S, Shih A, et al. Bending the curve: options for achieving savings and improving value in U.S. health spending, The Commonwealth Fund, December 2007. http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=620087. Accessed January 29, 2008.
2. Anderson G. Chronic conditions: making the case for ongoing care. Johns Hopkins University. November 2007. http://www.fightchronicdisease.com/news/pfcd/documents/ChronicCareChartbook_FINAL.pdf. Accessed January 29, 2008.
3. American Diabetes Association. Economic costs of diabetes in the U.S. in 2007. Diabetes Care. 2008;31:1-20.
4. DeVol R, Bedroussian A, Charuworn A, et al. An unhealthy America: the economic burden of chronic disease—charting a new course to save lives and increase productivity and economic growth. Milken Institute. October 2007. http://www.milkeninstitute.org/pdf/chronic_disease_report.pdf. Accessed January 29, 2008.
5. American Association of Diabetes Educators. About diabetes education. http://www.diabeteseducator.org/DiabetesEducation. Accessed February 5, 2008.
6. Norris SL, Nichols PL, Caspersen CJ, et al. The effectiveness of disease and case management for people with diabetes: a systematic review. Am J Prev Med. 2002;22(suppl):15-38.
7. Norris SL, Lau J, Smith SJ, Schmidt CH, Engelgau MM. Self-management education for adults with type 2 diabetes: a meta-analysis of the effect on glycemic control. Diabetes Care. 2002;25:1159-1171.
8. Salber PR. How managed care organizations contribute to improved diabetes outcomes. Am J Managed Care. 2008;14:9-12.
9. Gary TL, Genkinger JM, Guallar E, Peyrot M, Brancati FL. Meta-analysis of randomized educational and behavioral interventions in type 2 diabetes. Diabetes Educ. 2003;29:488-501.
10. Balamurugan A, Ohsfeldt R, Hughes T, Phillips M. Diabetes self-management education program for Medicaid recipients: a continuous quality improvement process. Diabetes Educ. 2006;32: 893-900.
11. Berg GD, Wadhwa S. Diabetes disease management in a community-based setting. Manag Care. 2002;11:45-50.
12. Burton WN, Connerty CM. Evaluation of a worksite-based patient education intervention targeted at employees with diabetes mellitus. J Occup Environ Med. 1998;40:702-706.
13. Chase HP, Pearson JA, Wightman C, Roberts MD, Oderberg AD, Garg SK. Modem transmission of glucose values reduces the costs and need for clinic visits. Diabetes Care. 2003;26:1475-1479.
14. Christensen NK, Williams P, Pfister R. Cost savings and clinical effectiveness of an extension service diabetes program. Diabetes Spectrum. 2004;17:171-175.
15. Cranor CW, Bunting BA, Christensen DB. The Asheville project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc. 2003;43:173-184.
16. De Weerdt, Visser AP, Kok GJ, van der Veen EA. Randomized controlled multicentre evaluation of an education programme for

insulin-treated diabetic patients: effects on metabolic control, quality of life and cost of therapy. Diabetes Med. 1991;8:338-345.
17. Diabetes cost savings legislation would save millions for Ohio insurance industry, business, and taxpayers in productivity, emergency room visits, and hospital stays. October 4, 2005 [cited January 7, 2008]. http://www.diabetes.org/uedocuments/10.4.05DCRA.pdf.
18. Eddy DM, Schlessinger L, Kahn R. Clinical outcomes and cost-effectiveness of strategies for managing people at high risk for diabetes. Ann Intern Med. 2005;143:251-264.
19. Fries JF, McShane D. Reducing need and demand for medical services in high-risk persons: a health education approach. West J Med. 1998;169:201-207.
20. Garrett DG, Bluml BM. Patient self-management program for diabetes: first-year clinical, humanistic, and economic outcomes. J Am Pharm Assoc. 2005;45:130-137.
21. Gilmer TP, O'Connor PJ, Manning WG, Rush WA. The cost to health plans of poor glycemic control. Diabetes Care. 1997;20:1847-1853.
22. Herman WH, Brandle M, Zhang P, et al. Diabetes Prevention Program Research Group: costs associated with the primary prevention of type 2 diabetes mellitus in the diabetes prevention program. Diabetes Care. 2003;26:36-47.
23. Herman WH, Brandle M, Zhang P, et al. Diabetes Prevention Program Research Group: within-trial cost-effectiveness of lifestyle intervention or metformin for the primary prevention of type 2 diabetes. Diabetes Care. 2003;26:2518-2523.
24. Katon W, Unutzer J, Fan M, et al. Cost effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression. Diabetes Care. 2006;29:265-270.
25. Keers JC, Groen H, Sluiter WJ, Bouma J, Links TP. Costs and benefits of a multidisciplinary intensive diabetes education program. J Eval Clin Pract. 2005;11:293-303.
26. Klonoff DC, Schwartz DM. An economic analysis of interventions for diabetes. Diabetes Care. 2000;23:390-404.
27. Knowler WC, Barrett-Connor E, Fowler SE, et al. Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med. 2002;346:393-403.
28. Menzin J, Langley-Hawthorne C, Friedman M, Boulanger L, Cavanaugh R. Potential short-term economic benefits of improved glycemic control. Diabetes Care. 2001;24:51-55.
29. Ragucci KR, Fermo JD, Wessell AM, Chumney ECG. Effectiveness of pharmacist-administered diabetes mellitus education and management services. Pharmacotherapy. 2005;25: 1809-1816.
30. Rosenblum MS, Kane MP. Analysis of cost and utilization of health care services before and after initiation of insulin therapy in patients with type 2 diabetes mellitus. J Manag Care Pharm. 2003;9:309-316.
31. Rubin RJ, Dietrich KA, Hawk AD. Clinical and economic impact of implementing a comprehensive diabetes management program in managed care. J Clin Endocrinol Metab. 1998;83: 2635-2642.
32. Shetty S, Secnik K, Oglesby AK. Relationship of glycemic control to total diabetes-related costs for managed care health plan members with type 2 diabetes. J Manag Care Pharm. 2005;11:559-564.
33. Sidorov J, Shull R, Tomcavage J, Girolami S, Lawton N, Harris R. Does diabetes disease management save money and improve outcomes? Diabetes Care. 2002;25:684-689.
34. Testa MA, Simonson DC. Health economic benefits and quality of life during improved glycemic control in patients with type 2 diabetes mellitus: a randomized, controlled, double-blind trial. JAMA. 1998;280:1490-1496.
35. Wagner EH, Sandhu N, Newton KM, McCulloch DK, Ramsey SD, Grothaus LC. Effect of improved glycemic control on health care costs and utilization. JAMA. 2001;285:182-189.
36. CDC Diabetes Cost-Effectiveness Group. Cost-effectiveness of intensive glycemic control, intensified hypertension control and serum cholesterol level reduction for type 2 diabetes. JAMA. 2002;287:2542-2551.
37. Ozminkowski RJ, Goetzel RZ, Smith MW, Cantor RI, Shaughnessy A, Harrison M. The impact of the Citibank, NA, health management program on changes in employee health risks over time. J Occup Environ Med. 2000;42:502-511.
38. Aldana SG. Financial impact of health promotion programs: a comprehensive review of the literature. Am J Health Promotion. 2001;15:296-320.
39. Department of Health and Human Services, Health Care Financing Administration. Federal Register, Part II; 42 CFR Parts 410, 414, 424, 480 and 498. Friday, December 29, 2000.

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 1 **Organizational Structure:** The DSME program will have documentation of its organizational structure, mission statement & goals and will recognize and support quality DSME as an integral component of diabetes care	A) There is documentation that describes or depicts Diabetes Education as a distinct component within the organization's structure and articulates the program's mission and goals. B) Documentation and/or procedures that support quality education shall include at least the following: a. Job descriptions of the Program Coordinator and instructional team that are congruent with program needs, including educational needs of target population. b. Diabetes education process and self-management support	Documentation of org chart of DSMT Program: YES ☐ NO ☐ Documentation of program mission and goals: YES ☐ NO ☐ Policies and procedures are available: YES ☐ NO ☐ Job Descriptions for all positions relating to the DSMT Program: YES ☐ NO ☐	Policies and procedures are an integral part of any quality process and must be developed for applicable program components. (Policy = directive or statement that must be adhered to. Procedure = guidelines for implementation of policy.) The mission is a brief description of the program's fundamental purpose. It answers the question, "Why do we exist?" Documentation broadly describes the program's present capabilities, customer focus, and activities. The targeted audience is identified in the mission statement. If diabetes education experience is used as the instructor qualification criteria instead of continuing education, the amount of previous diabetes education experience needed for the instructor who is not credentialed as a diabetes educator or a diabetes clinical management specialist shall be included in the instructor's job description.

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National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 2 **Advisory Group:** The DSME program shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.	A) A policy that identifies the structure and process, for the program's advisory group, will be maintained. a. This policy will address the advisory group's role in promoting quality DSMT programming.	Advisory Group Policy available including function and responsibilities (must include how group will promote quality and frequency of how often committee will meet: YES ☐ NO ☐ Documentation of Advisory Group Composition (must include at a minimum: Primary Care Provider, Educator and a Community Member with Diabetes) YES ☐ NO ☐ Program must have documentation of committee activities at least annually and available upon request. YES ☐ NO ☐	The advisory group for each DSMT program will vary according to program size, location and scope and complexity of services provided. AADE requires at a minimum the advisory group include: • primary care provider • educator • Community member with diabetes. The group must actively review and make recommendations on the DSMT annual program plan and continuous quality improvement plan.

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National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 3 **Population/Resources:** The DSME program will determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.	A) There shall be documentation of: a. Needs assessment for the target population. b. The availability of resources to meet these educational needs	Documentation must exist to reflect the following and should be reviewed annually : An identifiable process was used to assess the needs of the target population (e. g. Demographics, cultural influences, barriers) YES ☐ NO ☐ Unique needs of target population specified (language, literacy, cultural,): YES ☐ NO ☐ Allocation of resources specified (e.g. room, materials to meet target population requirements, staff, etc…) YES ☐ NO ☐	The development of a DSMT program must include identifying who it intends to provide services to (the target population/audience) Additional decisions and assessment about the target population are needed, and include the following: 1) The volume of people who will be in need of service on an ongoing basis 2) The type of diabetes that most potential participants have 3) Where your target audience primarily lives 4) Unique characteristics of large segment(s) of the target population that is relatively homogenous. Allocation of resources must be included and are based on assessment of the target population.

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 4 **Leadership:** A coordinator will be designated to oversee the planning, implementation and evaluation of diabetes self-management education. The coordinator will have academic or experiential preparation in chronic disease care and education and in program management.	A) A completed job application/resume of the program coordinator that identifies experience and/or education in program management and the care of individuals with chronic disease**,** congruent with the job description, is kept on file. B) The coordinator's position description will indicate that the coordinator is responsible for oversight of the planning, implementation and evaluation of the DSMT program. (See Standard 1) C) Coordinators are to follow the continuing education requirements of their professions (a minimum of 15 hours continuing education is required annually)	Coordinator's resume (reflects academic, continuing education, and/or experiential preparation): YES ☐ NO ☐ Job description must describe program oversight (must include planning, implementation and evaluation of the DSMT program): YES ☐ NO ☐ Program Coordinator has at a minimum 15 hours of CE credits (program management, education, chronic disease care) YES☐ NO ☐	The breadth and depth of responsibilities of the program coordinator will vary with the program size and complexity, but, at a minimum, the coordinator must have the ability to be responsible for planning, implementation and evaluation of services. The job description of coordinator will be congruent with the size and complexity of the program. (See Standard 1). The program coordinator must complete 15 hours of continuing education on an annual basis as it relates to their profession. If the program coordinator is also an instructor, the continuing education is diabetes-specific, diabetes-related, and/or behavior change self-management education strategies-specific (e.g., AADE7 self-care behaviors)

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 5 **Educators:** DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietitian, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructors' scope of practice and expertise.	A) Resumes and proof of licenses, registration and/or certification shall be maintained to verify that program staff is comprised of instructor(s) who have obtained and maintained the required credentials. B) If Community Health Workers (CHW) are part of the DSMT program team, there is documentation of successful completion of a standardized training program for CHWs and additional and on-going training related to diabetes self-management. a. Training includes scope of practice relative to role in DSMT C) If CHWs are part of the DSMT program's team, there shall be documentation that they are directly supervised by, the named diabetes educator(s) in the program. D) Proof of continuing education will be maintained to provide evidence that each instructor maintain their qualifications according to the specific criteria below and consistent with their job description: a. Instructors: i. 15 hours of continuing education annually for all instructors. ii. These hours must be from a nationally recognized	Instructor's current credentials (including licensure and/or registration proof) YES ☐ NO ☐ Instructor's current resume (Must include experience with diabetes education) YES ☐ NO ☐ 15 hours annual continuing education for all instructors YES ☐ NO ☐ At least one of the instructors is an RN, RD or pharmacist: YES ☐ NO ☐ CHW training, continuing education and name of supervisor, if applicable: YES ☐ NO ☐ Mechanisms for ensuring participants' needs are met. YES ☐ NO ☐	There is evidence that DSMT is most effective when delivered by a multidisciplinary team that is comprised of members with varying types and levels of expertise (both professional and CHWs) who collaboratively plan and implement a comprehensive plan of care. The concept of "team approach" must be implemented through collaboration and linkages with other health care providers of various disciplines outside of the program, when a participant's needs cannot be met by the program staff. Continuing education for instructional staff is specified as being diabetes-specific, diabetes-related, and/or behavior change self- management education strategies-specific (e.g., AADE7 self-care behaviors) CHWs will have non-technical and non-clinical instructional responsibilities; they will receive on-going informal training and formal training as appropriate. Mechanisms for meeting needs outside of scope of practice include: 1. Referral to other practitioner 2. Partnering with a professional with additional expertise (e.g., exercise

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National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
	accrediting body. E) For programs, particularly those that have solo instructors, there shall be a policy that identifies a mechanism for ensuring participant needs are met if needs are outside of instructor's scope of practice and expertise. F) There shall be documentation of: a. A process for ensuring that appropriate care coordination among the diabetes care team occurs. b. Team coordination/interaction.	Team coordination and interaction is documented in the patient chart (multi-instructional programs): YES ☐ NO ☐	physiologist or behavioral specialist) Quality care is more likely when the multidisciplinary team meets; this must be documented. The documentation can rely on a checklist or some other vehicle. The purpose is to make certain that care and changes in care are known by all team members in a multi discipline program.

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 6 **Curriculum:** Written curriculum reflecting current evidence and practice guidelines, with criteria for evaluating outcomes, will serve as the framework for the DSME program. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided: ○ Describing the Diabetes disease process & treatment options. ○ Incorporating nutritional management into lifestyle. ○ Incorporating Physical activity into lifestyle. ○ Using medication(s) safely and for maximum therapeutic effectiveness.	A. A written curriculum that meets the patients' needs will be maintained and updated as needed to reflect current evidence and practice guidelines. B. The curriculum: a. Uses principles and concepts of the AADE7self-care behavior framework (self-care behaviors): i. Healthy Eating. ii. Being Active. iii. Monitoring. iv. Taking medications. v. Healthy coping. vi. Problem solving. vii. Reducing risks. b. Includes content about the diabetes disease process/pathophysiology. c. Is tailored for the target population. d. Uses primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods.	A written curriculum tailored to meet the needs of the target population(Curriculum must include all content areas listed) YES ☐ NO ☐ Adopts principles of AADE7 and includes disease content: YES ☐ NO ☐ Curriculum is kept updated, reflecting current evidence, practice guidelines and is culturally appropriate(Needs to be document and shared with the advisory committee, at least annually). YES ☐ NO ☐ Curriculum maximizes use of interactive training methods: YES ☐ NO ☐	Medicare requires DSMT programs to have a written curriculum that includes specified content areas relating to the patient's understanding of self-management skills, knowledge and behavior change. The educational plan and comprehensive curriculum are based on the AADE7 and include a needs assessment, teaching techniques and tools, collaborative goal setting with implementation and criteria for assessing behavior change and goal achievement, and appropriate documentation. The curriculum and accompanying training materials must demonstrate that they are at the appropriate level of literacy and numeracy of the population being served and based upon evidenced-based principles of education and healthcare. Additionally, the curriculum shows that it takes into account cultural beliefs, attitudes and practices held by a majority of the population targeted to ensure successful DSMT. Using principles and concepts of the AADE7 self-care behavior framework for curriculum development or adaptation of standardized DSMT curriculums will provide continuity throughout the DSMT process (assessment through evaluation) and will center the focus of DSMT on behavior change, the primary purpose of

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
○ Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making. ○ Preventing, detecting, and treating acute complications. ○ Preventing, detecting and treating chronic complications. ○ Developing personal strategies to address psychosocial issues and concerns.			diabetes education. The program shows that use of primarily interactive, collaborative, skill-based training methods and maximizes the use of interactive training methods. Criteria for evaluating immediate outcomes (learning and barrier resolution) and, intermediate outcomes (behavior change goal achievement), using the AADE7 self-care behavior framework, (continuum of outcome measures) are part of the written curriculum.

CROSSWALK NSDSME/DEAP

NATIONAL STANDARDS, ESSENTIAL ELEMENTS, INTERPRETIVE GUIDANCE

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 7 **Assessment:** An individual assessment and education plan will be developed collaboratively by participant and instructor(s) to direct the selection of appropriate education, interventions and self-management support strategies. This assessment and education plan and the intervention and outcomes will be documented in the education record.	A) There will be documentation to identify that pertinent assessment data was obtained in a collaborative, ongoing manner between the participant and instructor. B) The AADE7 self-care behavior framework will serve as the foundation for the assessment and include the following elements: a. Relevant medical history b. Present health status, health service or resource utilization c. Risk factors d. Diabetes knowledge and skills e. Cultural influences f. Health beliefs and attitudes g. Health behaviors and goals h. Support systems i. Barriers to learning j. Socioeconomic factors C) There will be a written policy that describes the diabetes education process (assessment, planning, intervention and evaluation) and there will be documentation of the following for each patient: a. Educational plan b. Educational interventions provided i. If interventions not provided according to the plan, there shall be documentation about	Education Process Policy (Explain process for evaluating the educational intervention to meet the needs of the individual including evaluation of behavioral goals) YES ☐ NO ☐ De-identified Chart submitted and includes the following: Collaborative participant initial assessment (medical hx, health status, risk factors, diabetes knowledge and skills, cultural influences, health beliefs, support systems, barriers to learning, socioeconomic factors) YES ☐ NO ☐ Individualized plan of care based on assessment. YES☐ NO ☐ Intervention per plan provided and outcomes evaluated: YES ☐ NO ☐	The Diabetes Educational Process is comprised of an individualized assessment, goal setting, development of an educational plan, implementation of the educational plan and evaluation of the effectiveness of the DSMT interventions. The process is collaborative between/among the participant and instructor/s. An integral part of the process includes documentation in the education/medical/clinical record which promotes continuity of care. Communication back to the referring physician and other members of the diabetes care team is essential to high quality patient care and optimal health outcomes and demonstrated within the education process and patient charts.

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
	plan revision. c. Achievement of learning objectives D) Staff providing service will be identifiable in a way that can be authenticated. E) There shall be documentation to identify that an educational goal/s, and learning objectives and the plan for educational content and method/s were collaboratively developed between the participant and instructor(s).	Collaborative development of education goal, objectives and plan: YES ☐ NO ☐	

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 8 **Ongoing Support:** A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals, and the plan for on-going self-management support will be communicated to the referring provider.	A) There will be a written policy and documentation that identifies that a personalized follow-up plan to ensure on-going self-management support (DSMS) was developed in collaboration with the participant. B) There shall be documentation that identifies that the patient's outcomes and goals, and the plan for DSMS are communicated to the referring physician (or qualified non-physician practitioner).	Must submit a policy for personalized process and on-going self-management support strategies and communication of educational services to physician/ qualified non-physician practitioner: YES ☐ NO ☐ Evidence of the following in the de-identified chart: Physician Communication (e.g. summary of program, goals, DSMS plan) YES ☐ NO ☐ DSMS plan (support groups, on-line services, other programs such as weight loss, exercise counseling, any additional resources available. YES ☐ NO ☐	Achieving and maintaining behavior change goals that are necessary for successful diabetes self-management usually requires ongoing support upon completion of a diabetes education program or course. Diabetes self-management support (DSMS) can be provided by a variety of different people including health care professionals, community health workers, peer support and family; using a variety of different methods (telephone, web and e-mail, meetings, etc.). It is important to have an individualized plan for ensuring the provision of DSMS for most DSMT participants to help people continue to keep focused on diabetes. Communication back to the referring physician and other members of the diabetes care team is essential to high quality patient care and optimal health outcomes.

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 9 **Data Collection/Analysis:** The DSME program will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.	A) The evaluation policy shall use the AADE7 self-care behavior framework (or equivalent), core outcomes measures, behavioral and clinical outcomes for each patient individually and in aggregate. Outcomes will be compared to quality indicators to assess the effectiveness of the patients' care plan and the education intervention. B) Programs must set behavioral goals with their participants in order to evaluate the effectiveness of the education and interventions provided by the program. C) Programs must also collect clinical outcome measures in order to evaluate the effectiveness of the change in behavior. D) Programs must have a system in place to collect behavior/clinical outcomes in order to aggregate and evaluate effectiveness of the education and interventions.	Program must have a system in place to collect individual and aggregate achievement of behavior change goal(s) and outcomes and have the ability to produce the data minimally on an annual basis and as requested by AADE and/or Medicare (e.g. software system, excel spread sheet, integrated into the electronic medical record etc…) YES ☐ NO ☐ Policy required describing the process to collect data for behavior and clinical outcome measures. YES ☐ NO ☐ Policy to include how program will utilize data to achieve effectiveness of intervention: YES ☐ NO ☐	Individual patient outcome measures are used to guide the intervention and improve care for that participant. Aggregate population outcome measures are used to guide programmatic services and CQI activities for the DSMT and the population it serves (Standard 10) Data collection tools and processes are identified and used for data collection and analysis on an individual and aggregate program level. Program may use an electronic tool, such as the AADE 7 system or other systems available in order to collect the data and aggregate the data for analysis. In lieu of a software system an excel spreadsheet or other defined method may be used. Data must be utilized for individual level educational interventions and program level evaluation (Standard 10). Communication to the instructional team and members of the diabetes care team is essential to quality patient care and optimal health outcomes. Program data must be retrievable at any time per request from AADE or CMS and must be evaluated at a minimum of annually unless otherwise indicated (e.g. poor outcomes, program complaints, decrease in referrals etc…)..

Crosswalk NSDSME/DEAP

National Standards, Essential Elements, Interpretive Guidance

NSDSMEP	Essential Elements	Essential Elements Checklist	Interpretive Guidance
Standard 10 **Continuous Quality Improvement:** The DSME program will measure the effectiveness of the education process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.	A) There must be documentation of a quality improvement process and plan that utilizes the data collected in Standard 9 (Behavioral Processes measures and clinical outcome measures) to evaluate the effectiveness of the program educational interventions. B) Continuous quality improvement plans must be utilized and implemented as needed and shared with the advisory committee at least annually but more often if indicated by the data.	Program must have a policy in place that includes quality improvement on a program level and how data analysis will be used for program improvement YES ☐ NO ☐ Policy will need to indicate that CQI results will be shared with the Advisory Committee at least annually but more often if outcomes indicate immediate action. (Committee minutes and/or data collection can be requested by AADE or CMS at any time) . YES ☐ NO ☐	AADE requires that a CQI plan be in place that is consistent with the organization's mission and strategic plans, and evaluates the DSMT education process and program outcomes Program operation elements, e.g., wait times and program attrition are options for CQI projects. Data tracked and used for CQI purposes could also include other program quality indicators (data related to program operations/structure, process issues) such as wait time for educational services, reimbursement issues, number of referrals, etc.

Additional Documents Submitted

The following documents were also submitted with the applicant's follow up and reviewed by the department. We are providing links rather than including the full documents in the name of saving space in the report.

AAFP Team Essentials (American Academy of Family Physicians)
https://nf.aafp.org/Cme/CmeCenter/SessionDetails.aspx?id=fc08742c-49b1-4d50-9cc6-5aa783a0c02c&et=session

Building the Business Case for Diabetes Self Management: A Handbook for Program Managers
http://www.diabetesinitiative.org/documents/BusinessCasePrimerFINAL.pdf

Guidelines for the Practice of Diabetes Education
http://www.diabeteseducator.org/DiabetesEducation/position/Practice_Guidelines.html

Competencies for Diabetes Educators: A Companion Document to the Guidelines for the Practice of Diabetes Education (AADE)
http://www.diabeteseducator.org/export/sites/aade/_resources/pdf/competencies.pdf

Appendix D

Public Hearing Transcript

Diabetes Educator Sunrise Review
Public Hearing Transcript
August 2, 2013

KRISTI WEEKS: Good morning everybody. I'm going to start with telling you I'm going to read off a script. Sherry Thomas, who is our sunrise coordinator, writes these scripts for me because, otherwise, I'll start talking about who got kicked off Top Chef Masters on Wednesday night and really, really important things and we will go all day. So I'm going to read from the script and I apologize for that because it's not the most engaging way to run a meeting. Welcome to the public hearing on the Diabetes Educator Sunrise Review being conducted by the Department of Health. I am calling the hearing to order at 9:09 am according to that clock.

I am Kristi Weeks, Director of the Office Legal Services here in the Department of Health and I am also the legislative liaison for the Health Systems Quality Assurance Division. This is Sherry Thomas from our policy unit and she is the coordinator of the sunrise review process, as I mentioned. Many of you have been involved with the sunrise process and gotten to know Sherry either through phone or email or in person.

I would also like to introduce our hearing panel. The panel's role is to make sure we have all the information we need to make sound recommendations. Starting at the end, we have Dianna Staley. She is the compliance manager in the Office of Legal Services. In the middle, we have Alex Lee. He is a staff attorney in the Office of Legal Services. I stuffed the panel with my own people. On my near left is Danielle Welliver and she is regulatory analyst in the policy unit. The role of the panel is to ask questions, make sure that they understand the proposal, make sure that everyone else understands the proposal and then they make recommendations to management here in the department who actually make the final decision.

Today's hearing is for the proponents to make their presentation, and for opponents and other interested parties to comment on the proposal. Panel members and department staff will ask questions during the proponents' presentation and public testimony. After the hearing, there will be a 10-day written comment period before we draft the initial report. We want to allow you to provide additional information on topics brought up today, and allow those who could not attend the hearing to submit information. The address for submitting comments is posted on the wall.

The recommendations in our report will be based in part on this hearing. We expect the report to go to the Secretary of Health for approval in October. Once it goes to the Secretary of Health, there is a further process, which I believe I will describe later.

We ask that you stay after your presentation, if possible, because there may be follow-up questions. You must sign in by 10:00 am to assure we have time for you to speak today. Please be sure you have signed up on the sign-in sheet if you wish to testify. We also use the contact information on this sheet for updating participants during the remainder of the process.

Please keep in mind during your presentations and written submissions that the Sunrise Review process has statutorily mandated criteria. We stick to those criteria. As this is not a legislative hearing, political arguments or other factors not included in the criteria the Legislature has given us will not help or hurt the proposal we are reviewing. It is the Legislature's job to take those into account; they specifically have asked us to look only at certain criteria. It will be my job to try to keep us within the time limits as well as the limits of the review. The focus of our discussions should be on the applicant's report.

We hold two or three of these hearings each year. Over time, we've been able to identify some strategies for holding a productive hearing:

- Please note this hearing is being recorded and your testimony will be shared with interested parties. Because it is important that the recording is clear so future listeners can hear and understand it, we ask that you follow these two important rules:

    1. Please use the microphone when speaking. This includes panel members.

    2. Please do not call out information from the audience. If you are the person at the podium, please do not solicit information from your colleagues in the audience. This happens very, very often. The panel members will have an excellent question they will ask and the person at the podium says "I don't know" and a person out there will shout the answer. No, no. We have to have introductions. We have to have recordings because this is an official hearing. So if you have an answer out there, please come up to the podium and present that answer during your testimony.

- If your points have already been made by previous speakers, you do not need to repeat their testimony. Indicating your agreement with previous speakers will get your position on the record.

Now I am going to introduce the applicants. I would now like to welcome up the applicants to present their proposal to us. I'm going to ask the applicants to keep their presentation within the 30-minute time limit so we have time for panel questions and for others to testify. We will give you verbal signals if you go beyond the time limit. I don't know what those are going to be, but you will get them. Please use your time to focus on the sunrise criteria that are in the law and how your proposal addresses those criteria. The panel members are invited to ask questions during this presentation, which will then be followed by public testimony. I don't have the names of the applicants so I would ask that you introduce yourself. I apologize.

KIM DECOSTE: Is the microphone on now? My name is Kim Decoste and I represent WADE, the Washington State Diabetes Educators Association, and, primarily, the American Association of Diabetes Educators. I have been asked to be here because I am currently the chair of the licensure board for diabetes educators in Kentucky. We are the first licensure board and I won't claim to know more but supposedly because of that, we should. So I am going to move on and, hopefully, these ladies will help me if the slides don't work.

Thank you for giving us this opportunity to present our case. We do have very detailed slides in place for you all to be able to have, hopefully, more information that you will need when we are completed here. When we look at diabetes self-management education and training, we know that diabetes self-management education and training is an on-going process of facilitating the knowledge, skils and ability necessary for pre-diabetes and diabetes self-care. The process incorporates the needs, goals and life experiences of the person with diabetes or pre-diabetes and has got an evidence based standard. I think there are a number of points that are very important within this looking at DSME/T definition. We do individualize assessments of the patient's specific education needs, identify their specific goals, apply the intervention to achieve the goals, and then we evaluate the attainment. That's very key to successful diabetes self-management education.

What are the fundamental goals to support informed decision-making, the self-care behaviors, problem solving and active collaboration with the health care team? We try to improve clinical outcome, health status and quality of life. I am going to give you an example of that in just a second. Diabetes educators

prepare individuals to make informed decisions. We engage the person in effective diabetes self-management. We help to implement the self-care behaviors that allow the individuals to maximize their physical and psychological well-being. This is something I really like to be able to use and have shared this with decision makers in Kentucky. It is the DSME outcome continuum. When we look at this where does the diabetes educator work within this? Well, if you look at the continuum we have the learning so we help to share that knowledge and skill. This is done; remember back on the last slide, the evidenced based knowledge and skills and I think that is very, very key. And then from that, the intermediate goals and outcomes are the behavior change leading to the clinical improvement and improved health status. What I want share is one. In my program we have, after three months, I'll send a note back to the patients saying how have you done on these things. We have program goals, we have individual behavior change goals that are identified and this was is a note, I'll tell you it was a young guy who went to the other high school in town at the same time I was at my high school but you know, not that young. What he said was:

> The class was great. It taught me whole lot I did not know. Especially cutting down on carb intake. Before I came to class, my A1C was 10.2. (For those of you who know about A1C, that's really high). After learning to count my carbs on my next doctor visit, I got it down to 6.8! I feel better now than I have in years. I feel the class is the major reason. Thanks for all your help.

Well, if you look in that note he went across this, he learned the carbs, he changed his behavior, he had an A1C that moved in desirable range and he feels better than he has in forever. I, of course, called him back to congratulate him on his success and reminded him that he is the person that put in the action. I was just a tool to help him get there. That's so important, I think, that we recognize the team effort and that the patient really is at the head of that team.

Who are diabetes educators? We are health care professionals who help people with diabetes achieve behavior change goals whether it is related to the carb counting, weight loss, taking their medication correctly; so many different things. We help them achieve their goals and support them in making their personal changes. We provide the quality DSME and training which, in turn, lead to those better clinical outcomes and that improved health status. We counsel the patients on how to incorporate the healthy eating and physical activity. We help them understand their medication taking and how they work. Teaching them how to monitor their glucose, avoiding those risks of complications which we know are so costly, not only to them personally but to us as a society. We enable them to problem solve and adjust emotionally to diabetes. One of the behaviors we talk about is problem solving and what we are talking about is what do I do on a sick day? What do I talk about if my blood sugar is high? What do I on a field trip with my class? How do I handle those things? So we help folks in all of those ways.

The scope of the diabetes educators is unique in that its practitioners come from a variety of disciplines. Sometimes that makes is more of a challenge. Diabetes educators remain individually accountable to the standards set by the disciplines and by national, state, local and institutional regulations that define and guide their professional practice. The scope of practice, standards of practice and standards of professional performance for diabetes educators has been developed by the American Association of Diabetes Educators to define the scope, role and minimal levels of quality performance of the diabetes educators, to differentiate diabetes education as the distinct health care specialty, to promote diabetes self-management, education and training as an integral part of diabetes care and to facilitate excellence

Being a credentialed diabetes educator: That would be the only two credentials we have right now are CDE or BC-ADM that does not confer any permission to manage diabetes beyond the limitations of the individual's professional practice. Boundaries of practice are determined by state practice acts and sometimes this creates confusion even among the certified diabetes educators, not only in Washington and Kentucky, but all across the whole United States. They think that that credential gives them some power or right outside of their scope but boundaries of practice are determined by the state practice act

and we know that. So what you do here in Washington may be slightly different than what we do in Kentucky as far as the practice act.

Where is our diabetes self-management education provided in the health care system? You can see this is a pretty big list. Hospital outpatient centers are one of the main ones, tribal ambulatory care, veterans' hospitals. I come from the public health department. I have been almost 29 year in public health departments in Kentucky. Community centers. I'm not going to stand here and read them all to you but these are places where there are recognized or accredited programs providing diabetes self-management education according to the standards of care for diabetes self-management, education and support.

Who is providing it? This is from the national standards of diabetes self-management. These were updated just year before last and, actually, one of your Washington native sons or daughters, Linda Haas, is the primary author on these.

Instructional staff: one or more instructors will provide the DSME and, when applicable, diabetes self-management support. That's something that changed in the standards in this last rendition of them. They actually added diabetes self-management support and I think that is so key because we don't do this training and then just send them out there never to hear from us again or to not be supported in this ongoing sustainability of the diabetes self-management education and other behavior changes because we know that the key for a failure if we don't support them after we implemented these things. So this person will be a RN, RD or pharmacist with training and experience pertinent to the DSME or other professional with certification in diabetes care and education such as the CDE or BC-ADM.

Other health workers can contribute to diabetes self-management education and provide diabetes self-management support with appropriate training in diabetes and supervision and support. That's a bite in that last "other health workers can contribute". Sometimes, in Kentucky, when we were starting to implement our diabetes educator licensure, they were saying, "Well, are you saying I'm not allowed to say anything about diabetes education?" No, that's not what this says at all. We are all part of that team.

At this is place, I think of our community health workers. We couldn't get our job done without the community health workers because that is the person is may be following up with a person and say, you know, did you get your eyes checked like you did with your behavior change goal? That's a part of what helps complete that whole circle for us of being able to provide that ongoing diabetes education and support. This, even though the instructional staff on this one identifies just a few people, I would think licensed diabetes educators would be part of that instructional staff in Kentucky even if they don't come an RN, RD, or pharmacy. I can promise you that they will be. But I think it is important that we not leave those other people out too because we all have a role in that.

Education and Clinical Training: Diabetes educators, being a multi-disciplinary group, are educated at the undergraduate, graduate and doctoral levels depending upon the requirements of their primary disciplines. Two diabetes specific credentials are available in the US, certified diabetes educator and board certified in advanced diabetes management. Completed extensive hours of DSME related clinical experience within a two-year timeframe prior to sitting for an advanced credential. In Kentucky, we found that the ability to get some of those practice requirements to be able to obtain those advanced credential is a barrier and I am not convinced in what I did in the past several years in public health. I've been a CDE since the very first time it was offered but I don't know that I would be able to obtain those practice requirements because of the type of the things I would do. Sometimes, if I was out at community event providing information at a health fair, that didn't count as my practice time. So that is a barrier to me being able to get a credential that tells my patients that I am a qualified provider. I promise I am, even if I couldn't get that credential. So in Kentucky, we are counting on licensure to be able to recognize

those quality providers who are providing those evidence based care, good decision-making and helping to support the patients in that. I think that's very key.

Competencies of Diabetes Education: The qualified diabetes educators have achieved a core body of knowledge and skills in the biological and social sciences. This core body I attained when I was getting my nursing degree. That's what we are talking about with that. The communication, counseling and education and experience in the care of people with diabetes, that's that part that came afterwards. I got my basic education and then in my practice I have been able to get that experience requirement which is what brought me to that different level of providing this service to my patients. CDEs meet that the academic, professional and experience requirements set for by NCBDE. BC-ADM educators incorporate skills and strategies of DSME into more comprehensive clinical management of people with diabetes. The level of practice is characterized by care coordination and management, autonomous assessment, problem identification, planning implementation and evaluation of diabetes care. The providers at this level function either with protocols or, some of those people have prescriptive authority; that would maybe be a nurse practitioner or, someone in Kentucky, that would have that prescriptive authority. That would be determined by the state as well.

What sets the qualified diabetes educator apart from other disciplines? They have completed 250 hours of DSME related work experience within a two-year time frame, meets practice standards based on state or local regulations for specific disciplines and they additional continuing education related to diabetes within a two-year time frame.

When we look at harm to the public because I know that's one of the questions that I know that you all sent to me. We look at inappropriate insulin therapy by unqualified individuals. One example that I can give you on that is one of my colleagues, she's in California not in Washington, but she was telling me about a provider office that an unlicensed person trained the patient who has visual impairment to use his insulin pen. This diabetes educator was called in strictly for teaching how to use the talking meter. Nobody in their office knew how to use the talking meter. When she came in and talked to this patient, he really didn't know how to use his insulin pen. That person didn't do that individual assessment; didn't ask how well can you see. They didn't really look at that. This person, when asked by this diabetes educator to do a return demonstration and draw up the appropriate amount of insulin in the insulin pen, was not able to do that. That person had maybe been giving themselves an inappropriate amount of insulin that whole time. This certified diabetes educator I don't think would have sent that patient out the door in that rickety state, I would say. Harmful diet and nutritional therapy advice. The Food and Drug Administration takes action to remove from the market illegal products including some labeled as dietary supplements that claim to mitigate, treat, cure or prevent diabetes and related complications. We have had some issues in Kentucky with certain fruits that they say can cure diabetes and they have run very large ads in the newspaper. An unregulated field worth billion dollars with no barriers to entry lends itself to unethical behavior and practices. Unqualified individuals giving advice on medicines and behavioral therapies. Improper diabetes education can lead to more costly and debilitating comorbidities.

I'm going to turn it over to James Specker. I can respond to questions later if that's how this works.

KRISTI WEEKS: Unless they have something right now, so we don't have to call you back up. Does the panel have any questions for this presenter? Ok, you're still in the hot seat.

KIM DECOSTE: I'm still in the hot seat, ok.

DANIELLE WELLIEVER: Hi, Kim. I wanted to ask about the 250 hours of training. I know that the CDE is 1000 hours of training. Why the disparity? That's quite a bit less. Can you speak to that a little bit?

KIM DECOSTE: I think that is a number that would be open for discussion or change based upon what was decided. I can tell you that in Kentucky we did decide to go with a higher number than that. I think that would be an individualized state difference of regulatory type of a thing. That was how that was passed or that's how it was proposed in Kentucky through our regulations put forth by the licensure board.

DANIELLE WELLIEVER: I have one more question. You mentioned quality. Is there a definition for quality or do you have a definition for a quality trainer or educator?

KIM DECOSTE: I don't know if you are familiar with the standard of care. We can actually provide that document to you.

DANIELLE WELLIEVER: I don't need that but if you could...Thank you.

KIM DECOSTE: We can provide that document to you. It would be someone who does meet the requirements of what we describe there as far as the experience requirements as well as also in the practice requirements and following the standards of care, being competent within these standards in the different knowledge areas. AADE also has a competency document that looks at what they call different levels of diabetes educators and we would be, as a licensed diabetes educator in Kentucky, what we say, is that they would meet what they call a Level 3. So we can provide that document for you as well and it lists all sorts of different competencies and how they would utilize those. Whereas, I give an example, and that isn't saying that a person isn't competent in this, but if you look at the different levels say when I was a nurse in a hospital if I were to give take home instructions or teach a patient how to do insulin, that is a very appropriate nursing role for me to do that. They were very competent in that but that would be a level 2 educator. She doesn't even need to be a licensed diabetes educator because that's not her whole primary focus. That kind of helps you to think about when we are looking at the competencies documents when we provide that to you later. That may be more information than you needed on that but it will help look at that document critically that way and understand who it is that we are talking about.

DANIELLE WELLIEVER: Thank you.

ALEX LEE: Hi

KIM DECOSTE: Hi

ALEX LEE: So I just have a quick question.

KIM DECOSTE: Ok

ALEX LEE: You mentioned that some of these practitioners are certified diabetes educators and some are BC-ADM. I was just wondering, do you have a percentage of how many practitioners are CBEs versus BC-ADMs and do they ever overlap and share that same credential?

KIM DECOSTE: The answer is that yes, they do share the same credential sometimes and there is actually I think only one state that actually recognizes the BC-ADM as an advanced practice credential within their state laws and its somewhere in New England, I can't remember which one. That actually gives that person prescriptive authority and that type of thing. Lets them work as an advanced practice nurse. I have several colleagues who are BC-ADM and CDEs so there are a lot more than CDEs than BC-ADMs I can tell you that. We can get you that number for Washington if you would like that as well.

ALEX LEE: Thank you.

DIANNA STALEY: You talked about the roles that they have and how you set goals. I'm sure I saw all of these examples but didn't retain them all, where diabetes educators can work or do work. And so when you talk about your setting goals, how does the goal of the primary care practitioner play into it? You gave an example of your follow-up with the patients so I'm curious, what about the requirement for following up with the PCP and the overall healthcare team?

KIM DECOSTE: Exactly and you'll see that as part of the standard of care when we provide that document to you as well. In addition to me sending that patient's outcome questions in 3 months' time and then the next month I would send over a request for their A1C and then when we get that back…

DIANNA STALEY: What's that?

KIM DECOSTE: A1C. It's kind of an average blood sugar. It's a blood test that we do once every 3 months. It's our best predictor of good blood sugar control so it kind of give you an average. Whereas, if I stick my finger every day it only tells me what it is right then. It gives me an average and so that is our best predictor of our risk for complications. So that patient of mine moving his A1C from 10 to 6 something, he has reduced his risk eye problems, kidney problems, nerve damage. I mean I can't tell you how much he reduced it. So, in addition, after they come to classes or had an individualized encounter, I would send something to them saying your patient attended this; these are his or her behavior change goals. These are also recommendations we make on follow-up. Get his feet checked, get his eyes checked, have his flu shot. So it is a very comprehensive kind of a thing. So it is not just a stop in and do that and it is based on individualized assessment and that is so important.

DIANNA STALEY: Do diabetes educators in addition to work in various places, do you also have them in solo practice? Do they also work by themselves in a solo practice?

KIM DECOSTE: Some do and the last standards actually allowed that to happen that I could be an RN doing that. There is no way for me to be paid to do that right now. It just is being a registered nurse and registered dietician. It would happen more with a registered dietician because they can get reimbursement to be able to keep their shingle open on that.

DIANNA STALEY: Could a diabetes educator be that and work in a solo practice without an underlying professional other healthcare credential?

KIM DECOSTE: There is nothing that regulates it today.

DIANNA STALEY: So they could?

KIM DECOSTE: I don't ..as far as I know there is nothing in Kentucky that would stop a person but I can't speak toward Washington. If they were not trying to practice as a nurse or something like that so right now I don't know the answer in Washington. In Kentucky, there is nothing prior to our licensure that would keep someone from doing that.

DIANNA STALEY: I have a bunch of questions so thank you. Have you finished your process in Kentucky so you know how many licensees you have now?

KIM DECOSTE: We do not have it finished. We, hopefully, will start licensing people in October. Actually, our administrative regulatory committee hearing is this coming Monday and we hope to have it by the 15th. So our public comment kind of thing was last week.

DIANNA STALEY: How many programs can potentially provide that training and education?

KIM DECOSTE: I'm going to let James say because that's one of the featured spots.

DIANNA STALEY: Ok

KIM DECOSTE: So maybe if there are other questions and I'll hang around afterwards until everybody is done if you have other questions.

DIANNA STALEY: I have one more. You gave an example of an unqualified person. Do you know, did that person have any healthcare credential at all or was it a completely unlicensed person in a doctor's office?

KIM DECOSTE: I think they were what they call a medical assistant in California.

DIANNE STALEY: Thank you.

KRISTI WEEKS: Ok, at this time we will have James Specker, the other applicant, come up and provide the rest of the PowerPoint.

JAMES SPECKER: It looks like I have about 6 minutes. I'll get through as fast as I can. I am James Specker. I am representing the American Association of Diabetes Educators national. I work with all of our member states nationwide working on state issues not just on licensure but on other things that have been tacked on to diabetes educator.

So why do we feel it's necessary to regulate diabetes education for reasons beyond what Kim has been presented? We do believe that there is patient protection pieces here. We want to insure that those providing the DSME/T are trained and qualified. We would like a formalized legal process for entry into the field. In addition to that, we would like to set the minimum standards of care. I will go back to that 250 hours piece to answer that a little bit better. So according to the competencies that Kim spoke of we will provide all of you with a copy of that.

As we look at levels of diabetes educators, understanding that the CDE and BC-ADM are voluntary credentials and, as Kim says, we'd have to defer any permissions outside of your primary scope of practice. We looked at that level 3 educator, that non-credentialed diabetes educator, the CDE or BC-ADM, as having those 250 hours so those are the minimum standards of care that the people who have done research for the competencies decided was the absolute minimum in order to provide adequate diabetes education. So the current challenges right now, as was brought up, anyone can set themselves up as a qualified provider.
In no state in the country is there any regulation that would restrict someone from just opening up a shop in their house saying I'm a diabetes educator, come on and get some information. In my experiences and travels throughout the country, I have heard many stories of people operating diabetes education programs out of barbershops, out of their house and various other places who have no healthcare or clinical background whatsoever. It also means that restrictions in delivery and benefits varies for access for the person for diabetes.

With no formalized process, one of the key pieces of the DSME/T program is first and foremost the physician referral and without the physician understanding and knowing who these qualified individuals are that provide that care along with them, there is no referral. So utilization of this, and I'll get to this in a little bit, for DSME/T programs is, right now, 1 to 1.5 percent and it has been steady around there since

1997. We know that there are untrained, unlicensed unqualified providers operating outside of their legal scope of practice. For example, and I'm not picking on any one specific group, a registered dietician providing insulin therapy right now is operating outside of their legal scope of practice. We also know that prevalence is rising and increasing the cost of healthcare and complications.

Ok. One of the questions that was brought up to us prior to coming here is there another less costly way to protect the public other than licensing? What we believe is that regulating the practice of diabetes education is a cost effective solution for not just the state of Washington but on a national level. What we do know right now is that there are 437,000 diabetics in the state. Out of every 100 persons, 31 hospitalizations and 51 ER visits annually. Over 42% of diabetics have A1C levels above 7. The annual cost to the state is $11,900 per patient. That is $5.2 billion a year for medical costs for complications related to diabetes. We do know that there is a number of research and supporting evidence that supports the effectiveness not just healthcare outcomes but the economics outcomes as it relates to diabetes self-management training. A recent study on Medicare beneficiaries show that that there is an average cost savings of $16,200 per year per patient. Another study showed that there is a cost to the hospital of $551 per patient. A Robert Wood Johnson case study shows that there is a 26% return on investment and they are building the case for diabetes self-management and when we provide all of the citations to all the studies, we can provide additional supporting evidence if need be.

So to kind of look real quick at the prevalence rates in Washington and the location of accredited programs. As you see, there is a real direct correlation between access to qualified educators and accredited DSMT programs and the prevalence rate in the state of Washington. If you look at the northeast over there you will see where there is a lack of programs, prevalence runs 11% or higher. One of the things that we believe, and this goes back to that individual practicing independently in those types of areas, we believe that when you have qualified individuals providing care, they will be able to set themselves up in these rural areas and create that access that the patients need. It's sort of frustrating because I'm out of time. We, looking at the Washington Department of Social and Health Services goals as it relates to diabetes education and prevention, feel that this effort falls in directly in line with the goals set by DSHS. So just real briefly the time line:

In 1997, Congress enacted the DSMT benefit in the Balanced Budget Act but not having a legal definition, those providers with the most comprehensive knowledge were excluded since (inaudible) 108 and 109.

In an attempt to rectify, and we have been working on this since 1997, members of Congress have been really resistant because they cannot legal define the diabetes educator. As a result, as I stated, the utilization rate for the Medicare benefit has consistently stayed at that 1 to 1.5 percent due to access issues. In 2008, we decided to explore legally defining the diabetes educator in an attempt to increase access to DSME/T for the person with diabetes. In 2011, Kentucky was the first state to introduce licensing legislation that passed overwhelming in the House and the Senate. In 2011, Governor Bershear signed Senate Bill 71 into law. In 2013, (Indiana State) Representative Frizzell introduced legislation that passed overwhelmingly out the House and the Senate. Governor Pence, in a broad stroke, vetoed all six licensing bills that passed through the House this year without looking at each one on their own individual merits. We are going back again to have discussions with him and his staff to try to rectify this issue. This year we have also started to begin work in Pennsylvania, obviously, Washington and Florida to look at licensing of the diabetes educators.

What we believe licensure would accomplish: It would establish a legal scope of practice for those qualified to provide diabetes education. It would give that ethic and practice review procedure. Right now there is nowhere for a person with diabetes to go to report being given bad diabetes education. None of the primary groups oversees the practice of diabetes education so if it's an RD, you can't go to the

academy and complain. If it's a RN, you can't go to the nurses' association and complain because it doesn't fall within their jurisdiction of reporting bad diabetes education. We believe it will establish educational and clinical training requirements. It will add evidence based research to allow the qualified healthcare professional to continue provide the care that they are giving. We believe that it will increase access and we believe it will help reduce the cost of health care complications.

KRISTI WEEKS: Thank you. Do we have panel questions for Mr. Specker?

DANIELLE WELLIEVER: Thank you. There is absolutely no argument about the value of education and diabetes self-management training but one of the things that you talked about has to do with the delivery and benefit and barriers or access questions and you said, "No state regulation means restriction in the delivery the benefits and barriers to access and delivery". Can you talk about that? On the map, I was looking at the rural areas, it's the rural areas that are the darkest and there are no educators in those areas it looks like by your dot. It's also a poverty issue when you look at that map because, I've been a Washington state resident for so long I happen to know where the areas of poverty are on the one hand, too, and I know that stress plays a role. How does not having people licensed create a barrier rather than create access? I'm confused on that.

JAMES SPECKER: I think if you are allowing anyone to say that can say they can provide this service when we know evidence supports the efficacy of the outcomes, then you are denying them the access to that qualified individual since they are not made aware of it. So if anybody is saying my MA can give you diabetes education. They are the most qualified person that we know and it boils down to a policy issue, we believe that that is an added barrier and not supportive of what the real outcome is and that is to reduce by 100% the incidences of this home-based person with diabetes.

DANIELLE WELLIEVER: Some of the rural places…this is a very mountainous state and in some of the places there may be a very low population so if there is only a doc and a couple of nurses and other kinds of healthcare providers, how would you recommend then that diabetes education be provided in those places when there are very few healthcare professionals in that particular area to serve?

JAMES SPECKER: Well, those that are in that area, the requirements to have these continuing educations, these other requirements as far as practice and competency courses would allow them to attain those skills to provide that service to their community. In these low populations, one may be enough to service a big area. There is also the public health element that are incorporated into the DSMT as well.

DANIELLE WELLIEVER: Oh. Ok.

DIANA STALEY: Maybe I'm not getting it or not understanding it. When we talk about barriers, are we talking about barriers to getting the education they need or barriers to qualify an individual for both? As I think I heard you talking about in these rural communities, they are very isolated and very rural and coming from Kentucky…in some of your areas, you have that. You can go for several hundred miles and not see another car and that's Eastern Washington in a nutshell. Would this restrict the only PCP or ARNP or MD or PA from providing that education if they are the only ones there? Would they have to be a licensed diabetes educator for that endorsement or something else because that could be a barrier.

JAMES SPECKER: I would say yes, that they would need to meet those requirements. We know that not all physicians…I'm not going to step on anyone's toes but a family's physician that doesn't spend a lot of their time focusing strictly on what we understand and know and the evidence supports to be the most effective way to treat and manage diabetes.

ALEX LEE: Hi Mr. Specker. I just had a quick question on the unlicensed aspect that you raised. I am just curious when that situation happened and it looks like that is a harm that you are trying to prevent through this licensure, did the provider represent himself or herself as an established profession or are you saying they are unlicensed and they are representing themselves as a diabetes educator?

JAMES SPECKER: The examples that I was giving were folks that were not health care providers or associated with the health care industry in any way whatsoever and that are out there saying that I am providing diabetes education. In some minority communities, some of the examples that I got are people giving diabetes education out of their barbershop and those are the types of things that we hope to prevent.

ALEX LEE: So in that situation, would it be someone representing themselves as a physician or a nurse or….?

JAMES SPECKER: As a diabetes educator and providing diabetes self-management training and not necessarily saying I'm a physician diabetes educator or an RD diabetes educator but just a diabetes educator offering clinical advice, medical advice. The gamut of DSMT runs from behavior, health and medicines to other things that someone that doesn't have that clinical background really doesn't have the core competencies to expand on and/or provide care.

ALEX LEE: Thank you.

KRISTI WEEKS: Any other questions for Mr. Specker? Ok, you are off the hook for now. We will now take public testimony. You will be called up in the order in which you signed in if you indicated that you wish to give testimony. If your position has changed at any point, please let us know. So the first person is Maureen McKenzie from Snohomish County Community Health Center.

We do have about 2 hours left so at about 10 or 11. For people who are testifying, I am not going to put time limits on testimony but under 5 minutes maybe?

MAUREEN MCKENZIE: Yes, that would be my goal. Under five minutes.

KRISTI WEEKS: Excellent.

MAUREEN MCKENZIE: Ok, great. Good morning. My name is Maureen McKenzie. I am a family nurse practitioner and I have worked 25 years in community health clinics which serve the uninsured, immigrant, mentally ill and homeless communities. These are all populations at high risk for diabetes. The last 8 years, I have dedicated myself to diabetes self-management training of this diverse group of patients. I have implemented group visits as well as individual visits for our patients with pre-diabetes and diabetes. I have nothing but utmost respect for diabetes educators and I have consulted with our local diabetes educators on different occasions. Unfortunately, during my 15 years at Community Health Center of Snohomish County, the only diabetes educators that I have come in contact with are the two CDEs at our community hospital. All the others are working for drug companies. We clearly need more diabetes educators and I support the licensing of diabetes educators.

I do not support educators being the sole providers of diabetes self-management training or education. The populations that I serve at community health center need diabetes training from the team. I am really taking a lot of my argument from the clinical practice recommendations that come out from the American Diabetes Association yearly that really supports empowering the team when it comes to diabetes education. The team, which includes in our clinic, the doctors, PAs, nurse practitioners, RNs, nutritionist, and pharmacists. Our patients need to hear over and over again how to identify a carbohydrate, how to

combine their foods, how exercise improves the effectiveness of their insulin, how to take their medications. A single visit with a diabetes educator is not enough. This strategy for care of diabetics is supported by these practice guidelines that are put out yearly.

Under strategies taken from this for Improving Diabetes Care, Objective #1 is optimize provider and team behavior and I'm going to quote. It states:

> The care team should prioritize timely and appropriate intensification of lifestyle and/or pharmaceutical therapy of patients who have not achieved beneficial levels of blood pressure, lipids, or glucose control. Strategies such as explicit goal setting with patients; identifying and addressing language, numeracy, or cultural barriers to care, integrating evidence-based guidelines and clinic information tools into the process of care, and incorporating care management teams including nurses, pharmacists and other providers have each been shown to optimize provider and team behavior and thereby catalyze reduction in A1C, blood pressure, and LDL cholesterol. (Diabetes Care, volume 36, Supplement 1, January 2013 p. s50)

Which is all of our goals – to get those measures and goals for our patients. The "Chronic Care Model" is a system designed to activate patients to develop the best self-care practices and that's kind of a model that we are using in chronic care. The ADA Position paper states that to make this happen, and I'm quoting:

> Redefinition of the roles of the clinic staff and promoting self-management on the part of the patient are fundamental to the successful implementation of the Chronic Care Model. Collaborative, multidisciplinary teams are best suited to provide such care for people with chronic conditions such as diabetes and to facilitate patients' performance of appropriate self-management.
> Diabetes Care, volume 36, Supplement 1, January 2013 p.s50

My work at community health centers has been dedicated to developing the team and making evidence based instruction tools available to our patients. This means instructing RNs and medical assistants on how to do a good foot exam, developing insulin protocols that can be adjusted by RNs and pharmacists, making simple teaching materials available to clinic staff which educate the patient about carbohydrates, portion control and the plate method, providing pedometers and "Sit and Be Fit" DVDs to activate patients to improve their activity levels. In our diverse population, we must all be educating the patient when the patient is at the clinic. We are forever uncertain in our clinic when the patient will return to our care because of the myriad emotional, social and financial barriers that prevent optimal care.

Rebekah Scharf is here today with me. She is an RN clinical care manager at our clinic in Edmonds. She will share her contribution to the diabetes team approach.

In summary, I will quote from the "Diabetes Care Clinical Practice Recommendations for 2013"

> It is clear that optimal diabetes management requires an organized systematic approach and involvement of a coordinated team of dedicated health care professionals working in an environment where the patient-centered high quality care is a priority. (Diabetes Care, volume 36, Supplement 1, January 2013 p.s50)

As our clinics experience increasing numbers of diabetics, we will need the flexibility to move the staff that we have into greater roles of providing diabetes care to our populations and everyone who see the patient must be able to reinforce the self-management care needed to manage a chronic illness. In diabetes

care, we must make every touch with the patient count. And I am a soccer fan, and we know that, in soccer, every touch counts as does diabetes care. Thank you.

KRISTI WEEKS: Before you leave. First of all, I am going to ask if the panel has any questions. OK.

DANIELLE WELLIEVER: You talked about organized, systematic coordinating. Who does the coordinating in the team approach? Who is the coordinator?

MAUREEN MCKENZIE: That is a very good question. In our clinic, I have really been the coordinator and I have been the one who at our provider meetings tried to keep them updated yearly on the latest in terms of the standard of care for diabetes practice. Making sure that they know what materials are available to educate our patient. Training our RNs on the latest and the most effective ways to educate our patients. So yes, I would be identified as that person in our community clinic.

DANIELLE WELLIEVER: So for the individual patient, is it the primary care provider that does the orchestration or do they just refer them to the clinic and within the clinic, they make sure that every aspect of diabetes education gets handled. Is that the way it works?

MAUREEN MCKENZIE: Again, in a community health centers we are never sure how long that patient is going to be there so we want our pharmacist-saying do you understand your medicines, how are you taking it, tell me how you are doing, are you taking your insulin?

Rebekah will talk to this too how the RN, when the patient is in the clinic, they need to go into that room and make that connection and say I'm going to be calling you and following up with you. How are you taking your medicines? They should be reinforcing everything that's been learned. So we try to make that one connection and I am there as kind of identified as a specialist and so I get our patients that are having A1Cs of 14% or greater than 14% which is unfortunately not uncommon in our practice. I run group visits as well to provide a diabetes report for our patients and we have a nutritionist. We have lots of ways that we try to come around our patient population.

DANIELLE WELLIEVER: So a patient, a low-income person, or transient person who moves around a lot might just see an educator maybe once in a while so you try to maximize the visit when they are there.

MAUREEN MCKENZIE: When they are there, absolutely, maximize the visit. When they walk in to refill their medicine, we want that pharmacist to be making sure that they understand how to take their medicine.

DANIELLE WELLIEVER: Thank you.

DIANNE STALEY: Can I see the same type of approach for other disease processes that need some type of education.

MAUREEN MCKENZIE: I wish we did and we hope to move into this style of management with other diseases as well; asthma, as well as congestive heart failure, hypertension but at this point, diabetes is then kind of where we started in our practice.

KRISTI WEEKS: Ok if there are no more questions. My second point was..I saw that you were reading your testimony. If you are comfortable, we would love a copy of that but if you have notes on there…we have a copy? Oh, ok that's excellent.

MAUREEN MCKENZIE: I can send you an electronic copy, too.

KRISTI WEEKS: That would be lovely. Ok. Our next presenter is Rebekah Scharf from Snohomish County Community Health Center.

REBEKAH SCHARF: Good morning everyone. Can you hear me ok? My name is Rebekah Scharf. I am a registered nurse. My Bachelors is Science in Nursing. I work at Community Health Center of Snohomish County. I have worked for Community Health Center for two years in various capacities. I am a registered nurse there.

Our patients at Community Health Center are a very underserved population, often having a lot of barriers including having no insurance, mental illness, language barriers, homelessness and limited income. Given all these barriers, our patients are oftenknown to not follow through with their various treatment plans. They often do not show up for their appointments with us, which means that it's really important that when our patients do come to their appointments, that we educate them and that really empower our health care team so that we have people readily available to meet with these patients and to educate them when they do come to their appointments. It is often that sometimes when they walk out the door, that's it. They are lost to care; we don't have phone numbers for follow-up; they don't have addresses or other contacts so we can get in touch with them so it more important that we really reach them when they are in our clinic.

At Community Health Center, we currently have 4 different clinics, with a 5th opening this month. Our providers include medical doctors, physician assistants and advanced registered nurse practitioners. We have registered nurses at each one of our clinics. We also have mental health professionals and pharmacists so we have quite a team. And then we have Maureen who is an ARNP and leads our diabetic group visits as well as individual visits for a little more diabetes education. We have a registered dietician who serves all of our sites as well. It really takes a team to address all of the needs of our patients and a lot of times that education can fall to our clinic nurse and so we find that it is very important to have registered nurses at each site. We find that if they can meet with patients before or after an appointment with a doctor, that usually helps to add on some extra education. The nurses specifically with diabetes provide education about diet, exercise, glucose monitoring and medications. We also assist with the titration of insulin using specific protocols that we have to do that. We also follow-up with patients by phone to further discuss their care. We follow the American Diabetes Association guidelines and are checking to make sure that our patients are up-to-date on the yearly recommendations like for their eye exams, lab and foot exams. We have really found that by having our nurses follow up with patients and providers and establishing that contact, has really helped these patients to follow up when they leave by phone call or taking the next step to meet with Maureen or with our dietician.

My concern regarding limiting the education of patients with diabetes to the licensed diabetes educators is that this could limit the amount of education that our other licensed clinical professionals will be able to provide. For example, at Edmonds Community Health Center, we do not have diabetes group visits but I hope do hope to lead this type of educational support group some day at our location. With this new licensure, I'm not sure if that would be permitted. All of community health center's professionals teach within their scope of practice and if they are ever limited in the extent of education that they can provide, I feel that this will adversely affect the outcomes of our diabetic patients. Our organization needs the flexibility to have different members of the team provide diabetes education. It would not be possible to have a licensed diabetes educator at each one of our sites. It takes really our whole team to provide solid management.

In conclusion, making the diabetes educators the sole educators for patients with diabetes would severely restrict the access to care for our patients who have barriers, a lot of barriers - their health needs, poor social support, limited incomes, limited cognition, and poor literacy to name a few. Having a clinic that

can meet their multiple needs when they arrive for an appointment is crucial to providing good, sound, solid care. By allowing everyone on the team to support our patients with their diabetes, will really help our patients to develop expertise as well as confidence in their self-care, which is essential to living with diabetes. Even if community Health Center is able to have a licensed educator on staff, that person would need, as part of their role, to educate the other members of our healthcare team regarding the most up to date information on diabetes and educating and supporting our patients' self-care management. Thank you.

KRISTI WEEKS: Question for Ms. Scharf? Thank you. Off the hook. Next, we have David Knutson representing the Washington Osteopathic Medical Association.

DAVID KNUTSON: Thank you for the opportunity to speak to you today. The Osteopathic Medical Association has not taken an official position on this but they did ask me to come and make a few comments about the specific legislative proposal that has been submitted as part of this and also raise a couple of questions that they have as well.

The first is in Section 4 of the Bill. The language says that the Chapter does not alter or modify practice of a person licensed, certified or registered in a health care discipline in the state of Washington and list several occupations and professions. It does not specifically reference osteopathic physicians so we would ask that after the word "physicians" that "osteopathic physicians" be included as well.

In Section 5 of the proposal there would be a state board of licensed diabetes educators established made up of 5 individuals and again in Subsection 2, Sub A, it only calls out medical doctors licensed under Chapter 18.71 RCW. So our request would be that osteopathic physicians licensed under 18.57 RCW be included there as well as a potential member of the panel.

I guess the third question is in Section 6 of the Bill. This is the Section that says after the effective date the person may not use the title licensed diabetes educator or profess to be a licensed diabetes educator unless the person holds a specific license under this. There seems to be some confusion about whether existing healthcare practitioners that provide diabetes education are excluded from this proposal or would be required to be licensed under this proposal. So I think there needs to be some clarification there.

And then the final point I'd like to make is that when the Legislature established the regulation of occupations and professions several years ago, it created 3 levels of regulation: registration, certification and licensure. The legislative intent section was that the minimum level of licensure necessary to protect the public is the level that should be chosen. In hearing the presentation today, I'm not convinced that licensure is necessary in order to protect the public. I think that the panel may want to consider a level of regulation that is somewhat less than licensure, possibly certification or registration, to accomplish the purposes but not restrict the practices of existing health care practitioners. Thank you.

KRISTI WEEKS: Questions?

DIANNA STALEY: I do have a question for you. Do you have any comments or thoughts about creating a board?

DAVID KNUTSON: Creating?

DIANNA STALEY: A board for this.

DAVID KNUTSON: It's a little odd because the board that is proposed to be created calls out five different categories of individuals all of which may not be licensed under this chapter. If you have a

physician or a registered nurse or the other health care professions called out under this board, they potentially wouldn't be licensed as diabetes educator so, again, I think there are some internal and inconsistencies in the proposal that need to be worked out. And again, depending on what level of regulation the state would choose to impose, you would have a different disciplinary process; you know, the Uniform Disciplinary Act, as opposed to a separate licensure board for example.

DIANNA STALEY: Thank you.

KRISTI WEEKS: Ok. Thank you. Oh, I forgot. Ok. At this time, we are going to take a 5-minute stretch and stand break. If you need a quick trip to the restroom, it's right around the corner.

<BREAK>

<RESUME>

KRISTI WEEKS: Ok, we're going to go ahead and get started again. I'm going to ask Robin Fleming to step forward. Robin Fleming of the Washington State Nurses Association?

ROBIN FLEMING: Good morning. I'm Robin Fleming. I work for the Washington State Nurses Association as a nurse practice and education specialist. We acknowledge that diabetes is a serious public health problem. The applicant's report provides excellent data on the prevalence of the disease in Washington State. We also agree with the applicants that healthcare providers need sufficient diabetes knowledge to provide safe, competent care for persons with or at risk for diabetes. However, we do have concerns with regulation of diabetes education proposed by the sunrise review.

First, the scope of practice for registered nursing already includes diabetes education and implementation of diabetes self-management. I worked as a school nurse for more than a decade prior to my position at WSNA and I did a lot of diabetes care. I did home visits. I worked with kids. Each individual with diabetes is different and has their own set of issues that needs to be individually looked at and as a registered nurse, I was able to take care of those kids very well. While we support registered nurses who seek further education and training in diabetes education, and many of them do, this proposal would require registered nurses to obtain an additional credential for diabetes education that is not necessary.

We also believe the establishment of a Washington State board of licensed diabetes educators to regulate registered nurses with this credential would be duplicative as the Nursing Care Quality Assurance Commission already regulates the competency and quality of nursing care professionals by establishing, monitoring and enforcing qualifications for licensing through the existing standard of practice, to renew of competency requirements and more. We are concerned about the creation of a board to regulate diabetes education. While there exists a body of best practice for diabetes self-management, like many medical conditions, that body of knowledge will evolve. We do not believe that it is the role of the disciplinary board to control the practice of diabetes management.

Section 8.1 of the bill allows persons with a generally described training to obtain the proposed credential. This contradicts the applicant's report that requires completion of a primary discipline. Lack of clarity with regard to a minimum standard of education and training does not support the goal of a consistent quality of care for diabetes. Furthermore, because this proposal allows persons to obtain a credential of licensed diabetes educator without a primary discipline, it is possible for a situation to arise where a registered nurse would necessarily need to be supervised by a licensed diabetes educator that does not have the depth of training of a registered nurse. We believe that this would result in lower standard of care than what is currently envisioned by the voluntary credential that requires the underlying primary discipline.

Finally, this law would set a precedence for regulation of healthcare services that are specific to diseased states. We believe the health of patients is best served when nurses conduct thorough and holistic evaluations that take into account all aspects of a person's health. I appreciate very much the opportunity to comment. Thank you.

KRISTI WEEKS: Are there any questions? Again, if you would like to provide a copy of your written testimony, we would appreciate it. Thank you.

Next up, we have Kate White Tudor representing the Washington Association of Community and Migrant Health Centers.

KATE WHITE TUDOR: Thank you. My name is Kate White Tudor. I am the lobbyist for the Washington Association of Community and Migrant Health Centers and I would definitely appreciate and incorporate the comments from Maureen and Rebekah of the Community Health Centers of Snohomish County. They are one of our 26 member not-for-profits throughout Washington State. We operate over 180 clinic sites throughout Washington and we are seeing almost 800,000 patients every year. We are seeing about 10% of the State of Washington at our clinics.

I gather there was a little misunderstanding about what these clinics are. They are federally qualified health centers that are established under Section 3.30 of the Public Health Act under federal law and there is various ways in which we have to qualify to be qualified under federal law to received certain types of reimbursement and that includes patient majority board, not-for-profit status, we have to see patients regardless of their ability to pay, we have to offer sliding fee scale for our uninsured patients, and we have to provide comprehensive medical services, not just primary care services, but dental services, behavioral health services, interpretation, transportation, medical visits, case management, nurse visits.

It's a whole larger comprehensive approach to medical care, which is really the direction that this country is going in under the Affordable Care Act. I am also proud to report that all of our community health centers this year will be accredited as patient centered medical homes either by the MCQA or JAICO by the end of this year. So we are working, as the Snohomish County folks said, on a team-based approach to making sure that our patients get exactly what they need in every visit that they are in. Their lives are very challenging. They don't have a lot of resources to wait all day or they may be bringing little children in with them to the office and there is a lot they have to get done every time that they come and so we have a practice of making sure that we are efficient with the use of our providers, that they are working at the top of their licenses, and we are also efficient with the use of the patient's time knowing that their lives are complicated. So with our team based approach we are able to make sure, as our Snohomish county colleagues explained to you, that we educate patients about the disease picture that they bring into us.

They don't come in with one disease. They come in with a whole complex of different conditions and concerns and then they have problems with their blood pressure; they have problems with their diabetes; their children may come in with asthma; they have oral and periodontal disease; they may have problems with mental health and all of this is what our health centers are set up to hear and deal with and to touch each patient on all of the things that are concerning them and make sure they get the support that they need the very most that day.

And so if a patient with diabetes comes in, their doctor is likely to talk to them about what the disease is, what management means, the various options that folks have for management. They may hand them on to a nurse educator who will spend more time with that patient and talk with them about the medications that they might take, how the insulin gets titrated, etc. They may hand them then on to the pharmacist to fill that prescription. The pharmacist will sit down and say, "So you talked to the doctor, what did you

understand from that conversation?" Then they talk to the nurse "What did you understand from that conversation? Does this make sense?" A pharmacist is like the third check in the road to see did the patient get the information that they need to do what they need to do to keep themselves healthy when they go home. If that communication didn't happen, the pharmacist can send them back up to talk to the nurse educator again or maybe bring in the dietician this time. The nurse will be able to call them a week later and say, "So where are you in taking these meds? Is this working for you? Can you keep them refrigerated if you need to? Do you have power or do you need help with your utility bills to keep your medications refrigerated? Can you come back to the office so we can check your glucose levels? How about you do that in about three days? Can we send a car to pick you up?" So we are trying to make it as easy as possible for our patients to really get their health under control when they are facing so many challenges.

We are really delighted and excited to be doing that in a bigger way as we are working. Our goal is to enroll 141,000 of our currently uninsured patients into Medicaid through the Medicaid expansion or exchange when those programs go live and offer them new insurance in January. So we are ramping up our outreach and enrollment efforts in a really big way and we are adding new clinic sites. We are recruiting new providers. We are working with the national health service corps to help provide relief so that we can get the best-qualified providers where they need work. It is an enormous effort to bring a proven, tacit model of high quality team based care to the most vulnerable and poor citizens of Washington State.

We have already submitted a letter in our testimony to explain everything; that this idea of licensing diabetes educators would really interfere with the work and the efficiency of the teams that we have developed. It would be very difficult, given the large volume of patients within community health centers, who are dealing with blood sugar control issues and problems, to have a licensed diabetes educator who is, on top of all these members of the team, in control of the team based approach for one disease but not for all the others who would need to, potentially, in some of these clinics, be seeing several patients simultaneously at every hour of the day. I mean, we are seeing so many patients with serious health conditions on a daily basis that we would…I don't know what the volume of potential need to add staff would be but we are not-for-profit and we are operating close to the margin and we believe that using a team based approach where everybody is educated about diabetes and everybody can touch that patient multiple times improves the quality of the care we give to our patients and improves the safety of the patient by making sure that there are multiple different people touching them around their education and knowledge about the disease from multiple different directions and we think that if we isolated the functions to a single provider, that the outcomes would not be good and the patient care would not be as good.

We are concerned that the expense of credentialing a whole lot of highly qualified people to know about what they need to know right now would be a waste when we are trying to find the resources to see 141,000 additional patients by January. We would respectfully request that this not go forward to legislation.

KRISTI WEEKS: Questions?

DANIELLE WELLIEVER: From what I understand, Medicare and Medicaid certify programs. They don't certify providers for reimbursement and this is important for access to care. In your clinics then do you have these certified programs in all of your clinics?

KATE WHITE TUDOR: I don't think it is all of them. I think a letter that was submitted said 11 are certified by the state standards under the certified diabetic educator standards under Medicaid and we've

got an additional 6 who are working under the American Diabetes educators recognition for accredited program and we are continuing to work on getting accreditation for the rest.

DANIELLE WELLIEVER: Thank you.

KATE WHITE TUDOR: I would like to make you aware that of the 16 that are accredited there are some that are extremely small or work in collaboration with other providers so depending on the clinic size different, there are different levels of accreditation.

DANIELLE WELLIEVER: Thank you

KRISTI WEEKS: Thank you

KATE WHITE TUDOR: Thank You

KRISTI WEEKS: Next up we have Kay Hansen from the NTA. I could guess what that means but I'll let you explain.

KAY HANSEN: Thank you. Good morning. I am Kay Hansen. I am here with the Nutritional Therapy Association and I will say that my comments are going to be very brief. We are concerned with the overly broad scope of this proposal in that it talks about people at risk of diabetes. We are a training organization. We have trained approximately 775 people in Washington since 2001. We expect to train another 100 this year. We train here in Washington through the community college system. We do not treat. We don't diagnose. We are helping people with their dietary programs, giving advice. Our part in this whole thing is to keep them from getting to diabetes, helping them understand that a healthy lifestyle, a healthy diet and making choices for their families that are appropriate. We don't certainly disagree there being educational standards for people that want to call themselves diabetic educators but we strongly recommend that this be a title only situation and not be licensure to restrict other people from working with people who are at risk for diabetes.

KRISTI WEEKS: Questions?

Thank you. Next we have Greg Graham from the Nutritional Therapy Association.

GREG GRAHAM: Kay kind of introduced the Nutritional Therapy Association. We are based here in Olympia, Washington. We are an international association having trained people, at this point, all over the world. Our students include medical doctors, osteopathic doctors, naturopathic doctors, chiropractors, acupuncturists, massage therapists and lay people. Just here in the State, so the idea of somebody at risk for diabetes, unfortunately, everybody in America who eats a standard American diet is at risk of diabetes. According to the Center for Disease Control, 1/3 of all children born after the year 2000 are going to become diabetics. That was almost, I think based on age, say all children born after the year 2000 are at risk for diabetes. According to a recent study by the United Healthcare, they believe that 50% of the population will be either diabetic or pre-diabetic by the year 2020.

This is a huge problem and the idea that we are going to limit so tremendously the number of people who can give nutritional advice, to me is crazy. I think one thing that I would say is somewhat clear is that a big part of the purpose of the Bill is to get Medicare reimbursement for certified diabetic educators. I think that's fine, that should be paid for but, unfortunately, it would be at the exclusion of almost every other provider.

In our organization, we are not particularly concerned about reimbursement because we found that we have really great advice, people willing to pay for it out of pocket. Although it does obviously exclude some people who haven't got those kinds of means. I think one of the things I see is….my problem with the Bill is that there is a kind of a biased against natural healthcare field and I was disappointed, to our osteopathic friend out there, that it didn't include osteopathic. There is no naturopath or acupuncturist or anybody to represent the growing paradigm of health in American, which is natural healthcare. Another problem with this type of licensure is that it goes out of control so to use a very specific example of people giving dietary advice in a barbershop, then you should include beautyshops because that is another place where people often talk about nutrition. With this law, if someone was talking to their barber about the fact that they thought they had diabetes and the barber said, "Man, you better quit drinking five cokes a day and quit eating all those fried foods", they would have violated this law and be subject to penalties. The idea that nobody can talk about diabetes except a certified diabetic educator is kind of crazy. There are probably some barbers that give some good information. I don't know… I'm sure there are some that give bad ones but to try to regulate conversations between individuals… In this particular case, there is a fiduciary connection because obviously, people pay for their haircuts and that would bring them under jurisdiction of this law. Anyway, and then lastly, I really think when you talk about evidence-based medicine, I think, to me, that would be horrible to have people who didn't give appropriate advice for nutritional supplementation but, unfortunately, your presentation kind of implies that nutritional supplements are part of the problem, when they are clearly not. There are huge amounts of evidence-based medicine now that Vitamin D specifically is very preventative against diabetes and therapeutic for diabetics as well as Chromium, B Vitamins and essential fatty acids and so I think that any type of comprehensive diabetic education should include the responsible use of nutritional supplements. Anyway, kind of in conclusion, don't get me wrong, I'm not beating up the idea of certified diabetic educators. There is so much need that there needs to be… we need to take every possible kind of options toward educating people including certified diabetic educators and I'm sure that the type of specialized education that your members have is going to be very useful to many people but I think that licensure would be completely and totally inappropriate. Registration or certification or title protection. The Nutritional Therapy Association would definitely support that and we can support and be team members with your association. We definitely cannot support licensure and we will vigorously oppose that at all of our meetings this year if you attempt to move on. Thanks.

KRISTI WEEKS: Questions? Next

GRAY GRAHAM: Ok, thank you very much.

KRISTI WEEKS: Next we have Pam Kozu from Multicare Health Systems. I hope I pronounced that correctly. I had really easy names right off the bat.

PAM KOZU: Thank you for this opportunity. My name is Pam Kozu. I am a RN and MN. I was, at one time, a diabetes educator but now, I am the manager for diabetes services and (inaudible) at Multicare. In full disclosure, I am also a member of AADE. I do support this Bill only as a gateway to be able to have sort of a clean slate to be able to get Medicare coverage for RNs, pharmacist because right now it is difficult to move into the primary care offices without lots of extra work through compliance. It has been my experience that patients deserve to have highly skilled diabetes educators to help them navigate these challenges of living with diabetes. It is no small task to adjust insulin along with counting carbs and still going on taking care of the activities of daily living. The diabetes educator really has the specialized skills and background to do just that. The Washington Association of Diabetes Educators really, hopefully, provided all of that in their documentation. Patients with diabetes can be very complicated. Take the example of a patient with gestational diabetes or pre-gestational diabetes…in-patient,that is an area that we have a whole lot of opportunity for glycemic control. There is evidence in the literature more and more that diabetes educators have been crisscrossed when deployed in chronic

care models in primary care offices and licensure may open the door for helping with that in getting some kind of reimbursement. Currently, RDs are the only recognized providers to be able to get that and licensure should assure the public that education and training provided by a licensed professional will be accurate and safe. It will set standards. We have the confidence that we use for some provided by AADE and we use those in our organization to set our standards that they should be more standardized broadly across the nation. I don't have to tell you guys the cost for diabetes but it is important. Thank you.

KRISTI WEEKS: Questions? No? Thank you. Next, we have Jenny Arnold of the Washington State Pharmacy Association.

JENNY ARNOLD: Hello. My name is Jenny Arnold and I am speaking on behalf of the Washington State Pharmacy Association. There are certain points in the Bill that I would like to address. The first one is that we very much appreciate the inclusion of pharmacists in the Bill and the listing of them both specifically as a member on the board and as a healthcare practitioner that may be included in the licensure. We also support in Section 4 that it is not intended to impact the practice of pharmacists. We think that is very important.

There are a few concerns though that we have and they very much mirror what has already been expressed by some of the other organizations. As mentioned by the community health clinics, pharmacy practice is a very global sort of practice where you are taking patients as they are, looking at all their medications. When you pull out just diabetes, it may limit the ability of the average pharmacist to perform their tasks; for a licensed pharmacist to educate somebody about their medications. We would want to make sure that the Bill did not do that. Also, as mentioned by the osteopathic association and nursing association, this does seem to put in place an extra level of licensure and laws on top of the practice of pharmacy that may not be necessary and may not accomplish the goals that were previously outlined. I am not an attorney general by any means but we have seen situations with the Board of Pharmacy, for instance, where unlicensed individuals really are outside of their scope to be able to regulate. So the concerns of the barbershop, we are picking on them, providing information or the MA that is providing education above and beyond their scope, it may not really be within the scope of the board to limit that sort of ability and may just be too much for the board to really regulate. So I don't know that goal really will be accomplished by the goal of licensure.

Also, in Section 3, point #2, it mentioned the non-diabetes healthcare professional and that they must work under the direction of a licensed diabetes care provider. This, again, i a pharmacist who is providing a medication or review for a patient that has diabetes, do they now have to have a license to be able to educate that person and bill for educating them about their medications that is clearly within the scope of pharmacy? And so we have concern about the health care professional that is a non-diabetes educator but is working within their scope. Again, I do appreciate Section 4 where it is not intent of this to interfere with that.

Billing for services was mentioned as a goal of forming this level of licensure. Pharmacists have been licensed for well over 100 years as healthcare providers in Washington State. We currently are not recognized by Medicare as healthcare providers. We are vendors and we provide medications according to the standards but we are not able to bill for medical services generally. I don't know that this level of licensure absolutely guarantees that you are going to necessarily see payment for this level of licensure. That is something that we are working on as a profession so that we can better care for patients.

In Section 5, there is a mention of what non-CDEs would need to do to get licensure as a licensed diabetic care provider and we would have to see what would be required of a pharmacist to be able to get this level of licensure. The first two points about communication and training clearly is something that a four-year pharmacy degree, doctorate degree, covers but that level of what's required for experience to be able to

educate patients and be licensed under this, is a big question to us and until we know more, it is difficult to fully support the bill.

I think those were my…oh, the last point and then I'm done. Part of under Section 4, we discussed, it's not meant to limit the license activities of an individual. What it doesn't say specifically and what was mentioned by the two speakers that kicked this off, was that it is not intended to expand the scope of any licensed practitioner. I think it may be important in Section 4 to list that. That just because you are licensed under this and you are a nutritionist, you are not necessarily going to be able to jump to other levels. That there is still the limitations within your scope of practice and we don't really feel specifically that that is clearly outlined. Pharmacists wouldn't suddenly be able to prescribe (inaudible) drug therapy, insulin just because they were licensed under this. Those were our main concerns as we looked through the bill. Thank you.

KRISTI WEEKS: Questions? Thank you.

JENNY ARNOLD: Thank you for the chance to testify.

KRISTI WEEKS: We appreciate it. Now we have Pat Haldi from WADE.

PAT HALDI: My name is Pat Haldi and I'm with WADE. I'm a RN with an MN and I am a diabetes educator. I work in an in-patient rehab hospital. I have been doing it for over 30 years. I just want to thank each one of you for coming and I appreciate each testimony here this morning. I wish we had time to sit down individually all of us and have a chat besides having just a short time to have testimony.

I don't have all the answers and I don't pretend to. That's why we have people coming to help us with this. What I do know is that we are not intending to limit anybody's scope of practice that already has a license. For example, I'm an RN, OK, under my degree as a RN with a Master's degree and I also have, my specialty is in healthcare management, I can see patients without having to be a diabetes educator certified or just a diabetes educator without certification. I can teach about diabetes. But I'll tell you that I work with nurses all the time and they count on me to help them to know the current information on diabetes.

They work with spinal cord patients, stroke patients, they work with renal patients; they work with all kinds of patients and they can't keep up on the newest approaches of patient care for every disease they work with. I mean if we think that we can, then we might be Superman or Superwoman, because today there is so much that is changing. Since I have worked in diabetes, the changes have been so significant that even the physicians that I work with count on me to help them keep in touch with the new medications and the new treatments for diabetes. I don't pretend to know all of that but even the pharmacists that I work with appreciate some of the articles that I have been able to get out. For example, there is a new medication on the market where if …can't remember the name of it…your blood sugar will be high and you pee out the sugar and this is going to be a real good medication and when I look at our patients at the hospital, probably none of them will be on it because of the tricky potentials for harm for that.

So as a team, we work at… as team I work with physical therapists, occupational therapists, recreational therapists and, of course, we all have our separate license but we can't work outside of that license. For example, the RDs that I work with, they can't do blood sugar checking and they really shouldn't be doing insulin management. A lot of them think they can because of the certified diabetes educator; it's within that scope of training or learning or scope of practice.

The other thing is we all need to have advanced knowledge in whatever disease process that we are working with, whether it's heart disease or respiratory disease and so we know that. As an RN, I knew I had to have advanced training in order to teach diabetes management. That's why I went in and got my CDE. I'm not saying that everybody needs a CDE. The nurse over there that works in the community center, she's working under her scope of practice and with the leader there that teaches them how to do that, they count on her to know the most current information, which an ARPN can certainly become an advanced practice diabetes educator. We are not limiting what they can do and we appreciate the help the centers do.

Needless to say, we are here just to learn to work as a team and as far as the nutritionist; I think that James has something to say in response to that. We appreciate that to.

Sometimes our nurses think that what they personally believe in is the truth, for example, artificial sweeteners. I've often heard nurses say that they are bad for you and you shouldn't take them but that is not appropriate for people to be teaching something that they currently believe that you hear pros and cons.

Research can show all kinds of things. You can prove anything that you want to with research I think, with numbers. So there needs to be some basic information and scope of practice. Title act is not going to give us scope of practice. It just gives us a title protection. We need a legal scope of practice as to what we do that it's legal. Whether we get paid for it or not that is beside the point. Right now, I can probably go to work for one of the doctors I work for and go into the hospital and do diabetes education with their patients. Many will never get out of the hospital or be able to go home or go to a clinic because they are going to be home bound. So if I could bill for services, she could hire me to do that. That would be able to really increase access to care. It's not something to stop what you do in the community. It's just saying maybe you would like to hire a diabetes educator to train people to then train people. It's not that we are not going to want you to do what you do. We do. Thank you very much for the opportunity to speak and I know that James wanted to take a few minutes to clarify some things. Thank you very much.

KRISTI WEEKS: Do you have any questions for the speaker? Yes, we do.

PAT HALDI: You have a question

KRISTI WEEKS: No, I thought you did.

ALEX LEE: I appreciate the fact that you have a CDE and you are also an RN so you have been in that environment. I've just noted that a couple of the speakers have raised a concern that there would be some conflict of that collaborative process or someone said that one of their practitioners may be supervised by a diabetes educator. There was that concern raised. In your experience have you ever seen any sort of conflict in that collaborative process in these positions working with other people on the care team?

PAT HALDI: No. No, I haven't. As far as the nurse, she can do the diabetes education on the discharge plan. You know that is part of her responsibility to teach what patients to do when they go home and they only have a few seconds to do that in while they are pushing them out the door and they have seven patients and two are coming in the door. So that they really don't have very much time.

ALEX LEE: That was my assumption but thanks for clarifying that.

PAT HALDI: Thank you.

DANIELLE WELLIEVER: I have one question and it had to do with your initial proposal and you said that this would address a qualified workforce shortage. I wondered if it is because then you would require folks to get this extra training and that is how you would address that? I mean, how does it address workforce shortage problems?

PAT HALDI: I think that it would increase more people to be diabetes educators. We have a lower number diabetes educator because they are not recognized for what they do. You would have more people wanting to do that role if there was a legal scope of practice. If we were actually acknowledged as a profession and not someone with just an extra credential. It would make as a student, I would think that is something I would go into; that it would be a profession.

DANIELLE WELLIEVER: OK. Thank you.

KRISTI WEEKS: Ok, as it was mentioned, Mr. Specker wanted to come in for a brief rebuttal or follow-up.

JAMES SPECKER: I want to clarify my comments and the responses to your question regarding physicians providing diabetes education. I think that when I answered that I implied that a physician operating within their scope of practice would need to get additional training and that is not the intent of this legislation. The intent of the legislation is not to restrict any one person from operating inside what they currently do. So the nutritional therapist would still be allowed to do what they do in those instances where…let me get this…In an ideal world, the DSMT should be provided with the team approach. From personal experience, when my mother was diagnosed, her physician gave her an RN, an RD and a LTS (inaudible) to handle that broad spectrum of what we know as DSMT.

You bring up the American Diabetes Association clinical practice guidelines but also, at the same time, kind of discredit the national standards for accredited programs which are written by the ADA in association with diabetes educators where it says one or more instructors will provide DSMT and, when applicable, DSMS and I think that is because with the state of healthcare as it is, it does not allow it because of cost for the team approach. If you can't do this team approach like these community health workers do then there would be no reason to have licensure because each individual within that team would be operating within their primary scope of practice. So the RN would do the RN duties in that DSMT. The RD would do the RD duties. The pharmacist would do the pharmacist duties. In those instances which we know are more times than not, and I think the woman from the community health center said 10% so that other 90% of the state are operating programs and this is not factual, I'm making an example here, are operating programs with one individual providing that full spectrum of the DSMT. That is what the intent of this is.

Yes, there is some things that were brought up and I think that there is some language that can be cleaned up to clarify a few things and identify a few more groups. The intent is not to dominate the market. The intent is to increase access and insure that the care the patient is given is quality care based off the evidence that we know for DSMT.

KIM DECOSTE: At this point I would like to make…there seems to be some confusion over all the supervision that a licensed diabetes educator …if I was the licensed diabetes educator, I would supervise the other nurses or team leader. It would never be taking the team leader approach away from you at your community health center. It would be… the people that I view in that are really… you would be supervising as such and maybe supervising.. maybe there's a better word for it even. A look at those other people we rely on; the community health workers, the lay health workers. Those people who we do count on to be able to get the job done but do really require supervision or some oversight. That person is essentially practicing a little bit on the license when we allow them to go out and to give information and

that kind of thing. That is who we are talking about with that. It would not be that a licensed diabetes educator would tell the pharmacist that you can't give medication instruction to someone. That is a responsibility of the pharmacist when I go to the pharmacist to get a prescription when I need that or if they recognize something. So it is not changing any of that including the person from the nurses association on the school nursing. I have been fortunate enough as a diabetes educator to be called into the school to do some extra things and stuff, too. None of that would change. The school nurses would still be the school nurses and we do have so many kids with chronic diseases in school and that would still be a requirement that we are able to do that but in looking at the comprehensive diabetes self-management education it is more than just one of piece of the pie. We are looking at that whole big picture and to me there is a little difference between giving diabetes instruction or a little bit of diabetes information and doing that comprehensive package that I think is so important for getting those good outcomes.

KRISTI WEEKS: Any final questions?

KIM DECOSTE: Thank you all.

KRISTI WEEKS: Back to the script. Thank you for taking part in this public hearing. Here are the next steps in the process:

- There is an additional 10-day written comment period starting today through August 12th at 5:00 for anything you feel has not been addressed.
- We will share an initial draft report with interested parties in September for rebuttal comments. Those of you participating today will receive the draft as long as we have contact information for you.
- We will incorporate rebuttal comments into the report and submit it to the Secretary of the Department of Health for approval in October.
- Once the Secretary approves the report, it is submitted to the Office of Financial Management for approval to be released to the Legislature. OFM provides policy and fiscal support to the Governor, Legislature, and state agencies.
- The report will be released to the Legislature prior to legislative session, and will be posted on our Web site once the Legislature receives it.

Are there any questions about process or next step? I thank you all very much for taking your time and giving us your input as we make recommendations on this proposal.

Diabetes Educators: Washington State Sunrise Review

Washington State Diabetes Educator Licensure Committee

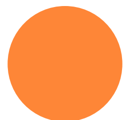
August 2, 2013

Diabetes Self-Management Education/Training (DSME/T) Overview

DSME/T is:

The ongoing process of facilitating the knowledge, skill, and ability necessary for pre-diabetes and diabetes self-care. This process incorporates the needs, goals, and life experiences of the person with diabetes or pre-diabetes and is guided by evidence-based standards.

- Assessment of the patient's specific education needs
- Identification of specific patient's DSME goals
- Apply interventions to achieve goals
- Evaluation of attainment

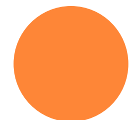


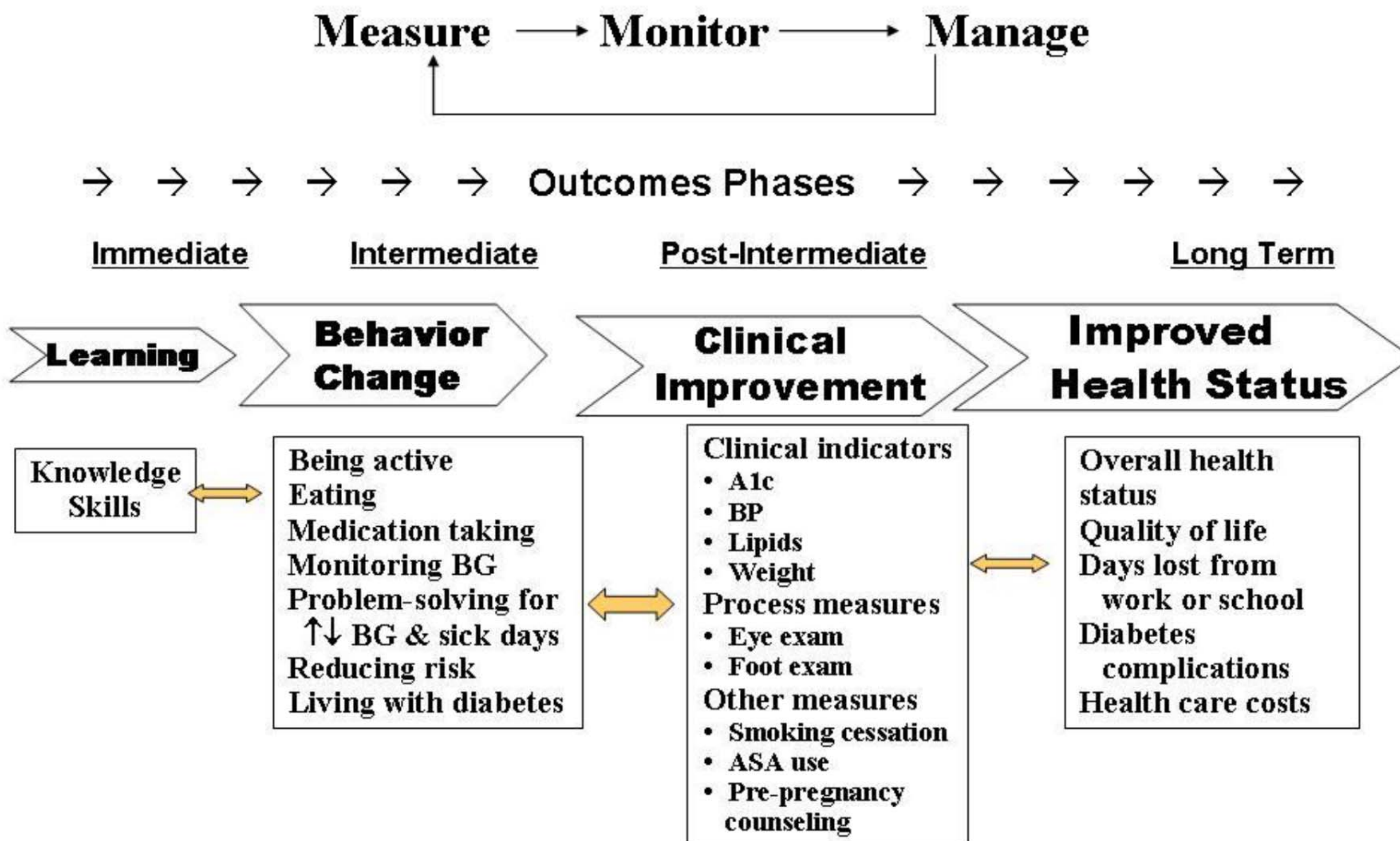
Fundamental Goals of DSME/T?

The overall objectives of DSME are to support informed decision making, self-care behaviors, problem solving, and active collaboration with the health care team and to improve clinical outcomes, health status, and quality of life.

Diabetes Educators Prepare Individuals to:

- Make informed decisions
- Engage in effective diabetes self-management
- Implement self-care behaviors that allow individuals to maximize their physical and
- psychological well-being.



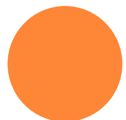


In 2012 we saw a clinical and statistical decrease in A1cs from 8.4 to 7.1 in accredited programs where quality DSMT was provided

WHO ARE DIABETES EDUCATORS?

Diabetes educators are healthcare professionals who help people with diabetes achieve behavior change goals by providing quality DSME/T which, in turn, lead to better clinical outcomes and improved health status.

They counsel patients on how to incorporate healthy eating and physical activity into their lives. They also help them understand how their medications work, teach them how to monitor their blood glucose to avoid the risk of complications, and enable them to problem-solve and adjust emotionally to diabetes.



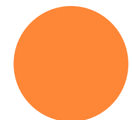
THE SCOPE OF THE DIABETES EDUCATORS

Diabetes education is unique in that its practitioners come from a variety of health disciplines. Diabetes educators remain individually accountable to the standards set by the discipline and by national, state, local, and institutional regulations that define and guide professional practice.

The Scope of Practice, Standards of Practice, and Standards of Professional Performance for Diabetes Educators has been developed by the AADE to define the scope, role, and minimal level of quality performance of the diabetes educator; to differentiate diabetes education as a distinct healthcare specialty; to promote diabetes self-management education and training (DSME/T) as an integral part of diabetes care; and to facilitate excellence.

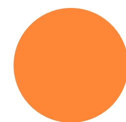
Being a credentialed diabetes educator does not confer any permission to manage diabetes beyond the limitations of the individual's professional practice.

Boundaries of practice are determined by state practice acts.



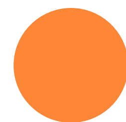
WHERE IS DSME/T PROVIDED IN THE HEALTHCARE SYSTEM

- Hospital Outpatients
- Tribal Ambulatory Care
- Veterans Hospitals
- Public Health Departments
- Community Centers
- Churches (Setting)
- Pharmacies (Community and Chain)
- Physician Offices
- Home Health Agencies
- Endocrine Clinic
- Senior Centers
- Federally Qualified Health Clinics (FQHCs)
- Medical Centers
- Solo RD Practitioners
- Weight Loss Center
- County Health Department
- Rural Settings
- YMCAs



Education and Clinical Training

- Diabetes Educators, being a multi-disciplinary group, are educated at the undergraduate, graduate and doctoral levels depending on their primary discipline.
- Two diabetes-specific credentials are currently available in the US: the Certified Diabetes Educator (CDE) and the Board Certified in Advanced Diabetes Management (BC-ADM).
- Completed extensive hours of DSME/T related clinical experience within a two year timeframe prior to sitting for an advanced credential.

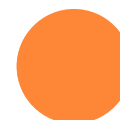


Competencies of Diabetes Education

- The qualified diabetes educators have achieved a core body of knowledge and skills in the biological and social sciences, communication, counseling, and education and who have experience in the care of people with diabetes.

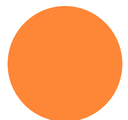
- Certified Diabetes Educators (CDEs) meet the academic, professional, and experiential requirements set forth by the National Certification Board for Diabetes Educators (NCBDE).

- Board Certified in Advanced Diabetes Management (BC-ADM) educators incorporate skills and strategies of DSME/T into more comprehensive clinical management of people with diabetes. This level of practice is characterized by care coordination and management, autonomous assessment, problem identification, planning, implementation, and evaluation of diabetes care. Providers at this level function either with protocols or have prescriptive authority.



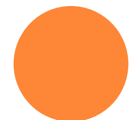
WHAT SETS THE QUALIFIED DIABETES EDUCATOR APART FROM OTHER DISCIPLINES

- Completed 250 hours of DSME/T related work experience within a two-year timeframe.
- Meets practice standards based on state/local regulations for specific health care discipline
- 40 hours of continuing education related to diabetes and/or DSME/T within a two year timeframe.



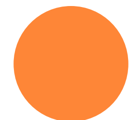
HARM TO THE PUBLIC

- Inappropriate Insulin Therapy by unqualified individuals
- Harmful Diet and Nutritional Therapy Advice
- U.S. Food and Drug Administration takes action to remove from the market illegal products, including some labeled as dietary supplements, that claim to mitigate, treat, cure or prevent diabetes and related complications
- An unregulated field worth billion of dollars, with no barriers to entry, lends itself to unethical behavior and practices
- Unqualified individuals giving advice on Medicines and Behavioral Therapies
- Improper diabetes education can lead to more costly and debilitating Comorbidities



Why Regulate Diabetes Education?

It is necessary to regulate…	Current Challenges…
To **protect the public** from being misinformed about their disease which can lead to **costly hospitalization rates and comorbidities**	Currently **anyone can set themselves out as a qualified provider** of Diabetes Self-Management Training
To **ensure those adequately trained and qualified** are practicing	No state recognition means **restrictions in the delivery of the benefit and barriers to access** for the person with diabetes
To create a **formalized and legal process** for entry into the field	The **prevalence rise is increasing costs and health complications** for the person with diabetes

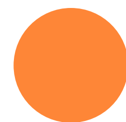


IS THERE ANOTHER, LESS COSTLY WAY TO PROTECT THE PUBLIC OTHER THAN LICENSING?

Regulating the practice of diabetes education is a cost effective solution for the State of Washington:

- 437,048 l Total Number of Diabetics (Overall)
- Out of every 100 people with diabetes there are approximately 31 Hospitalizations and 51 ER visits annually
- 42.06% of diabetics have HbA1c levels above 7.
- Annual cost of medical care for diabetics (including hospitalizations) in this WA is $11,900 (Over 5.2 Billion)

- Evidence supports the effectiveness of self-management training: JS2
  - Medicare savings at $1,620 per patient per year
  - Hospital Savings at $551.00 per year per patient
  - A 26% ROI in a Robert Wood Johnson Case Study, "Building the Business Case for Diabetes Self-Management"

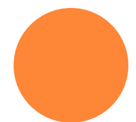


DSME/T Programs Vs. Prevalence in Washington State

Prevalence of Diabetes
(2011 Overall)

N/A
2.25% or Less
2.26% - 3.35%
3.36% - 5.04%
5.05% - 6.74%
6.75% - 8.44%
8.45% - 10.14%
10.15% - 11.84%
11.85% - 14.00%
14.01% or Greater

The correlation between qualified diabetes educators in an accredited DSMT programs and the rates of prevalence where there is no access speaks volumes to the need for ensuring we provide adequate care to those with diabetes

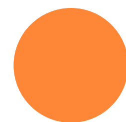


WA Department of Social and Health Services Goals

JS1

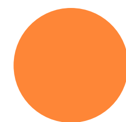
- Maximize the use of proven self-care management and other services by individuals with multiple chronic conditions.

- CDSME and the Diabetes Prevention Programs will meet these service requirements with a ready network of host organizations and implementation sites.

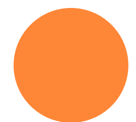


What Would Licensure Accomplish?

- Establish diabetes educator **Scope of Practice**
- Establish an **ethics and practice review procedure**
- Establish **educational and clinical training requirements**
- Recognize diabetes educators as the, evidence-based research, **qualified health care professionals** they are
- **Increase access** for the person with diabetes to proven Diabetes Self-Management Training Programs
- Help **reduce the costly health complications** associated with the disease and reduce the overall prevalence



Time Line



Appendix E

Written Comments

Diabetes Educator Sunrise Review Comments

Name	Comment
Thomas M Tocher MD, MPH, FACP Snohomish County	I am the Chief Clinical Officer at a community health center in Snohomish County, and am a board-certified internist with over 20 years of practice experience. I am writing to respond to the proposal to require licensing of diabetic educators in the State of Washington. I oppose this proposal because I believe it would limit patient access to diabetic education resources by severely restricting the number of people who could provide diabetic education. To become a certified diabetic educator requires 1,000 clinical hours. For community health centers such as ours, we want to be able to provide diabetic education in a team-based manner, in keeping with the tenets of the Patient Centered Medical Home. This means that we want to use a number of different team members—RNs, Pharmacists, Medical Providers, Nutritionists—to educate the patients about their diabetes. This proposal moves us away from that goal, and creates more silos and barriers to team based care. I would ask that you vote to deny this proposal to require licensing of diabetic educators.
Lindy Bretsen RN Kitsap County.	I would very much like to have updates on the Diabetes Educator Licensure. I am an RN and work in an Urgent Care type setting. This would influence what type of teaching I can do for my patients.
Patrick Plumb Mayor of Tonasket	I would like to have this filed as a public comment on the Proposal to License Diabetes Educators. I am Patrick D. Plumb, chargemaster@nvhospital.org, 509-322-7300. I speak IN FAVOR of the proposed legislation. I have lived with the diagnosis of Type 1 diabetes since I was 11 years old. I am now a 34 year old with no diagnosed complications after 23 years of living with the disease. I have interacted with numerous diabetes specialists and found most to be lacking in the knowledge of long term diabetes management. There have been three individuals that I credit for saving my life over the years in the respect of diabetes management. One person that I interacted with was the first and only RD-CDE that I interacted with in my own hometown, and that was the late Donna Gama. She was amazing and inspired me to increase my knowledge of diet and diabetes self management with the ability to adjust insulin levels and cutting to the chase on what diet would meet my needs to maintain my ability to participate in teenage activities. The world of diabetes lost a great person when she passed away. On top of that, she was not supported well by my local hospital groups in North Central Washington and bounced between multiple service providers because they did not understand diabetes. She stayed up on current best practices, reading multiple publications on diabetes care, and went to diabetes training events in the state. Another person that has made a huge impact in my life is Deborah Belknap, RN CDE. She was able to plant the seed about me starting pump therapy while I was a camp counselor at Camp Fun in the Sun, an INHS program for kids and teenagers that have Type 1 Diabetes. Her knowledge would be the measuring stick to compare all diabetes educators for in the state. Lastly, I was prescribed for pump therapy by K Douglas Thrasher, DO. His extensive diabetes insulin pump experience should be replicated nationwide. We employed Dr. Thrasher at Tonasket Family Medical Clinic in Tonasket, WA until we were unable to extend his contract. He currently works at Eisenhower Medical Associates in La Quinta, CA. I think this board should have 3 diagnosed diabetics (Type 1 and 2) from the public on it if at all possible. It is disappointing if I work for a hospital that I would not have the ability to be considered to be a member of this advisory committee. I do not have medical credentials, but I do work with the Business Office in a Critical Access Hospital in Tonasket, WA. I would like to strongly affirm the statement made in case 2 in the Applicant Review and Cover Sheet page 8 and 9. This situation happens much more often than is reported. I would like to publically credit LESLIE MERKLIN-BARBER BSN, RN, CDE with having the guts to have reported this incident and hopefully it does not

	happen again. Registered Dieticians SHOULD NOT BE ABLE TO TREAT DIABETIC PATIENTS WITHOUT SIGNIFICANT TRAINING AND EDUCATION MINIMUM STANDARDS. These standards should require more than web based training or checking off a form that they read material. They should have to take saline shots and test their blood sugars over a month, and if they deal with patients that have pumps, they should have to wear one for 2 weeks, switching sites at a rate that would be typical for a Type 1 diabetic, using saline or another non-blood sugar affecting substance, while also testing 4-6 times a day for glucose. For that measure, have them test at 0200 and 0400 and see if their attitude changes a bit during that time period. Strong language should be sent to the FDA that Insulin should be available for over the counter purchases. Insulin is not a drug that is widely abused, and in an emergency over the weekend, I have had to drive to Canada to purchase insulin because they do not require a separate physician to write a prescription for it. MIND YOU I PURCHASED INSULIN ON CANADA DAY, JULY 1. Try doing that in Washington State on July 4th. Establishing minimum education standards is a start, and 15 hours a year is a worthy start, but it should ramp up every 5 years. There is no reason that for such a complex disease that we cannot commit to getting more education than an EMT-B does for ongoing education in this state. I strongly urge the Governor to appoint Deborah Belknap, RN CDE to this board. She currently works for INHS in Spokane. She should be the first appointment made after this committee is established. I would be willing to serve on this board if it is not a requirement that I cannot work for a healthcare organization. Please remove that requirement. I am currently the Mayor of Tonasket, WA; I am a member of the Noridian Provider Education and Outreach Board, I was a licensed EMT-B in the 2000's, I have been elected to Tonasket City Council and Tonasket School District in the past 20 years. I was a diabetes camp counselor for INHS in their Camp Fun in the Sun program for 7 years. I was also a diabetes camp attendee for 3 years. My father was a Type 1 diabetic that received a kidney/pancreas transplant 9 years ago. I still have Type 1 diabetes to this day. Please support and pass this legislation with the corrections noted above for proposal, H-1847.3/13.
Ginny O'Kelly, RD and CDE Wenatchee WA	It is my pleasure to write a letter in support of state licensure for diabetes educator. I have been a Certified Diabetes Educator for over 10 years. I work at a Community Health Center. With my certification, I have earned the respect of the doctors in my clinic and am able to assist them in providing appropriate education and consultation that is up to date. I use information validated by research with outcomes tracked by our electronic medical records. Without my certification, I would be very limited in terms of the type of service I can provide solely as a Registered Dietitian. I act as a key person on a team of doctors, pharmacists, nurses, and psychologists. My team has prevented thousands of amputations and kidney failures throughout my career. The doctors recognize the certification with their trust and support. The state should do the same. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self-care management that more often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.

Debbie Perrault, RN CCP Central Washington	While though I agree that diabetic educators should carry a license or a certification, much of the education on diabetes that I do involves diet and exercise, more or less on a nursing level. I do not mange medications, insulin or pumps. Many of the people we see are Medicare or Medicaid and will not take the time to attend a class at our local hospital. So a brief 30 to 45 minutes educational piece on diet and exercise while they are in the office is often what they will receive. So I have concerns that our patients will not get any education on their diabetes. I guess how tightly is the state going to regulate this?
Philip Reilly, MD Seattle WA	As Clinical Director of a large primary care community health center which provides comprehensive diabetes care, I am very concerned that the measure as proposed would limit essential services to our diabetic patients. There are various levels and modes of training for our diabetic health educators, and I agree that we need to achieve and maintain a high level of competency. The stated need in the proposal is that diabetes education is important, but there is no statement that the current regulatory structure impacts that negatively and there is no rationale that the new structure would improve access to good education. Many providers have been working for years to provide diabetic education, I think our efforts should be recognized and supported rather than disregarded. We need to focus on improving access to comprehensive, high quality care—and the measure as proposed does not address access, although it addresses quality, and I fear that it would greatly limit access.
Ann Wright, RN	It is my duty to write this letter in support of state licensure for diabetes educators. I am an RN who works for an ARNP who specializes in diabetic education. I hope to sit for the CDE exam next year and feel that licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals, such as myself, who are the front line of this war against the epidemic of diabetes, which may be the most costly chronic disease of this nation. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management. I have heard of some amazing "cures" that patients have been exposed to. Unfortunately these often result in diabetic complications i.e., blindness, kidney failure, amputations, heart disease, etc. This leads to financial burdens for the patient, the state and the nation. I fully support WADE as they seek legislation for licensure for diabetes educators. I personally see this a positive action to fight against this serious and costly disease. It will become a major public health issue with devastating consequences if we don't get a handle on this. Thank you for your consideration in this matter. I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. Thank you for your time and consideration in this matter.

Cindy Brinn MPH, RD, CDE, BC-ADM	It is my pleasure to write a letter in support of state licensure for diabetes educator. I am a registered dietitian and certified diabetes educator and have worked with PeaceHealth St. Joseph Medical Center in Bellingham for over 20 years. The growth of diabetes in the past several decades is overwhelming and yet there is so much hope and cost saving outcomes when individuals receive excellent care and coaching from a knowledgeable diabetes educator. Physicians are not able to cost effectively support these patients with the time required to improve their health; a wise diabetes educator is a big asset in the management of these patients and we work very closely with physicians as a team to support this population. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. Experienced and effective diabetes education comes from experience, training and following guidelines and strategies outlined by our national organizations. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
April Thomas, RD, MPH, CDE Bothell, WA	It is my pleasure to write a letter in support of state licensure for diabetes educator. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Kristen Fahnoe, RD, CD, CDE, CPT	It is my pleasure to write a letter in support of state licensure for diabetes educator. I am a registered dietitian, and I have been specializing in diabetes education as a certified diabetes educator for the past ten years. WADE's pursuit of licensure for diabetes educators signals the beginning of an exciting time of growth and further outreach within our community. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the

	war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self-care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Clark Martin, PhD	Sounds to awfully narrow specialty. Couldn't it be subsumed within something like a general health and physical well being counselor? Clark Martin, PhD
Desiree Webster RD, CDE Mt. Vernon, WA	It is my pleasure to write a letter in support of state licensure for diabetes educator. This is a topic near and dear to my heart. I've been a Certified Diabetes Educator for around 7 years. What I offer my patients is a solid medical and scientific background that required specific training in all aspects of diabetes care AND something just as valuable—direct experience working with patients on a daily basis. I see their blood sugar logs, I hear about their day to day struggles first hand. I tailor their education and their needs from deep insight and expertise in working closely with these patients—not from a "one size fits all" regimen. This cannot be achieved by someone who has not worked intimately with these patients and this disease—this is not the knowledge and expertise someone gains from brief encounters or by relying on their backgrounds in other areas. It is a knowledge gained through a specific focus on this intricate disease and by experience that comes from many hours of problem solving and and a solid education drawn from the core curriculum of the American Association of Diabetes Educators. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Louise Suhr, MN Seattle	I am writing to share my concerns with the proposal to regulate Diabetes Educators, as described on the Washington State Dept of Health website. With the growing burden of diabetes in particular and chronic illness in general, further limitations on education provided to patients is the WRONG direction to take, and will place undue burden on many clinics providing such care. Please do not further regulate an already complicated field. Also, what is meant by "under the direction of"? Your wording is obtuse and does not serve to promote clarity of practice.
Susan R. Wang, MS, RD, CD, CDE Kirkland, WA	I want to write a letter in support of state licensure for diabetes educator in the state of Washington. I have been a diabetes educator for over 20 years working in a several capacities. I have personally had many patients who have come to me for diabetes education who had been given misinformation about the treatment of their diabetes. Some have 1) been hurt directly; 2) had their proper treatment delayed, increasing their chances of diabetes complications later; 3) paid extra money or wasted time and effort on less or ineffective treatments. I feel that licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front

	line of the war against the epidemic of the most costly chronic disease our generation face. Diabetes in a growing epidemic in Washington as well as worldwide. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self-care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. To make advances against this devastating disease, we must improve health care education and providing licensure for diabetes educators is a good step in that direction.
Cindy Robison, LICSW/CDP Spokane WA	I would hope that Licensed Social Workers could also be added to the list for Diabetes Educators. In our clinic here, we have two individuals who have their CDE and are highly qualified. They provide excellent services to the patient's we serve. I would hope some kind of licensing and oversight would be provided as the information provided to our patient's must be accurate and based on current knowledge. Thank you.
Dawn Corl, RN,MN,CDE,CDTC Seattle, WA	I am currently a CDE and Diabetes CNS working in a large urban medical center. I have read the proposed legislation and arguments in favor of licensing Diabetes Educators. My role is to "teach the teachers" by developing continuing education diabetes education offerings for staff nurses as well as programs that support and enhance diabetes education and care of patients. I have several concerns I would like to air. In the proposed legislation, the scope of practice and supervision of licensed health care providers who are not licensed as diabetes educators was unclear to me. The proposed legislation states that the non-diabetes educator "must work under the direction of a licensed diabetes care provider." There is a definition of "supervisor" in the proposed legislation ("provides mentoring and general oversight for the delivery of appropriate, effective, ethical and safe patient care"). However, it is not clear if a "licensed diabetes care provider" is the same as "licensed diabetes educator", nor if the terms "under the direction of" are equivalent to "supervision". For example, if this licensure went into effect, would medical centers be required to hire licensed diabetes educators to provide direct discharge diabetes education for all diabetes inpatients and outpatients? Or would the licensed diabetes educators be required to assess and develop a plan of care, identify self-management goals, provide a self-management training plan, evaluate the individual patient's outcome, and record a complete record of the individual patient's experience and follow-ups for each diabetes inpatient and outpatient? Or would the licensed diabetes educators be required to assure that staff working at the medical center had appropriate resources and were prepared and competent in providing diabetes discharge or outpatient education? I believe that it is likely that licensure as proposed would increase the demand (and associated costs) for diabetes educators. Additionally, the need for safe, effective, ethical and appropriate diabetes education grows daily. I do not believe that adding additional barriers required for licensure through limited and expensive educational and supervised experiential requirements provided only by accredited training programs will assure an increased supply of diabetes educators. It would, of course, provide a revenue stream for diabetes educator associations and other proponents for this legislation. Thank you for the opportunity to express my views.
Maureen McKenzie, ARNP MN Snohomish	I support Diabetes Educators being a licensed profession. And yes, Certified Diabetes Educators (CDEs) are well-informed, highly qualified for the work of educating patients with diabetes. I do not support that CDEs should be the only profession who educates patients with diabetes. What WADE, (Washington Association of Diabetes Educators) fails to point out is that EVERYONE needs to be educating the patient; the doctor, the nurse, the pharmacist, the nutritionist and the diabetes educator. If we relegate

county	diabetes education to just Certified Diabetes Educators, we will have fewer patients informed about their diabetes self management. One of the well-researched strategies for patient success is that it takes the team; the doctor, the nurse, the pharmacist, the nutritionist and the diabetes educator to be successful in educating patients with diabetes. By limiting Diabetes Self-Management to only CDEs, it means fewer people educated about their diabetes. Primary care settings, rural clinics and community health centers that provide care to low income patients will be most constricted in providing care to their patients. Diabetes Educators are mostly located in urban areas. In my practice as a family nurse practitioner in a suburban area, we have two Certified Diabetes Educators on staff at our local hospital that serve the community. The only other CDEs that I have met were working for drug companies. The health care professionals in rural and community health centers need to develop expertise in all areas of patient care. Primary care settings must be allowed to provide self-management support to patients in their setting. Diabetes is a disease that falls on a spectrum for care; education spans from the simple to more complex. The span is: 1) pre-diabetes that can be managed with diet and exercise, 2) diabetes that can be managed with diet and exercise, 3) diabetes that can be managed with oral medications, diet and exercise, 4) diabetes that needs the addition of insulin to oral meds, 5) diabetes that needs multiple injections of insulin a day to 6) type 1 diabetes that requires insulin or is life –threatening. Education must start from day one of diagnosis of the illness. As primary care providers it is our responsibility to tool our patients with information and support to make the needed changes to manage their illness. Depending on the patient, simple information is adequate to promote change. Other patients need repeated reinforcement at every visit and need to hear from all the health professionals who interact with them about how to bring their diabetes under better control. The more complex diabetic patient who is utilizing an insulin pump and continuous monitoring clearly need an experienced practitioner such as an endocrinologist and CDE to support them in their care. But, if we limit diabetes self-management to CDEs fewer people will receive the needed education that must occur immediately after diagnosis. Of note in my 25 years of work in a community health care setting I have not had one patient who uses an insulin pump. I support the State of Washington to allow Diabetes Educators to become a licensed profession. I do not support Certified Diabetes Educators to be the only profession licensed designated to provide education to patients with diabetes. The research supports a team approach to diabetes education. All health care professions; doctors, nurses, pharmacists and nutritionist must support the patient with diabetes education. Especially in community health centers and rural clinics, the flexibility of allowing all health care professions prepared in diabetes care to provided this service, provides timely and frequent diabetes education and support to patients with diabetes.
Heather Denis RD CD CDE CPT Bremerton WA	My name is Heather Denis and I am the current chair of the Washington Association of Diabetes Educators. I also sit on the board of directors for the Juvenile Diabetes Research Foundation. I have worked as a diabetes educator for the past 14 years. I have also lived with Type 1 diabetes for 31 years and have a 14 year old child that was diagnosed at the age of 7 with Type 1 diabetes. I have seen the impact of correct diabetes education in my career and personal life and I have also unfortunately seen the impact of in-correct diabetes education by providers that are not properly qualified. I cannot begin to share with you the many tears that have been shed in my office by patients that have been living a life of poorly controlled diabetes because they "did not know any better". Just yesterday, I had a patient that I was starting on Novolin 70/30 insulin. She had been to her pharmacy earlier in the day to pick up the prescription and the pharmacist instructed her to administer this insulin after meals. This is an insulin that is to be administered 30 minutes before meals. Had the patient gone ahead and done as the pharmacist instructed, the patient would have suffered hypoglycemia as a result. I hear many of these stories.

	Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications. I fully support legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Deanna Minich, PhD, FACN, CNS Seattle, WA	I am writing to oppose the Sunrise Application being considered for a Diabetes Educator credential and regulatory board. The proposed regulation and draft legislation would require me to obtain a second occupational license in order to advertise services I already provide and am trained to provide as a doctoral-trained, Certified Nutritionist in the state of Washington. WADE and its parent organization AADE want a state scope of practice defined in order to allow Diabetes Educators to obtain insurance reimbursement under Medicare. They essentially want to create a profession to deal with one specific disease. Furthermore, the broad terminology regulating those who work with anyone “at risk for diabetes” would encompass all residents of the state. This application maintains that Diabetes is so complex that people need specific training in order to meet the needs of those with Diabetes and at risk for Diabetes. Diabetes is a lifestyle disease. Those at risk for developing it can be helped by any number of professionals who have training to help people change dietary, exercise, and stress behavior patterns. I don’t believe we need a separate regulation and credential for this. Those professionals who chose to get more intensive training focused on treating those already diagnosed with Diabetes are free to do that if it meets their professional needs. But should every professional who works with this population be forced to do this or face having limitations put on how they advertise or be required to work under supervision (quite possibly someone with less experience and education)? My credential, the Certified Nutrition Specialist (CNS), already requires Continuing Education and if I needed more training specifically in Diabetes care I would voluntarily pursue it. In addition to my CNS credential, I also have Doctorate and Master’s degrees in nutrition. I have been in clinical practice since 2002, most recently at the Functional Medicine Research Center in Gig Harbor, WA, where I would see patients with type 2 Diabetes. I have also done further study with the Institute for Functional Medicine that gives me training in various facets of nutritional and clinical medicine. In fact, I currently teach physicians and dieticians how to manage patients with chronic diseases through my work with both the Institute for Functional Medicine and The Personalized Lifestyle Medicine Institute in Seattle, WA. The citizens of Washington need more nutrition care providers who are experts in the care of diabetes, not legislation that would restrict access and hamper qualified people who are already providing services. Surprisingly, many of the professions exempted from the proposed regulation have little or no requirement for nutrition training (Social Workers, Psychiatrists, Exercise Physiologists), when nutrition is a key piece of diabetes prevention and treatment. At the same time advanced degreed, Certified Nutritionists in the state of Washington would be prohibited from providing diabetes care unless supervised or seeking additional licensure. Therefore, I respectfully request that you deny this request for a new occupational license.
Liz Lipski, PhD, CCN, CNS, CHN	I am writing in regard to the Diabetes Educator Sunrise. As stated in the application, diabetes is a complex and serious illness. Diabetes Educators can improve outcomes, reduce the need for amputations, kidney dialysis, and generally extend and improve many people’s quality of life. While it is complex, ANY health professional can

Laruel, MD	easily master these skills by taking a few specialty courses. It's not rocket science. If, however as stated 517,804 people in Washington have diabetes and there are currently only 330 certified diabetes educators, that allows for 1 diabetes educator for 1569 people. We need more qualified clinicians who can counsel people about diabetes and prevention of diabetes, not fewer. This bill also discusses people "at risk for diabetes". According to ES Ford, in 2010 metabolic syndrome affects 34.3% of adults. Children of the current generation are expected to have shorter life expectancies due to type 2 diabetes than their parents. If this passes into law, only licensed diabetes educators will be able to discuss prevention of diabetes. This gives them unrestricted access yet no access to other health professionals to provide counseling. The wording suggests that all clinicians will providing counseling to people who have diabetes or who may get diabetes will need to be supervised by a diabetes educator. I don't believe that this has been well considered at all. This request, states that "No person may represent himself or herself as a licensed diabetes educator or use any title or description of services without applying for licensure, and meeting the required qualifications…" Therefore a nurse practitioner, nutritionists or pharmacist that advertises or puts information about these services on their website will be in violation of this act. Non RD nutritionists can be licensed in Washington, yet nowhere are they considered in this bill. Most RD's have BS degrees. What about other licensed health care providers such as naturopathic physicians, acupuncturists, and chiropractors. Why is there no mention of including us in this bill? As I've mentioned, I worked in a large clinic providing diabetes education many years ago. I took courses that provided me with the knowledge and skills to do this appropriately. Most health professionals are serious about their work. They do it to serve others. When I was providing diabetes education, I attended training courses. Medications and recommends change and you need to keep your training current. Clinicians naturally update training without any licensing mandate. While this amendment provides examples of potential and actual harm, in any field that is this complex there are always going to be instances where a clinician makes a mistake. It happens. Licensing will not insure that this doesn't occur. Is this really needed? Who wins? Do the people with diabetes actually win by limiting who can provide this service? Or is it the American Association of Diabetes Educators who benefits, while leaving consumers with fewer health options?
Washington State Podiatric Medical Association Signatory, Susan K. Scanlan DPM,	The following comments are submitted on behalf of the Washington State Podiatric Medical Association (WSPMA), a statewide organization representing podiatric physicians and surgeons. WSPMA members provide care to thousands of Washingtonians who have diabetes, and in that role provide education on how to reduce the potential long term effects of that disease. WSPMA has great respect for the work performed by nationally accredited diabetes educators. However, WSPMA does not believe that licensure is warranted. All of the individuals who could qualify as diabetes educators are already credentialed by the State of Washington. In fact, with the passage of the medical assistant legislation, any individual who has virtually any type of direct patient contact beyond merely administrative duties is required to be regulated. As a result, the examples given by the proponents as evidence of a need for regulation are not persuasive because a complaint could be filed against each of those individuals under our current regulatory system. In the alternative, we could support certification in order to protect the title "certified diabetes educator" or similar words. While the legislation is written to require licensure, a close reading of the Applicant Report shows a focus on title protections, the core component of a certifying credential. "Management of diabetes is complex. It is very important that the health care professionals who set themselves out as diabetes educators be well educated and appropriately credentialed in the delivery of diabetes

	education." (Page 2) (emphasis added) "Diabetes education is unique in that its practitioners come from a variety of healthcare disciplines. In Washington State there is no set of enforceable standards to protect the public from a non-qualified individual calling himself or herself a Diabetes Educator and providing poor care." (page 14) (emphasis added) "Nationally, qualified healthcare professionals may obtain the Certified Diabetes Educator (CDE) or Board Certified in Advanced Diabetes Management (BC-ADM) credential; however the public may not be able to discern the difference between a CDE and some unqualified person who uses the title of Diabetes Educator." (page 14) (emphasis added) In fact, the legislation itself creates title protection. Section 6(1) reads: "After the effective date of this section, a person may not use the title of "licensed diabetes educator"…unless the person holds a license under this chapter." In fairness, the Applicant Report also includes language about the creation of a scope of practice that is normally associated with licensure. WSPMA believes this is unnecessary for the reasons noted above, but also because it is potentially very confusing. Note the following statement from the Applicant Report on this topic: "The proposed standards for licensure of Diabetes Educators are not more restrictive than necessary to insure safe and effective performance. The license also is non-intrusive on healthcare professionals holding a license in the state of Washington. Licensure only serves to expand the scope of practice for those individuals who set themselves out as a diabetes educator." (page 18)(emphasis added) This is a very confusing, as some health care professions already have the full legal authority to provide all the components of diabetes education. In addition, legislation to regulate diabetes educators cannot expand the scope of practice of any profession, unless that profession's statutes are amended. As written the legislation is confusing, in part, because of the complexity involved in writing a licensure bill when you have such significant areas of overlapping scope. The legislation attempts to be all things to all people, and does not succeed. If the Department of Health recommends licensure, we would suggest, at a minimum, that the following changes be made: **Section 2**. Definitions seem duplicative, and some are confusing. We don't think you need a definition of both "diabetes education" and "practice of diabetes education." In addition, you don't need both "diabetes educator" and "licensed diabetes educator." Further, the definition of "accredited training program" is not found except in this definition section. Finally, we don't understand the use of the word "supervisor" and how it's applied in this legislation. **Section 3**. We have two concerns with subsection (2). First, it would seem to require that a physician (nondiabetes educator health care professional) who is not also a licensed diabetes educator must work under the direction of a licensed diabetes educator. That is unacceptable, and in conflict with Section 4. Second, there are no "nonhealth care professional(s)" who could provide any part of diabetes education. As mentioned earlier, with the regulation of medical assistants, there are no longer any "nonhealth care professionals" who would have the legal authority to deliver diabetes education. **Section 4.** A separate section should be created for exemptions. And in that section, we recommend the use of general language that does not require the listing of different professions. However, if professions are listed, then WSPMA would request that the relevant RCW chapters are included to eliminate possible confusion. For example, while podiatric physicians and surgeons would consider themselves included within the "physician" category, we note that the Applicant Report does not refer to them as physicians…but rather as "podiatrists." • In addition, Section 4 seems to negate the stated goal of the legislation by allowing any regulated person, regardless of training, to refer to themselves as a diabetes educator. The language reads: "…and nothing in this chapter may be construed to limit, interfere with, or restrict the practice, descriptions of services, or manner in which they (other regulated health

care professionals) hold themselves out to the public."

- The language in Section (4)(2) is somewhat of a restatement of what's included in subsection (1), so the same comments apply. We would direct the proponents to the exemption language in the recently passed medical assistant legislation as an example.

Section 5. This section creates a State Board of Licensed Diabetes Educators. While we have no objection to the creation of another board, although we think the cost of operating a board will result in licensure fees higher than the proponents expect, we do have concerns on portions of subsection (9) that authorize the Board to adopt rules on certain subjects.

- Subsection (9)(a) should be deleted. The Uniform Disciplinary Act is the code of ethics for all credentialed health care providers. WSPMA sees no reason to create a separate code of ethics for diabetes educators.
- Subsection (9)(b) should be deleted or substantially rephrased. The State of Washington cannot delegate to the American Association of Diabetes Educators the setting of standards for diabetes educators credentialed in this state.
- In addition, WSPMA is uncertain as to what would constitute a "standard of practice" or "standard of professional performance." We believe these issues are already dealt to some extent through the Uniform Disciplinary Act.

Section 6. The language in subsection (3) should be substantially reworked. It does not require the completion of an "accredited training program" which would seem to be the core requirement.

- In subsection 3(a) if the disciplines are listed, then please include the relevant RCW chapters to include 18.22 for podiatric physicians and surgeons.
- Subsection 3(b) is confusing. Who would be authorized to provide diabetes education that is not currently required to be regulated?
- In subsection 3(c) is the "comprehensive diabetes education course" referring to an "accredited training program?" In addition, we do not believe that the Board should set the supervision requirement. It should be set in statute.
- Subsection (d) includes additional authority to the Board. We believe that this must include some type of acknowledgement of prior learning.
- Bottom line, we are confused as to whether there are two pathways for licensure. One would be related to the completion of an "accredited training program" and the other is a pathway created by a board.

Section 7. There is no need for this section. The topic of unprofessional conduct is covered by the Uniform Disciplinary Act.

Section 8. It would appear that the grandfather provision in subsection (1) is left to the judgment of the Board and undefined standards. Subsection (2) is straightforward and leads us to ask: Isn't the intent of the legislation to require some type of national certification in order to become credentialed? If not, why is there a definition for "accredited training programs?"

A continuing theme throughout the Applicant Report, and the intent section of the legislation, is that licensure will address the "current workforce shortage of qualified professionals who can deliver diabetes education." In reality, regulation always functions as a restriction on entry, and therefore will not solve this problem. Further, the Applicant Report states that there should be no reciprocity, which makes no sense since Washington State is a magnet state for health care professionals, and the lack of reciprocity will only worsen, over time, the current workforce shortage noted by the Applicant.

Another continuing theme that is both direct and indirect is the sense from the Applicant Report that physicians are not referring enough to diabetes educators…that physicians don't know the importance of the diabetes educator's role in holding down health care costs. Regulation will not address these concerns, except that it may make it more clear who is a "diabetes educator," something that can be achieved through certification.

We respectfully request that the Department not recommend regulation of diabetes educators at the licensure level.

Andrea Dahlman	As a nutritional therapy practitioner, I spend time daily talking with clients about their blood sugar. This is an issue with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to prevent diabetes. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In has been my experience that every person I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Chelo Gable Vashon, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is an issue with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to prevent diabetes. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Kathleen Kronz, LMP, NTP	I am opposed to the new diabetes Educator Credential Bill. The proposed credential and bill would require professionals who already have a state occupational credential in WA to get a second one as a Certified Diabetes Educator, and to do 15 hours a year of Diabetes continuing education. This would either be on top of any CE's the primary license may require or it would force you to do all

	your CE's in Diabetes care and to go beyond the 15 if you had other professional interests. The bill is too vague saying in one place that it restricts the use of the title Licensed Diabetes Educator but in another it says: "No person may represent himself or herself as a licensed diabetes educator or use any title or description of services without applying for licensure, meeting the required qualifications..." One of the requirements for for a new occupational regulation is that it be demonstrated that harm to the public is occurring from not having a regulation. That burden of proof has not been met. Only unsubstantiated anecdotes or theoretical harm has been offered and this is not sufficient evidence to warrant additional regulation and the burden on professionals that come with it. The bill refers throughout to people with Diabetes or at risk for Diabetes. This is far too broad as people at risk for Diabetes could be the entire population of WA! This in turn would mean that everyone who provides services to these folks could be required to either have this license or work under the supervision of someone who does. The bill attempts to exempt licensed health professionals from having this license but is written in such a way as to suggest even licensed health professions either have to be licensed with this new credential or work under the supervision of someone who has it. Nutritionists who can be Certified in WA are not mentioned anywhere in the bill which if left this way would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. Professionals who are already covered under Medicare as providers of Diabetes Self Management training would no longer be covered unless they got this new credential! The American Association of Diabetes Educators has also introduced legislation at the federal level that would have this same impact. This proposed legislation as written would place restrictions that would have the effect of lowering the nutrition care resources available to prevent Diabetes by increasing regulatory requirements for providers. This would indeed raise costs to the state and individuals instead of slowing the Diabetes epidemic. We are not opposed to having a voluntary credential for those who choose it for marketing or insurance purposes or for the consumer to know a provider's specific background. But it should not: limit providers who already provide preventive care, require dual occupational licensing, or interfere with existing insurance reimbursement for health care providers.
Anne Gienapp, NTP	I am a certified Nutritional Therapy Practitioner, and I often talk to my clients about blood sugar and its relationship to health. Blood sugar management is an issue for many of my clients, including children. In my practice, I focus on educating my clients about ways of reducing blood sugar, and discuss dietary plans that help them avoid blood sugar issues, including diabetes. Essentially, I provide my clients with information and dietary approaches that may help them avoid diabetes and related health issues. I understand that this week, a legislative hearing is scheduled to consider new licensing board and license for Diabetes Educators. The bill would make it necessary to be licensed as a Certified Diabetic Educator (CDE) in order to provide council to those who have a diagnosis of diabetes or those who are at risk of diabetes. In my experience, every person who eats a standard American diet and experiences standard American levels of stress is at risk of becoming diabetic in their lifetime. The bill also expresses concern that the public is harmed from lack of regulation. I disagree; many licensed health professionals, including Nutritional Therapy Practitioners, have thorough training and knowledge that can effectively help individuals address blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of someone

	who may have little or no specific training in nutrition. Acupuncturists, Chiropractors, and Naturopaths are also not mentioned in the bill and would face the same burden. Since dietary tools are a key component of Diabetes care, the bill could have the unintended consequence of limiting access to qualified nutrition resources by raising regulatory requirements for providers and ultimately increasing healthcare costs to the state and individual consumers instead of slowing the Diabetic epidemic. In my opinion, this bill is not in the best interests of the public and it is my hope that this bill is carefully examined and modified so that all health care practitioners with appropriate training are able to provide their knowledgeable services to those facing diabetes and related health issues. Thank you in advance for your thoughtful consideration of this request.
Hanna Hendrickson, WA State	To Whom It May Concern, The pending licensure regarding restricting nutritional advice regarding diabetes has come to my attention. The impacts of an exclusionary licensure concerns me. I agree that diabetic nutrition counselors should be given the opportunity to obtain additional certification which distinguishes their knowledge in the eyes of the public. However, the restricting language of the bill will cause expense and difficulty in gaining help to us, the public. There are many educators who are highly knowledgeable in proper diabetec nutrition. A variety of educators allows nutrition counseling costs to remain competitive and reasonable for the public pocket. A variety of able nutrition counselors also guarantees that each citizen who needs assistance will have access to an able educator of their choice rather than causing difficulty in searching for a specifically certified educator who is allowed to provide help. Please write the bill as title protection legislation only and not as an exclusionary licensure.
Dorothy Sager, B.S> LMP, CNT	I am writing to ask you to restructure the proposal in such a way that highly trained nutrition professionals including Nutritional Therapists Certified by the Nutritional Therapy Association of Olympia, WA can continue to provide valuable services and consulting to the many people who are at risk for developing diabetes. So many people are totally unaware of the behaviors and dietary choices they make every day that are putting them at risk. At this time there is abundant research and clinical evidence of the proper way to shift lifestyle habits and diets to prevent this crippling and costly disorder in our culture. Properly educated and certified professionals who pass extensive practical and written examinations should be able to continue to provide consulting to their clients and referrals who are seeking their help with dietary concerns . Two points from the document by the Nutritional Therapy association are below. • This proposed bill mentions professions such as social workers, psychiatrists, or exercise physiologist as being exempted from the licensure requirement while other highly trained nutrition professionals are omitted. Nutritional Therapy Practitioners (NTPs) are highly trained professionals capable of providing sound dietary advice to those who wish to prevent diabetes. • The Nutritional Therapy Association, Inc. is not opposed to the idea that Diabetic Educators have the opportunity to obtain a voluntary credential that will differentiate their education in the eyes of the public. We believe that this bill should be written as a "title protection only" regulation and not an exclusionary licensure bill. I urge the Washington Department of Health to make appropriate changes to ensure all certified and appropriately trained nutrition professionals can continue to provide their valuable services to the many people who need them, especially those who may not yet be aware of their risk.
Linda Fels, NTP Bellingham, WA	A proposal to create a new Certified Diabetes Educator licensure has come to my attention. The idea of limiting the ability of other practitioners to provide education to persons with diabetes or even anyone at risk for diabetes goes far beyond the scope of the Sunrise Act. According to the WA state website on the Sunrise Review process “a business profession should be regulated or scope of practice expanded only when: Unregulated practice can clearly harm or endanger the health, safety or welfare of the public, and the potential for the harm is easily recognizable and not remote or dependent upon tenuous argument.” Where is the evidence that current practices in our state pose harm and endanger health? Many different licensed and credentialed practitioners currently give effective diabetes education in our state. Restricting this much needed education to a specific credentialed group will lower the availability of this

	information to the public. And please realize that including anyone at risk for diabetes actually includes our whole state population! The proposal would place a huge burden on the state's healthcare costs by creating a new bureaucracy and limiting choices. I object to any proposal giving one group special treatment in the marketplace. If we are truly interested in fighting this diabetes epidemic, we need more access not less. As a Nutritional Therapy Practitioner, I want to protect and preserve my right to practice and to be able to provide my clients help with their dietary concerns. I am not opposed to having a voluntary credential for those who choose it for marketing or insurance purposes or for the consumer to know a provider's specific background. But it should not limit providers who already provide preventive care, require dual occupational licensing, or interfere with existing insurance reimbursement for health care providers. Thank you.
Jodi Cohen,	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is an issue with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to prevent diabetes. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Deborah Lahti, NTP Seattle area	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is an issue with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to prevent diabetes. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.

Barbara Schlitz, CN, RN Clinton, WA	I would like to register my opposition to the Sunrise Application that is being considered for a Diabetes Educator credential and regulatory board. This application, if passed, would require me to obtain a second occupational license in order to continue to provide the customary services I was trained to provide as a Master's-degreed, Certified Nutritionist in the state of Washington. I understand that WADE, under its parent organization AADE, wants a state scope of practice defined in order to allow Diabetes Educators to obtain insurance reimbursement under Medicare. It appears that they wish to create a profession that deals with a specific disease. In addition, the wide-ranging terminology regulating those who work with anyone "at risk for diabetes" would include all who reside in our state. My Masters program included all that is necessary to meet the needs of those with Diabetes and at risk for Diabetes. Diabetes, in reality, is a lifestyle disease. Nutrition professionals are well-trained already to help people learn how to change dietary, exercise, and stress behavior patterns. I don't believe we need a separate regulation and credential for this. Those professionals who chose to get more intensive training focused on treating those already diagnosed with Diabetes should be free to do that, if desired. It is unnecessary for every professional who works with this population to be forced to do this or face the consequences of having limitations put on their practice, or worse yet, be required to work under supervision of someone who may in actuality have less experience and education. I have been in clinical practice since in the state of Washington since 1996. During this time, I also worked in clinical research, participating in IRB-approved trials involving type 2 diabetics and those with metabolic syndrome. Type 2 Diabetes is increasing at an alarming rate. This legislation would restrict qualified people who might be of great benefit to those at risk, or already diagnosed with type 2 diabetes. It is of great curiosity to me that many of the professions that are exempt from this proposed legislation currently have little or no requirement for nutrition training. This includes Social Workers, Psychiatrists, Exercise Physiologists, etc.. At the same time advanced degreed, Certified Nutritionists in the state of Washington would be prohibited from providing diabetes care unless supervised or seeking additional licensure. Does this makes sense? With respect, I request that you reject this Sunrise Application.
Cathrine Louise, Seattle, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Erin Anderson,	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who

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Pam Kozu RN. MN Tacoma, WA	It is my pleasure to write a letter in support of state licensure for diabetes educator. I am the diabetes services manager for MultiCare Health System. It has been my experience that patients deserve to highly skilled diabetes educators to help them navigate the challenges of living with diabetes. It is no small task to adjust insulin along with counting carbohydrates and still go on taking care of activities of daily living. The diabetes educators need to have a background that is so eloquently stated in the documents provided by the Washington Association of Diabetes Educators. There is evidence in the literature to support the work that diabetes educators provide in helping to curb costs especially when deployed in the chronic care models and in the primary care offices. The licensure for diabetes educators will begin to open the doors for diabetes educators to serve as a billable provider in these settings. Currently, the RD is a recognized provider by some insurers in this setting but we are limiting the ability to provide care in settings most convenient to the patients. This offers an opportunity to standardize the care and training. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front lines of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Candice Gruginski RN, CDE, NTP, CFCN	I am writing today to ask you to not pass the Diabetes Educator Licensure bill as it is currently written. I am both a Certified Diabetes Educator (CDE) and a Nutritional Therapy Practitioner (NTP). While I support the idea of a CDE being able to bill medicare and medicaid as a licensed healthcare provider, I do not support the idea of excluding other trained professionals from providing education regarding diabetes and the prevention of diabetes. I became a NTP after working closely with another NTP and realizing that other professions have valuable insight into this complex disease. I would venture to say that my knowledge gained in Nutritional Therapy training has helped me be more successful in educating clients than my CDE credential. Please, do not place restrictions on who can provide diabetes education. Diabetes and diabetes prevention is a huge issue. We need help from a variety of disciplines, including alternative therapies. This is not the time to restrict the number of trained individuals who can provide this service. People need to be given choices about who they see for education. Some people thrive using alternative therapies from trained practitioners while others prefer mainstream medical approaches. We need to make people aware of their options and let them choose the education that best meets their needs. Thank you for your time and consideration in this matter.
Rachael Alm	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime.

	According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Nancy Jo Newman NTP	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful
Rebecca Cody Olympia WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Michelle Hill-DeJesus	It has come to my attention & raised my concern that there are some new proposed regulations in regards to who can assist Diabetes patients in WA. With the rampant course of disease due to the SAD (Standard American Diet), every possible opportunity to outreach to our general population; to promote healthier lifestyles should be welcomed and embraced. We are all on the same team regardless of what exact initials follow our name, and we should band together in

	workshops & support sessions to create a united front to fight this disease.
Jennifer Lind, Kirkland WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Marcie Larsen, BA, NTP, CGP	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Janette Buffington Centralia WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their well being. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. We all know type diabetes 2 is directly correlated to diet...Many doctors support this fact, Dr. Gabriel Cousens MD. being only one of them. Dr. Mercola, Dr. Michael Murray, Dr. Andrew Weil, and many more. It's a fact. It is my hope that this bill is carefully examined and modified to include all health care practitioners with

<table>
<tr><td></td><td>appropriate training. When I work with clients, I use the above mentioned Doctors protocols to help people. Am taking continuing education classes all the time..Required to keep my licensing, and enjoy learning in my trade.

Thank you in advance for your thoughtful consideration of this request.</td></tr>
<tr><td>Sasha Baxter

Bothell, WA</td><td>I am opposed to the proposed bill to license diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime.

According to the CDC, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less.

I am not opposed to those who wish to obtain credentials as Diabetic Educators. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation.

Thank you for your time and consideration.</td></tr>
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I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation.

Thank you for your time and consideration in this matter.</td></tr>
<tr><td>American Nutrition Association,

Neil Lavin, Secretary</td><td>I am writing on behalf of the American Nutrition Association, a national organization of nutrition professionals and enthusiasts. We are requesting the Department of Health oppose the Sunrise Application for the creation of a new License and Licensing Board for Diabetes Educators.

Diabetes, as the application suggests, is a serious, costly and epidemic disease. However it is precisely for those reasons Washington needs all the current provider resources and more, to both counsel people already with diabetes and to prevent future growth of it. All Washingtonians are at risk of diabetes and all professionals with training to address any aspect of it need to be utilized to provide services to the level of their training.

We are concerned that the proposed regulation and legislation will not protect and promote an “all hands on deck” approach, and in fact could be a step backwards. The proposed application and regulation as written:

• places undefined advertising and titling restrictions on those who do not get the proposed Diabetes Educator License;
• appears to both exempt certain health professionals and simultaneously restrict them;
• defines the target consumer population as those with Diabetes and at-risk for Diabetes; the latter potentially includes all Washingtonians;
• does not provide existing evidence of harm from current providers to substantiate need for the proposed restrictions;
• neglects naming nutrition professionals among those health professionals who currently work with people who have diabetes or are at risk for diabetes; and
• requires duplicate occupational licensing of health professionals who already work with and to prevent diabetes
•
As an educational organization that is involved with both consumers and professionals promoting the use of nutrition to prevent and reverse disease, we cannot support any legislation that would in effect reduce the</td></tr>
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	capacity of qualified nutrition practitioners to address the Diabetes epidemic. We therefore respectfully request you deny this application.
Steve Van Nuys, NTP	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Menany Bell Tukwila, WA	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. Thank you for your time and consideration in this matter.
Heidi Meyerholtz Seattle, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is an issue that almost all of my clients encounter. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to prevent diabetes. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you for your time in considering this request.
Amy Spencer, Seattle, WA	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime.

	According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Gwen Kreiger Olympia, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Dawn Davidson Kingston, WA	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Dana Luchini, Gig Harbor, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the

	supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request,
Nina Torres Seattle, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. We should be working together in order to bring the right support to the people that are affected by this condition. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Maxine Johnson NTP Redmond, WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar especially since, over the last two years the focus on sugar and its effects on our culture has emerged to the front page. This is a concern with almost all of my clients, including children. My skills and intention as a healthcare practitioner is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools and knowledge to choose foods and establish dietary habits that keep blood sugars balanced. The bill refers to people with Diabetes or at risk for Diabetes. That pretty much covers all of us! The bill also expresses concern that the public is harmed from lack of regulation. I believe that could not be further from the truth. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. Instead of encouraging discussion on the topic this bill would limit discussion. Furthermore, as regulations go, the entities with the most money will dictate how the discussion will occur, when they will occur, and what the discussion will consist of. In the end, the entities who have the most to lose will dictate to those who simply want to tell the truth. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. How? Because those listed as exempt from the licensure requirement include professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, which is a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. Again – this gagging of all nutritionally-based health care providers except members of the Washington Association of Diabetic Educators

	is nothing more than a grasp to control the content of conversation to enhance the bottom lines of the status quo… namely the ADA and pharmaceutical companies, among others. This certainly is not in the best interest of an at-risk client or a client who has been diagnosed. It is my hope that this bill is carefully examined and modified to include ALL health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Judy Banel Western WA	As a Nutritional Therapy Practitioner in Washington State, I am very aware of a huge percentage of the population is at risk of becoming diabetic in their lifetime. As Nutritional Therapy Practitioners we want to protect and preserve our right to practice and to be able to provide guidance to any who seek our help with their dietary concerns. Regarding the proposed bill for Diabetes Educator Licensure, here are the facts: • The Bill is poorly written and could have the unintended impact of limiting access to qualified nutrition resources by raising regulatory requirements for providers and ultimately increasing healthcare costs to the state and individual consumers instead of slowing the Diabetic epidemic. This proposed bill mentions professions such as social workers, psychiatrists, or exercise physiologist as being exempted from the licensure requirement while other highly trained nutrition professionals are omitted. Nutritional Therapy Practitioners (NTPs) are highly trained professionals capable of providing sound dietary advice to those who wish to prevent diabetes. The Nutritional Therapy Association, Inc. is not opposed to the idea that Diabetic Educators have the opportunity to obtain a voluntary credential that will differentiate their education in the eyes of the public. We believe that this bill should be written as a "title protection only" regulation and not an exclusionary licensure bill. Please take these into serious consideration before supporting any bill which could greatly limit our abilities to help many in need of nutritional education.
Jeannie Dowers NTP	I am opposed to the proposed bill to license diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. This is a concern with almost all of my clients, including children. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you for your time and consideration in this matter.

Ann Whitson, MA, NTP	I am opposed to the proposed bill to license diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals such as Acupuncturists, Nutritional Therapists, and Naturopaths from working with clients who are at risk of becoming diabetic in their lifetime. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every client who eats the standard American diet and experiences standard American stress is at risk for Diabetes. At a time when more intervention and dietary advice is needed, the citizens of Washington should have more, not less, access to those who can provide individualized nutritional guidance. The bill also expresses concern that the public is harmed from lack of regulation. The opposite is true. Many licensed health professionals have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions that require no training in nutrition, a key component of Diabetes care, such as social workers, psychiatrists, or exercise physiologists . I am not opposed to offering credentials for Diabetic Educators requiring specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Jean Jones, RN Tacoma	I am opposed to the proposed bill to license diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators or having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.
Danielle Brooks L.M.P., N.T.P., C.H. Redmond WA	It is my understanding that the Washington Association of Diabetic Educators is asking that the WA Dept. of Health consider a Licensure Bill that could potentially make it necessary to be licensed as a Certified Diabetic Educator (CDE) in order to provide council to those who have a diagnosis of diabetes or those who are at risk of diabetes. After looking at this bill I feel that it is poorly written and could have the unintended impact of limiting access to qualified nutrition resources by raising regulatory requirements for providers and ultimately increasing healthcare costs to the state and individual consumers instead of slowing the Diabetic epidemic. This proposed bill mentions professions such as social workers, psychiatrists, or exercise physiologist as being exempted from the licensure requirement while other highly trained nutrition professionals are omitted. Nutritional Therapy Practitioners (NTPs) are highly trained professionals capable of providing sound dietary advice to those who wish to prevent diabetes.

	I am not opposed to the idea that Diabetic Educators have the opportunity to obtain a voluntary credential that will differentiate their education in the eyes of the public. This would best be written as a "title protection only" regulation and not an exclusionary licensure bill. I am however, opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training.
Kay Hansen Olympia WA	On behalf of the Nutritional Therapy Association, Inc. I would like to express my concern with the proposed bill requiring licensure for those providing nutrition education to persons with or at risk of diabetes, which could essentially include the majority of those eating a typical highly processed, fast-food diet. As written, this proposed legislation would place restrictions that would have the effect of lowering the nutrition care resources available to prevent Diabetes by increasing regulatory requirements for providers. This would indeed raise costs to the state and the suffering of individuals instead of slowing the Diabetes epidemic. Since 2001 the Nutritional Therapy Association has partnered with Community Colleges in Washington to provide comprehensive nutrition training to hundreds of practitioners. These Nutritional Therapy Practitioners are an important resource within their communities for those seeking appropriate dietary advice to protect and support their health and wellbeing. In reviewing the proposed bill, I urge you to seek ways of expanding the nutrition resources available to the citizens of Washington, not limit them. Do not place unnecessary restrictions on skilled practitioners that are ready and able to provide much needed intervention in the prevention of diabetes. Please know that I am not opposed to the establishment of specific standards of education for those seeking to obtain certification as Diabetic Educators. A bill that would create those statutes should be classified as “title protection only” and not a licensure regulation. Thank you for your consideration in this matter.
Karen Dvornich Waterville WA	As a nutritional therapy practitioner, who lost my husband to complications from diabetes, and have diabetic clients, I can assure you that Nutritional Therapy Practitioners as well as many licensed health professionals, have extensive training that helps, not harms, clients to resolve their blood sugar regulation issues. I only wish I had this training while my husband was still alive. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. However, if passes as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition.

	It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you for your time and consideration on this matter.
Holly Guentz, NTP BSN Candidate	Please protect the rights of Nutritional Therapists, Certified Clinical Nutritionists, and other trained holistic nutritionists to advise patients diagnosed with diabetes and patients at risk of developing diabetes. The health of Americans is at stake. We need to support all efforts to promote healthy dietary habits in American people today! The Issue: The Washington Association of Diabetic Educators is asking that the WA Dept. of Health consider a Licensure Bill that could potentially make it necessary to be licensed as a Certified Diabetic Educator (CDE) in order to provide council to those who have a diagnosis of diabetes or those who are at risk of diabetes! Based on what Nutritional Therapy Practitioners know about the Standard American Diet (SAD), a huge percentage of the population is at risk of becoming diabetic in their lifetime. As Nutritional Therapy Practitioners we want to protect and preserve our right to practice and to be able to provide guidance to any who seek our help with their dietary concerns. Here are the facts: •The Bill is poorly written and could have the unintended impact of limiting access to qualified nutrition resources by raising regulatory requirements for providers and ultimately increasing healthcare costs to the state and individual consumers instead of slowing the Diabetic epidemic. •This proposed bill mentions professions such as social workers, psychiatrists, or exercise physiologist as being exempted from the licensure requirement while other highly trained nutrition professionals are omitted. Nutritional Therapy Practitioners (NTPs) are highly trained professionals capable of providing sound dietary advice to those who wish to prevent diabetes. •The Nutritional Therapy Association, Inc. is not opposed to the idea that Diabetic Educators have the opportunity to obtain a voluntary credential that will differentiate their education in the eyes of the public. We believe that this bill should be written as a "title protection only" regulation and not an exclusionary licensure bill.
Kathaleen Briggs Early, PhD, RDN, CDE, Assistant Professor, Nutrition and Biochemistry, Certified Insulin Pump Trainer	I am submitting this letter in support of licensure for diabetes educators. I want to urge the Department of Health to move ahead with the sunrise review process in the hopes that this can become law in our state. Our state licenses a number of professionals from physicians and dentists, to athletic trainers, phlebotomists, genetic counselors, and dispensing opticians. Diabetes education is clearly unique and important health care service which should also be licensed to protect the public's interest. Licensure of diabetes educators will set standards of practice for professionals who are on the front lines of the most costly chronic disease our state faces. Almost 6 out of every 100 adults in Washington has diabetes; a rate which has doubled since 1995. In 2012, the cost for diabetes-related medical expenses in Washington totaled $5.11 Billion, and indirect expenses totaled over $1.36 Billion. Poor diabetes self-management often results in costly complications (e.g., improper foot care leading to financial, physical and emotional toll of amputation). Complications related to diabetes can be prevented and/or reduced by proper diabetes self-management education and training. Currently, without licensure, anyone can offer "diabetes education". I fully support the efforts of the Washington Association of Diabetes Educators (WADE) as they seek licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem throughout our state. If we are to make advances against this devastating disease we must improve and strengthen health care

	education and providing licensure for diabetes educators will do just that.
National Association of Nutrition Professionals Nicole Hodson Ex. Director Rancho Cordova, CA	I am writing on behalf of the National Association of Nutrition Professionals (www.nanp.org), a nonprofit professional business league for holistically trained nutrition professionals, and in opposition of the hearing regarding licensure of Diabetes Educators. Regulating an occupation that has not demonstrated harm to the public is wasteful, at best. To date, only unsubstantiated anecdotes or theoretical harm has been offered, and so there is not sufficient evidence to warrant the additional regulation. Additionally, the bill refers throughout to people with Diabetes or at risk for Diabetes. This is far too broad, as people at risk for Diabetes could be the entire population of WA! This in turn would mean that everyone who provides services to these folks could be required to either have this license or work under the supervision of someone who does. Furthermore, the bill is too vague, saying in one place that it restricts the use of the title Licensed Diabetes Educator but in another it says: "No person may represent himself or herself as a licensed diabetes educator or use any title or description of services without applying for licensure, meeting the required qualifications..." Nutritionists who can be Certified in WA are not mentioned anywhere in the bill which if left this way would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. Additionally, professionals who are already covered under Medicare as providers of Diabetes Self-Management training would no longer be covered unless they got this new credential. The American Association of Diabetes Educators has also introduced legislation at the federal level that would have this same impact. This proposed legislation as written would place restrictions that would have the effect of lowering the nutrition care resources available to prevent Diabetes by increasing regulatory requirements for providers. This would indeed raise costs to the state and individuals instead of slowing the Diabetes epidemic. While we are not opposed to having a voluntary credential for those who choose it for marketing or insurance purposes or for the consumer to know a provider's specific background, it should not: • limit providers who already provide preventive care, • require dual occupational licensing, or • interfere with existing insurance reimbursement for health care providers. Finally, the proposed credential and bill would require professionals who already have a state occupational credential in WA to get a second one as a Certified Diabetes Educator, and to do fifteen (15) hours a year of Diabetes continuing education. This would either be on top of any CE's the primary license may require or it would force you to do all your CE's in Diabetes care and to go beyond the fifteen (15) if you had other professional interests. Our association requires ten (10) CEUs per calendar year for professional membership renewal and fifteen (15) per year for our Board Certified members. If this bill were to pass, all of our WA members' CEUs would have to be in Diabetes care, leaving out other critical training necessary in maintaining a well-rounded nutrition credential.

	For these reasons, we strongly urge you oppose this bill. Please feel free to contact me directly via email at execdir@nanp.org or by phone at 831-975-5227
Krizten Breidenich, NTP	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is an issue with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, in essence giving them the dietary tools to support their well being. I noticed the bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard Amercian stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, including Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to heal their blood sugar regulation issues. Nutritionists (who can be Certified in WA state) are not mentioned anywhere in the bill. If passed as written, this would mean they would have to either become licensed as a CDE or work under the supervision of one who very potentially would be someone with less training and experience. They are not included in the list of licensed health professionals which include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also left out and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Rebecca Proulx, NTP Cle Elum WA	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners

	with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Jennifer Johnsen, NTP	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Megan-Rylee Uhrich, Olympia, WA	I am opposed to the proposed bill to licensed diabetic educators. As written, the bill could be interpreted to exclude many highly trained natural health and wellness professionals from working with clients who are at risk of becoming diabetic in their lifetime. According to the Center for Disease Control, from 1980 through 2011, the number of Americans with diagnosed diabetes has more than tripled, from 5.6 million to 20.9 million. At a time when more intervention and dietary advice is needed, the citizens of Washington should have additional access to those who can provide individualized nutritional guidance, not less. I am not opposed to those who wish to obtain credentials as Diabetic Educators of having specific standards of education in order to obtain CDE certification. A bill that would establish those statutes should be classified as "title protection only" and not a licensure regulation. Thank you for your time and consideration in this matter.

Leslie Merklin-Barber BSN, RN, CDE Western Washington	It is my pleasure to write a letter in support of state licensure for diabetes educator. As a person living with diabetes for the past 24 ½ years I know I would not be where I am at without the support I received from my CDEs (Certified Diabetes Educators) back in 1988. I was given such a great start with my diabetes that I went on to become a Diabetes Educator 5 years later and earned my own CDE in 1994, by sitting for the exam, which I've sat for a total of 3 times and most recently renewed by CE of 75 hours over 5 years . I am very proud to carry the credential of CDE. What I am now very concerned about is that anyone can say they are a health educator or life coach and teach patients about diabetes without having the credential of CDE or the knowledge and experience a CDE carries. I have personally worked with dietitians and other health care providers who "claim" to have the same knowledge as I have in regards to diabetes management and care. However, when I see patients who have been in the care of these "counterfeit" diabetes educators I find patients with diabetes so out of control and disillusioned about their own abilities to manage their diabetes, I have to start back at the beginning. I frequently hear "if I had this information when I first got started, I would be in better health today". (Research has shown that when patients get their diabetes in control and maintain control for the first 10 years, they can delay/prevent complications by 20 to 30 years.) The following is an example of what I am most concerned about. I saw a patient with type 2 diabetes about 4 years ago (for the first time). She had previously seen a RD upon her diagnosis of diabetes. At our first visit I asked her how her blood sugars were. She stated she had not started checking her blood glucose as she was told all she needed to do was lose some weight and it wasn't time to start checking yet. I got her monitoring her blood glucose that day and her BG was > 250 mg/dl and was having a very difficult time staying awake during our appointment. Her A1C was around 11%. After seeing me for 3 months and monitoring her A1C had come down to around 7% and she felt much better and alert during our entire appointment. Now 4 years later my patient has neuropathy in her feet and has a fair amount of pain related to the neuropathy. This RD has told people she is a diabetes educator yet she does not have the credentials of CDE, and despite my encouraging her to take the exam she has refused to go the extra mile for her patients. I have seen several patients in the recent past previously seen by this RD and everyone of them I go back to the basics on blood glucose monitoring and daily management routines (eating 3 balanced meals/day with snacks as needed, how to take their

	medications, the importance of activity, coping with diabetes, reducing the risks for complications and problem solving).. This RD is a danger to our community with diabetes if she continues to give them information that does not move them into self-management mode for their diabetes. One reason for licensure would be to keep this particular RD from doing to other patients what she has done to the particular patient. Licensure will assure the public that the education and training provided by a licensed professional will be accurate and safe. Licensure will set standards of care provided by professionals who are at the front line of the war against the epidemic of the most costly chronic disease our generation faces. In 2012, the cost for diabetic medical expenses in Washington totaled $5.11 billion, and indirect expenses totaled over $1.36 billion. The current lack of standards in the training and education provided to those with a diagnosis of pre-diabetes and/or diabetes contributes to poor self care management that more than often results in diabetes complications i.e., improper foot care leading to financial, physical and emotional effects of amputation. In conclusion, I fully support the efforts of WADE as they seek legislation for licensure for diabetes educators. I personally see this action as a vital move in the fight against a serious and costly epidemic that poses a major public health problem. If we are to make advances against this devastating disease we must improve health care education and providing licensure for diabetes educators will do just that.
Judith Ames	Trends of obesity and diabetes are of grave concern in the US. The field of nutrition, as seen in an ever changing stream of advice, is a controversial one. To limit the support being offered at this time would be a mistake. To limit the advice to ***any*** single perspective is a disservice to the public. It is useful to think of how monopolies limit choice in the field of health as well as in business. The bill refers to people with Diabetes or at risk for Diabetes. As a nutritional therapy practitioner, I find blood sugar control to be of primary concern for the majority of my clients. I help them resolve blood sugar issues, which can escalate into diabetes, by giving them the dietary and lifestyle tools to support their well-being. The bill also expresses concern that the public is harmed from lack of regulation. Studies indicate that limiting licensure limits the number of providers. Many licensed health professionals, as well as Nutritional Therapy Practitioners, lifestyle and nutritional coaches, nurses, high school counselors, sports coaches, bloggers, and trained nutritionists have extensive training and knowledge that helps clients to help people manage their blood sugar. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request

Kari Elliott, NTP	As a nutritional therapy practitioner, I often talk to clients about their blood sugar. This is a concern with almost all of my clients, including children. My intention is to help them avoid blood sugar issues, including diabetes, by giving them the dietary tools to support their wellbeing. The bill refers to people with Diabetes or at risk for Diabetes. In my experience, every person that I meet who eats the standard American diet and experiences standard American stress is at risk for Diabetes. The bill also expresses concern that the public is harmed from lack of regulation. I very much believe the opposite is true. Many licensed health professionals, as well as Nutritional Therapy Practitioners have extensive training and knowledge that helps, not harms, clients to resolve their blood sugar regulation issues. If passed as written, natural health practitioners would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners with appropriate training. Thank you in advance for your thoughtful consideration of this request.
Kathleen Givan RN MS CDE	I regret to say that this opportunity for comment did escape me as the deadline for comment was July 31, not august 2nd as I had thought. However, this comment is in support of those who champion the rights of individuals with Diabetes to have providers who are supported by standardized credentials. To that point, the provision of Diabetes Education must be sourced in a process that is authentic. The only standard which presently exists is that of a Certified Diabetes Educator whose credential is earned through The National Board. It is a concern that the ambitions of a few individuals has clouded this issue and portends to represent a large body of educators such as the Washington Association of Diabetes Educators since few if any of the members of that body had any opportunity to discuss or propose alternative ideas. There is no legitimacy in the effort to license Diabetes Educators if the CDE is not the basis for minimum standard of provision. Sincerely, Kathleen Givan RN MS CDE

Pam Kozu RN, MN Manger Cardiovascular/Diabetes Services, Multicare	Thank-you for taking the time to review such an important issue. My initial stance on this issue was in support of licensure. I have taken the time to study the issue in depth and I no longer believe that licensure is the best strategy for the diabetes educator going forward. In my experience, at Multicare, we hire licensed RD's, RN's and Pharmacists to provide diabetes education to our patients. The proposed law would only add an additional layer of licensure that is not necessary to for this profession to move forward. I believe there are other strategies that can be employed to reach our goals. I also believe this licensure requirement would limit our ability in the medical homes for the MA's to provide some basic diabetes education that they have been asked to provide on a regular basis for some time. I am not in favor of licensure for diabetes educators. Thank-you for your attention.
Tammy Caruthers RN BC MSN Ed.D	I believe they should be licensed as they are providing information of a very serious nature. Licensing would require updates in their training and allow only qualified individuals to give this information.
Maxine Johnson, PT, NTP Redmond WA 98052	As a certified nutritional therapy practitioner I am concerned and very much opposed to the pending legislation that would require a person to be licensed before they could speak about diabetes to someone at risk for developing diabetes or to someone who has been diagnosed with it. As a natural health care practitioner, I am trained to speak about blood-sugar dysregulation including hypoglycemia, hyperglycemia and the lifestyle that precludes these conditions. It is well within my current scope of practice to assess a client's health status and guide them to making nutritional choices that will support healthy blood sugar balance even if they have already been diagnosed with diabetes. But let me make myself clear – I do not diagnose nor treat any disease including diabetes. I am trained to bring dysfunctional body systems, that includes blood-sugar imbalances, into balance using food and nutritional supplements and exercise (I am also a personal trainer). I have had wonderful results with my clients who are compliant with the program. They have lost substantial amounts of body fat and have been able to keep their blood

	sugars within healthy ranges and have either reduced medications or have been able to avoid them altogether. This pending legislation would silence me and other healthcare practitioners like me from speaking to almost everyone we see about blood sugar dysregulation because almost everyone we see who is suffering from a chronic ailment also has blood-sugar dysregulation. We have found in many cases that type 2 diabetes is the result of years of consuming a diet rich in refined foods and deficient in nutrient-dense foods that have been properly prepared. So that is what I teach. I teach people who are suffering from chronic ailments resulting from blood sugar imbalance to choose foods that will bring their bodies back into balance and I have had remarkable results! Guiding people in this way often helps them avoid dangerous drugs and gives them the tools to take control of their health in the healthiest and most natural way. Because almost everyone in this country who is choosing to eat the Standard American Diet (SAD) is at risk, requiring licensure to even have conversations regarding blood sugar would not only place another obstacle in the way of someone seeking help, it would also "funnel" these at-risk clients away from natural choices and into the allopathic system that relies on drugs and poor health choices. Let me give you an example. About a year ago I had a client who was diagnosed with Type 2 Diabetes. I had worked with her before as a personal trainer so she called me again for help. I had since become certified in Nutritional Therapy so I was able to help her with both exercise and nutrition. We worked together for 7 months and she lost 62 lbs! In addition, she was able to avoid drugs and was able to reduce her blood pressure medication as I cooked for her and taught her how to cook nutrient-dense proteins, healthy fats, and vegetables – she completely eliminated grains from her diet. Her diet consisted of: • whole chicken • whole turkey • salmon • pot roast • homemade bone broth for her soups • homemade sauerkraut • avocado • raw almonds and macadamia nuts • all types of green vegetables • all brightly-colored vegetables

- full-fat, homemade mayonnaise
- full-fat, homemade sour cream
- full-fat, homemade yogurt
- real butter

But an interesting event occurred as she was going through this.
One day, as she was waiting in her doctor's office for her checkup, she noticed a little pamphlet in her doctor's waiting room. It said on the front "Top 10 Diabetic Snacks" and she opened it. Inside it listed these allowable snacks (my comments added):

1. 20 potato chips (now found to be one of the unhealthiest snacks a person can buy)
2. 3 cups of popcorn (although "low-calorie" it is also low nutrient and is all carbohydrate)
3. ½ cup ice cream (will be either high sugar per oz, highly processed low/non-fat, or sweetened with chemicals)
4. 2 Oreo cookies (sugar and hydrogenated fat)
5. ½ cup canned fruit (processed/nutrient-deficient)
6. Jell-O Pudding Snacks (processed/nutrient-deficient and contains harmful chemicals)
7. Tuna salad with 4 saltines (tuna salad is ok depending on the mayonnaise, but saltines are made with hydrogenated fat)
8. Processed cheese sticks (processed food)
9. Simply Jif Peanut Butter (processed – added sugar and hydrogenated oils)
10. 1 small apple or orange (good – although 1 cup of berries is better)

**Almost every one of these foods is processed by a huge food company and is virtually void of the vitamins and minerals that a diabetic needs for proper blood-sugar balance and hormonal balance.

So my client questioned her doctor as to why a pamphlet like this was in her waiting room. The doctor said "because most of my patients really don't want to change their lifestyle – they want to continue eating as they are and rely on the drugs to keep their blood sugar stable".

Consequently, this doctor was shocked, as she watched my client lose weight and bring her blood sugars under control without drugs using food and exercise only. She said she had never seen this before. The sad thing is that she was content to just prescribe medication and keep that little snack list in her waiting room for her patients. At no time did she

	express trying to help my client avoid drugs or change her lifestyle. Quite the opposite. She continued, for a short while, to urge my client to get on Metformin. And what is very troubling is that is probably all this doctor knew. Is this the best our medical system can offer? Is this the type of care this pending legislation will continue to support? And because of this, how can one not be suspicious that the request for this legislation is nothing more than a ploy to keep suffering clients in the allopathic system and on drugs and keep practitioners like me who can truly help them regain health, silenced. Who stands to benefit from the passage of this legislation? Certainly not the patient/client! But the drug companies would continue to benefit, along with the Big Food conglomerates who have created a whole market of processed foods targeted for the diabetic consumer. If you research the suggested snacks for diabetics listed above, you will see that most of them are highly processed with virtually no minerals left in them at all. If passed as written, natural health practitioners like me would have to become licensed as a CDE or work under the supervision of someone who potentially has less training and experience. Those listed as exempt from the licensure requirement include several professions such as social workers, psychiatrists, or exercise physiologists who may have no training in nutrition, which is a key component of Diabetes care. Acupuncturists, Chiropractors, and Naturopaths are also omitted and would face the same burden. It is my hope that this bill is carefully examined and modified to include all health care practitioners, including Nutritional Therapy Practitioners, with appropriate training or that the legislation not be passed at all. My question is also where is the system broken? Are people not getting well because we don't have enough regulation? No. It's because we don't have enough education getting to the client on how whole, nutrient-dense foods and regular exercise can help them avoid diabetes and/or help mitigate the harm and effects of diabetes on their bodies. Thank you for your time and consideration,
Patrick Plumb	The second presenter and the subsequent question about the rural/poverty areas are getting information, but it is not GOOD information and it is not made on best available science. The passing reference to Telehealth services needed to be expounded upon. The other question to the second presenter that was next about saying you can drive hundreds of miles in Eastern Washington is kind of a stretch..... she needs to come visit Tonasket WA on invitation from the Mayor. We

	have more than 1 car. Our primary care providers refuse to address insulin pumps and have tried to refer me to Wenatchee (2 hour drive, multiple cars I see on Hwy 97) who still do not meet a good standard as far as I am concerned as a Type 1 diabetic of 23 years without noted complications. It was a great point from talking about the team approach that the ARNP referred to from Snohomish County Edmonds, her identifying a multiple disciplinary approach is awesome and should be replicated. Evidence based guidelines is crucial to making a difference in diabetes self management. I would support her being appointed to a board for licensure of DSMT. Follow up by a coordinator at clinics should be a scope of practice for all clinics in the state. This commenter sounded awesome!! I would strongly support the point of the second presenter in saying accountability is crucial and having a board to investigate practices that are not performing to standard or someone acting out of their scope of practice is what is going to be the difference between a healthy life or a slow and painful death for diabetics such as myself. I agree with the gentleman that said that Osteopathic Physicians need to be included in the laws to be able to provide diabetes education and services and allow anyone with a Doctor of Medicine or Doctor of Osteopathy to provide them. I do not agree with him that it doesn't require licensure. The issue isn't dealing with physicians it is dealing with other licensed staff or non-licensed staff that are providing the services. The RN that commented that suggests that licensure is not necessary is wrong. I am not sure that this lady has ever went to a diabetes camp. Maybe she should try doing that and see how a team of providers can help with diabetes care. Just because you have an RN does not mean without extensive training can give me holistic diabetes education. The FQHC folks spent a lot of time explaining their services but didn't talk enough about diabetes. I appreciated her comments about working to the top of their licensure, that's why we need DSMT licensure so we can assure they too are working to the top of their licensure. Doctors diagnose diabetes. Registered Dietitians do not, but they think they can give dietary suggestions that may not be in line with diabetes best practice standards, and that is why we need licensure for any people that want to treat diabetic patients.

	It certainly is crazy that a layperson or a chiropractor right now can say that they can "cure" diabetes and they also can perform diabetes care. If this dude can prove to me that acupuncture can cure Type 1 diabetes, he's the crazy one, not the beauty shop person. Licensure is not going to regulate speech, it is going to limit people putting up a sign and saying that they are diabetes educators. This guy built so many straw men it is ridiculous. I agree with the lady that suggested licensure will open the gateway to Medicare reimbursement. Diabetics need providers of services to have specialized care. This also could provide an opportunity for HCA to improve their policies on diabetes educator reimbursement. The pharmacist representative needs to explain how pharmacies can bill for flu shots around the state. Primary care providers or endocrinologists should have to sign off on what the diabetes educator recommends as a plan of care and adjustment, they should not be able to make permanent changes to the record without a provider sign off. The Primary Care Physician really needs to be the hub of the entire diabetes care spectrum of services. The whole reason this issue came up is because RDs and RNs ARE trying to tell patients how to manage their insulin outside of their scope of license. That is the reason to establish baselines of people that are providing this service through licensure. It will subsequently improve access to diabetes care. Instead of the term supervisor it should be Care Coordinator and Educator. The key item that was not addressed at the formation of the board is that I could not serve on this board as a diabetic because I work at a hospital. I think that 2 more positions should be added to the board without strings attached for someone with diabetes and also for a clinic manager. Please change this portion of the legislation to reflect that. I would be more than happy to testify at the legislature in support of this proposal and I look forward to seeing this finalized.
Glen Felias-Christensen BS, RN, MPH	Thank you for the opportunity to offer my opinions. I am an RN with almost two decades of experience in the community health setting. Almost 10 years of that has been working with diabetics 40+ y/o, the majority being low income older adults with limited support systems and multiple co-morbidities. In this setting, I did not have

	the pleasure of having a "mentor" to supervise my every move with regards to the diabetes education I provided my patients. Despite my not having a CDE, or even "formal" education on diabetes education, I have managed to help a senior with dementia, living alone and at risk of being evicted, bring down his A1c level from 15% to 7% in two years time; prevent for several years, hospitalizations of another senior who previously had regular visits to the ER for hyperkalemia; and avoid the amputation of several seniors with diabetic foot ulcers through my foot care - all in collaboration with their health care providers and other community providers (just a few examples from the many DM patients I've worked with). One point I'd like to make with these examples is that my lack of "proper credentials" did not prevent me from providing excellent diabetes care and self-management education that actually improved the lives of my patients and reduced health care costs by preventing their need for higher levels of care. It's not that I did not want to obtain a CDE, but the requirements to get it was such a barrier for nurses like myself who worked in autonomous settings with no clinical supervisors or medical directors. I had even given up trying to get the CDE and left the diabetes education field altogether, only to find myself still passionate about the field and returning to it. I am now trying to focus on doing more to bring ongoing essential diabetes education to older adults, yet I am still not in supervised clinical settings so I doubt I will ever have the opportunity to obtain a CDE because I don't want to leave the community setting. This new proposal will only make it even harder for dedicated nurses like myself to continue providing diabetes education to older adults who have had diabetes for several years, who do not necessarily respond to the standard approaches used for younger adults or even middle-aged adults. It is especially difficult to "reach" older adults who are poor and marginalized, with few support systems, when they can't afford to pay for the diabetes classes or need more support than the allotted number of covered hours for "review" education. These seniors would benefit from receiving diabetes education in the community, outside of the clinic or hospital setting, on an ongoing basis. If this proposal passes, it is highly doubtful that community settings would be able to afford the newly licensed CDE, creating another barrier to bringing essential diabetes education to those who are in need of it. I disagree with the statement that "...the proposed legislation will

	ensure quality by developing a legal scope of practice, education requirements, continuing education requirements, and establishing an outlet for consumers reporting..." More education and regulations do not necessarily lead to better quality. A nurse with just a few years of experience who has fulfilled all the CDE requirements but hasn't developed a strong ability to build rapport and establish trust is not necessarily going to provide more "quality" education than a nurse with many years of experience working with many kinds of patients but has not completed all the CDE requirements. In this sense, I think the definition for "quality" used in this proposal is too rigid. If this proposal passes, I anticipate fewer patients actually receiving ANY diabetes education. As it is, there are patients who can't afford to pay for the "accredited" DE programs, so they go without it and end up not managing their diabetes well. We should be trying to increase our "reach" of hard to serve patients, not decreasing them, which is what will likely happen if CDE's become so difficult to obtain because of the additional requirements, and patients are required to only get their education through these CDE's. Those proposing this change might consider the "ulterior motive" underneath it -- job security. Who wouldn't want to protect their job field from over dilution? Making it even harder to practice diabetes education by requiring licensure will make it necessary to rely on the few with the licensure. Is this ultimately truly patient focused? Would the new licensure really allow us to reach more patients? Or will it simply allow the nurses with the licensure to put yet another alphabet soup of letters after their names and command higher incomes?
Sincerely, Kathleen Givan RN MS CDE	I regret to say that this opportunity for comment did escape me as the deadline for comment was July 31, not august 2nd as I had thought. However, this comment is in support of those who champion the rights of individuals with Diabetes to have providers who are supported by standardized credentials. To that point, the provision of Diabetes Education must be sourced in a process that is authentic. The only standard which presently exists is that of a Certified Diabetes Educator whose credential is earned through The National Board. It is a concern that the ambitions of a few individuals has clouded this issue and portends to represent a large body of educators such as the Washington Association of Diabetes Educators since few if any of the members of that body

	had any opportunity to discuss or propose alternative ideas. There is no legitimacy in the effort to license Diabetes Educators if the CDE is not the basis for minimum standard of provision.

National Certification Board for Diabetes Educators

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August 23, 2013

Sherry Thomas
Washington State Department of Health
Health Systems Quality Assurance
PO Box 47850
Olympia, WA 98504-7850

Dear Ms. Thomas:

The National Certification Board for Diabetes Educators (NCBDE) is writing in regards to the Sunrise Review application that would require diabetes educators to become licensed in Washington. The proposal, H-1847.3/13, applies a licensure requirement to health professionals who provide diabetes self-management training for persons with or at the risk of diabetes.

NCBDE has administered the only national Certified Diabetes Educator® (CDE®) certification program since 1986. Almost 18,000 health professionals are currently recognized as CDEs, including 501 CDEs who reside in Washington. In achieving certification, a candidate must have fulfilled rigorous eligibility requirements, including licensure/registration in a recognized health care profession, Diabetes Self-Management Education/Training (DSME/T) practice experience and, evidence of completing acceptable continuing education programs. Once eligible, a candidate must pass a psychometrically valid competency assessment examination before certification is awarded. In passing the examination, CDEs demonstrate distinct and specialized knowledge in the provision of DSME/T, thereby promoting quality care for persons with diabetes.

NCBDE applauds the idea of addressing the need for qualified diabetes educators to care for a significantly increasing population of persons with diabetes or prediabetes. We also support efforts to broaden recognition of the discipline. Achievement of such goals can dramatically improve the quality of care for, and lifestyle of, citizens who must live with this devastating disease.

However, NCBDE is concerned that H-1847.3/13 falls short of fulfilling those goals and will encourage the licensure of health practitioners inadequately prepared or qualified to provide DSME/T. We hope you'll consider the following points in regard to the proposal as drafted:

1. **H-1847.3/13 does not require a non-certified health care practitioner to successfully pass a standardized, psychometrically valid competency assessment examination.**

Not all licensed diabetes educators in Washington will have had to demonstrate the ability to apply DSME/T knowledge to the care of persons with diabetes or prediabetes. While eligibility pathways may vary in certification programs, all eligible candidates must take and pass a standardized examination, thus creating a "level playing field." In so doing, a certification program establishes a single, consistent foundation for awarding a credential. H-1847.3/13 would permit certain health care practitioners to receive the same credential (in this case a license) as all diabetes educators without having to pass a standardized examination, thus demonstrating equal competency or knowledge.

The current proposal sets up two very distinct tiers of diabetes educator – one who has taken and passed an examination and one who is not required to pass an examination. Given this two-tiered structure, there is no assurance that acceptable "minimum standards for patient safety" will be achieved. In fact, the proposal may even lower the bar by licensing educators on the basis of the lowest common denominator. This is particularly troubling when one contemplates the licensure of someone who has failed NCBDE's certification examination to become a CDE® or AADE's certification examination to attain the board certified advanced diabetes management credential (BC-ADM).

It is also unlikely that any other licensure process in Washington, including most NOT in the health care arena, allows licensure without a competency assessment at some time in the individual's preparation, e.g., the need for home inspectors to pass an examination to become licensed when an individual working in the health care field as a diabetes educator could theoretically become licensed without having taken any sort of examination to verify their level of knowledge.

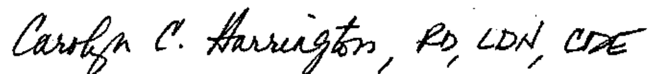
2. **Licensure and certification are not mutually exclusive.**

When standards for licensure and certification are synergistic they do support the improvement of standards of care. In the case of H-1847.3/13, the licensure and certification standards are so incompatible that we believe that standards of care will be adversely affected. It will discourage health care professionals from seeking peer recognition through certification in favor of easily obtaining a license without demonstrating competency to provide care.

NCBDE understands that state licensure laws are intended to protect the welfare of its citizens. With respect to this proposal, however, we believe that it will achieve the opposite. It will place citizens at risk by failing to minimize opportunities for unqualified and incompetent health care practitioners to care for persons with diabetes.

Thank you for the opportunity to present our feedback in response to the Sunrise Review application for proposal H-1847.3/13.

Sincerely,



Carolyn C. Harrington, RD, LDN, CDE®
Chair, NCBDE Board of Directors

Certification Board for Nutrition Specialists℠

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August 26, 2013

Washington State Department of Health
111 Israel Road SE, Tumwater, WA

Dear Ms. Weeks, Ms. Staley, Ms. Welliver, and Mr. Lee,

The Certification Board for Nutrition Specialists appreciates the opportunity to give further comment on the Diabetes Educator Sunrise Application. These comment appends our earlier testimony sent on August 6th 2013.

We would like to express at the outset that we support both WADE and AADE in their endeavor to provide high quality education targeting the disease of diabetes, and to let both the professional and lay public know who has met that standard through some form of state recognition. We also recognize the benefit of having a government credential that would extend insurance coverage for diabetes self management training to qualified providers who may not otherwise qualify.

We believe that these goals can be accomplished under a lesser form of regulation defining a scope, such as certification-title protection. This would not place an additional regulatory burden on providers already actively involved as team members or sole providers of diabetes education.

A person with diabetes who believes they have been given bad information can file a complaint with the professional licensing board of the provider in question. There are also a variety of civil channels for pursuing such complaints already well established. We therefore respectfully disagree with the testimony stating that such a person has no avenue of recourse for care they believe was harmful or incompetent. Licensure, as enforcement data from many professionals shows, has never been a guarantee against the missteps of bad actors however such complaints and anecdotes of poor care are still exceedingly small in number. We wholeheartedly support the efforts to improve the training and credentialing opportunities for those involved in care of patients with pre-diabetes or diabetes as long as the opportunities do not simultaneously have the consequence of barring those already providing care.

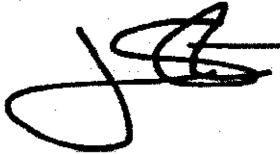
We also question the basis for the underlying suggestion that care provided by

Sidney J. Stohs, PhD, CNS, FACN, ATS, President
Jeffrey Blumberg, PhD, FACN, FASN, CNS, Executive Vice President
Corinne L. Bush, MS, CNS, Vice President ■ **Stanley J. Dudrick**, MD, CNS, FACN, Vice President
Jonathan W. Emord, JD, Vice President

professionals who are not certified diabetes educators is not evidence based. Our Certified Nutrition Specialists like many other health professionals are trained in evidenced based care, and in the ability to identify anecdotal evidence versus that grounded in scientific data collection.

Finally, we ask the Department to take into consideration the downstream consequences of an exclusive scope licensure regime for a single disease. No health professional is expected to be a specialist in every area covered under his or her scope of practice. It is a combination of professional ethics, continuing education, and professional collaboration that helps create the environment in which individuals deliver the best care possible. Offering the opportunity to deepen one's training in a given specialty area is to everyone's benefit. However mandating licensure in each of those areas would not be sensible or cost effective public policy.

Very truly yours,



Judy Stone
Legislative Policy Director
Certification Board for Nutrition Specialists

Appendix F

Rebuttals to Draft Recommendations

Diabetes Educator Sunrise Review Comments

Name Co	mment
Dan Rubin, Consultant	From the perspective of a member of the public, a person with diabetes and a professional in health policy who is largely retired after many years of active involvement, I support the conclusions of this Sunrise Review. I agree that there are other ways to achieve quality objectives and I agree that licensure has the potential to create barriers to broad reach and innovative approaches in diabetes education. Program accreditation and individual certification by non-governmental bodies remain more appropriate methods. Increasing specialization has unintended negative consequences in rural areas and within many specific language/culture groups that do not have the concentration of need and market necessary to sustain the professional model of full-time specialists. We desperately need flexible integration of good services in health care, not proliferation of more and more institutional and professional hegemonies. I have great respect for diabetes educators I have known but I do not support this approach. Since I am a consultant, I will stress that I have no financial stake in this issue and to my knowledge none of my consulting clients (all non-profit organizations), have any position one way or the other. I am commenting as an individual.
Frank Hensley, Diabetes victim Member, Medical Quality Assurance Commission	I support the Department's opposition to licensing Diabetes Educators. It is backed by sound reasoning. It would discourage other capable people from providing much-needed diabetes education. And we simply don't need to license every conceivable activity. (This is my personal opinion and does not represent a position of the Medical Quality Assurance Commission.)
Edwin Hill, PhD	I agree with the DOH's analysis of the issues regarding the licensure of Diabetes Educators--It is not necessary and could cause more harm than good. Please work to deny Diabetes Educators from becoming a separate Profession that requires Licensure in the State of Washington! Thanks!
Dennis and Norene	DOH has sent out still another document, one of many received by practitioners. This one is 230 pages in total! Who has time to read (in detail) and take time to understand all these proposals? No wonder practitioners need to stack and file patients like cordwood in an electronic system and follow only one-size-fits-all standard practices. They are so busy with record keeping, formatting required information, and getting signatures on agreements to absolve them from liability that they no longer have time to know their patients as individuals, take time to understand their lifestyle and address compliance issues. In this respect, I believe that increasing the bureaucratic burden further will only make the situation worse. What is most needed is knowledgeable and competent individuals with integrity who deal individually with patients and are able to work with them to achieve their highest level of functioning. There are already standards and means of addressing complaints. Nothing in this proposal will do much to enhance health, although it will grow the bureaucracy and endorse allopathic medicine. If allopathic medicine were already successful, the incidence of diabetes would not be continuing to increase. Too much govt is a major problem in medicine today. It is driving the best and brightest practitioners

	from the field. Those are always the first to leave simply because versatile and talented individuals can seek opportunities elsewhere. Part of the solution might be reducing the budget for DOH to what it was 10 years ago, or less. It has become a millstone about the necks for many who were once much more successful at restoring health. Instead of making sure they have a right to practice and do what works, nowadays it has become is a limitation on the scope of their practice and reduced successful outcomes… by admission of your own statistics.
Kathie Itter Executive Director Washington Osteopathic Medical Association	Thank you for the opportunity to comment on the Diabetes Educator Sunrise Review Draft. On page 12 of the draft it states that osteopathic physicians asked to be included in the list of health care practitioners eligible to be licensed diabetes educators if the bill is enacted. **This is incorrect.** If you review the testimony of David Knutson on page 146, the request was that osteopathic physicians be included in the in the list of professions whose practice is not altered or modified by language establishing the license of Diabetes Educator. In other words, osteopathic physicians want to be exempt from the requirement to license diabetic educators. Their scope of practice already includes diabetes education and to require a secondary license to do so is a waste of time and money. I would appreciate a response indicating that this correction has been made.
Karla Gray LICSW, OTR/L Director Adult Inpatient Services	Thank you for asking for comments regarding the licensure of Diabetic Educators. I support the recommendation to NOT license diabetic educators in Washington state, regardless of what other states have done and the recommendations of a national organization of diabetic educator. Below, I have copied specific rationale presented in the Executive Summary of the distributed Diabetic Educator Sunrise Review DRAFT which I particularly agree with and provided my comments. Thank you, again, for soliciting comments. The proposal does not meet the sunrise criteria for the reasons below: 2. The proposal will result in unintended harm to particular populations. By limiting the number of health care professionals who can provide diabetes education, barriers to access will be created, particularly among those who rely on community health centers and rural clinics for services. People who live in poverty, are geographically isolated from centers of populations, or are physically disabled have limited opportunity to access a primary care provider without having to wonder if the insurance claim will be denied because the person is not a licensed diabetic educator. 3. The proposed legislation will likely prevent or discourage doctors, nurses, and other qualified health care professionals from providing diabetes education to their patients as fully as they may have otherwise done. Diabetes is a complex disorder and no single discipline has all of the most up to date information that ensures successful management of/adjustment to the variety of potential sequelae that are unique to each individual. Diabetes is one of those conditions that is best managed by a team of professionals, each bringing their unique contributions to the patient who makes decisions about what to incorporate into his/her life. 4. The proposal would place a second burden of state licensure, renewal frees, and education requirements on already licensed health care professionals operating within their scope of practice. Working in a hospital I, an occupational therapist, frequently worked with people who had modified a routine to accommodate a dietary change or medication regime, purchased a piece of adaptive equipment, or used a particular style of clothing based on recommendations made by internal 'diabetic educators'

	who had no knowledge about either the patient or the environment in which they lived and were so incongruent with the patient's goals, lifestyle, home environment, physical abilities, or cognitive ability that the patients had essentially given up trying to manage their condition. I was struck at how many times the patient had been poorly served either by people who were under the erroneous impression that they knew everything about what needed to be done (or were territorial enough that they didn't want other professions involved) or our historical system of providing health care in silos and hoping the patient could figure out what they needed and how to get it. 5. The proposed legislation would result in expanding the scope of practice beyond the current level of training and experience of some health care practitioners. See comment under 4 above 6. There are currently processes in place for the public to file complaints against practioners who provide substandard care or commit unprofessional conduct. Licensing for diabetes educators for the purpose of providing oversight and discipline will be a costly and unnecessary duplication of regulation. Agree 7. The public can already reasonably expect to receive quality team-based diabetes education services from health care professionals working within their scope of practice. With ongoing support from the community, including not-for-profit diabetes and chronic disease education programs, the public can be effectively protected in a cost beneficial manner. As long as the health care professionals have informed themselves of the role of other disciplines in educating the patient/family and developing effective management interventions. In addition to failing to meet the sunrise criteria, the proposed bill contains numerous factors, errors and contradictions that would make it difficult to implement because it: 1. Does not place this new profession in the Uniform Disciplinary Act (UDA), chapter 18.130 RCW. 2. Appears to both exclude and include certain professions. Excludes occupational therapists, physical therapists, recreational therapists, vision therapists, ophthalmologists, optometrists, and others 3. Requires non-diabetes educators to work under the supervision of a diabetes educator when providing DSMT. Because of contradictory language within the bill draft, considerable confusion exists about whether or not highly trained and independent practitioners such as physicians would be required to work under a diabetes educator when providing DSMT. Concur! 4. Defines unprofessional conduct differently than the UDA and has very narrow sanctions. Concur! 5. Allows for automatic licensure if the applicant who has national certification without regard for other factors such as the applicant's disciplinary or criminal history. I am not aware of any profession that is guaranteed automatic licensure in the state.

Lis Houchen	On behalf of the members of the National Association of Chain Drug Stores (NACDS) operating in Washington State, I would like to submit our comments on the proposed licensing of diabetes educators. NACDS members in Washington include Bartell Drug Company, Costco Wholesale, Genoa Healthcare, Good Neighbor Pharmacy, Haggen/Top Food and Drugs, Health Mart, Hi-School Pharmacy, Medicine Shoppe International, Ominicare, Pharmaca Integrative Pharmacy, Rite Aid Corporation, Roasauer's Supermarkets, Safeway, Inc., Sears Holding Company (Kmart), Shopko Stores, Supervalu (Albertsons), Target Corporation, Walgreen Company, and Wal-Mart Stores, Inc. These nineteen companies operate 798 pharmacies, employ over 102 thousand full and part-time employees and pay over $1.04 million in state and local taxes. We appreciate the time and effort the Department of Health dedicated to reviewing the Legislative request to conduct a Sunrise Review of a proposal to license diabetes educators. NACDS and its members agree with the findings of the Sunrise Review Committee in that the mandatory licensing of diabetes educators would raise unnecessary barriers to existing patient education, treatment and coordination of care. Community retail pharmacists operating in the State of Washington recognize the magnitude of the diabetes epidemic and are actively providing extensive patient counseling and medication therapy management to individual patients with diabetes as a mechanism to engage patients in better managing their disease. In many communities throughout Washington, pharmacists are the first line of defense and most readily accessible heath care providers. Pharmacists are the most highly trained professional in medication therapy management and disease state management including diabetes. Pharmacists already received a minimum of six years and in many cases eight years of college, with four years enrolled in a College of Pharmacy where they study medication uses, dosing, side effects, interactions and patient care. As highly trained and accessible healthcare providers, pharmacists are uniquely positioned to play an expanded role in ensuring patients take their medications a prescribed. By requiring additional training and licensure community retail pharmacists would be denied the ability to continue providing the detailed care to diabetes patients which is currently allowed by their scope of practice. As a result there would be an unnecessary interruption of care for patients who need one-on-one counseling and assistance in managing their disease. Therefore, on behalf of our members, NACDS respectfully asks that the Sunrise Review Committee send forward their recommendation to not pursue the licensure of Diabetes Educators and preserve patient access to needed health care services.
Kathryn Kolan, JD Director Director of Legislative and Regulatory Affairs	On behalf of the Washington State Medical Association (WSMA) and its 9,800 physician and physician assistant members, we are submitting comments on the . We look forward to working with you as the Department of Health (Department) moves forward with this proposal. Thank you for the opportunity to share our comments. The WSMA shares the concerns of the Department with regard to the proposed regulation of diabetic educators and agree that the proposal does not meet the sunrise criteria for the reasons as identified by the Department. Specifically, the WSMA agrees with points made in the Diabetes Educator Sunrise Review sections identified as "Detailed Recommendations to the Legislature" that begins on page 15 of the draft summary and recommendations[1]. We believe that the points made by the Department offer sufficient reason for the proposal to be rejected. Thank you for the opportunity to share our concerns. If you have any questions, please feel free to contact Kathryn Kolan at (360) 352-4848 or kak@wsma.org.

Claudia Sanders, Senior Vice President for Policy Development	On behalf of its members, the Washington State Hospital Association (WSHA) supports the Washington State Department of Health's recommendation to oppose licensure requirements for diabetes educators. WSHA understands the importance of requiring credentials to ensure that those serving patients have the appropriate education, experience, and training. Like other health organizations, hospitals hire employees that meet at least the state credential requirements for their profession. As discussed in the draft sunrise review report, there may be times that adding credential requirements limit the number of health care professionals who can serve patients. With the implementation of the Affordable Care Act, WSHA is concerned about shortage of primary care and other skilled providers who can care for the influx of new patients. In some rural areas, it can be difficult to recruit and retain qualified health professionals. WSHA's concerns are not about the specific merits of diabetes educator licensure, but rather the need to consider how adding credential requirements impacts the supply of health care professionals operating within their scope of practice. As the department considers other sunrise reviews, it should continue taking workforce issues into consideration. WSHA understands that this is an intricate balance between protecting patients by ensuring health care professionals meet competency standards and providing patient access to health care professionals. WSHA believes that the department should preserve its flexibility so that health care professionals can continue providing needed services. If you have any questions, please feel free to contact me.